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COMPARISON OF HEALTH INSURANCE PROPOSALS FOR OLDER PERSONS, 1961–62

PREPARED BY THE STAFF

OF THE

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INTRODUCTORY NOTE

This comparison of the major health insurance proposals for older persons which have been introduced thus far in the 87th Congress has been prepared by the Staff of the Special Committee on Aging. The basic provisions of the various bills have been charted without editorial comment. However, because I believe it is essential to safeguard the user against misinterpretation, I am prefacing the chart with a few words of explanation.

Some of these proposals, although financed through the Federal Government, offer the beneficiary the option of choosing among private health insurance plans—indeed one proposal relates exclusively to private insurance. The fact that a legislative proposal spells out a package of health benefits to be obtained through private insurance does not mean that such benefits are actually available, nor does it mean that the benefits specified could be made available for anything like the premium amount provided through the proposed plan. Language that says the private plan must have an "actuarial value" equal to that of the Government plan does not mean that the individual would pay no more in premiums than the cost of the Government plan.

It is obvious that commercial insurers cannot offer equivalent benefits at a lower cost than that of a Government plan even if they were to forego all profits—a very unlikely possibility. Yet so long as an option is provided, the sales pressure which insurance companies could bring to bear on those older people who constitute the better risks might be such that many individuals unskilled in the complex art of understanding insurance policies would contract for coverage costing more than equal protection under the Government plan. By the same token, such an approach would also tend to leave the poorer, more expensive risks to burden the Government plan. It is essential that a social insurance health plan be based on community rating, as Blue Cross and Blue Shield were supposed to be on their initiation. The entire group of older people to be insured, the good and the bad risks together, must be in the one plan if it is to be soundly financed.

Moreover, option provisions would mean that social insurance contributions would be used to pay profits to private insurance companies, thus spending dollars which buy no protection.

Terms also can be confusing. For example, "guaranteed renewable" means only that premiums or benefits may not be modified for an individual, but is no guarantee against rising premiums for all those covered by the policy. Options for private insurance must be carefully scrutinized with respect to such provisions as lifetime maximums and exclusions of preexisting conditions.

Another such example is the use of the phrase "free choice" to characterize proposals offering options for private insurance. Such options invariably result in higher costs, or less protection for the same costs. "Free choice" when it means the right to choose one's own doctor is meaningful and most important. "Free choice" when it means merely the right to choose among insurance carriers offering less protection or charging higher premiums than the Government plan lacks all meaning and represents only a misleading slogan.

Three basic questions should be kept in mind in assessing these various proposals. Is not our Social Security system the one mechanism through which people can provide for themselves, on a group basis and at a price they can afford to pay, hospital insurance for their later years which is paid up prior to old age? Is not this the method through which our older population can be relieved of the intolerable burden of rising and unpredictable health costs or of ever higher insurance premiums against these costs? Will not the utilization of this social insurance method to help meet the necessarily higher health costs of older people provide both stimulus and opportunity for private profit and nonprofit insurance plans to devise more acceptable and less expensive programs to meet the health costs not covered by the legislation or of younger groups in the population?

PAT MCNAMARA,
Chairman, Special Committee on Aging.

COMPARISON OF HEALTH INSURANCE

Administration bill Anderson (S. 909), King (H.R. 4222)	*McNamara (S. 65)	*Holland (H.R. 94)[1]
The Method in Brief		
Through Social Security financing, provides health benefits at age 65 without further contribution. Benefits are specified and uniformly available for hospitalization, nursing homes, home health services, and outpatient diagnostic services.	Through Social Security financing, provides health benefits on retirement without further contributions; through general revenue financing, covers other retired aged. Benefits similar to King-Anderson, except no deductibles.	Through Social Security financing, provides health benefits for all persons eligible for OASDI benefits, including younger beneficiaries. Benefits similar to King-Anderson (except no deductibles) plus surgeon's fees.
Eligibility		
All persons 65 or over eligible for OASI or railroad retirement benefits regardless of current earnings. Eligibility automatic.	All "retired" men 65 or over and women 62 or over—i.e., who have total earnings of less than $2,400 a year or $100 in each of 3 months or who are 72 or over (other than railroad and Federal retirees)[2].	All persons eligible for OASDI benefits, including younger beneficiaries.
Includes 15 million—5 out of 6—aged in 1964. Almost all aged eligible in future.	1962 coverage estimate 16.1 million (15 out of 16) including 13.2 million OASI beneficiaries, 1.5 million OAA recipients, and 1.4 million other retirees.	January 1962 coverage estimate approximately 17.5 million, of whom roughly 14.6 million are aged.

See footnotes at end of table, pp. 6 and 7.

PROPOSALS FOR OLDER PERSONS, 1961–62

Javits (S. 2664 as amended May 2, 1962)	Lindsay (H.R. 11253)	Bow (H.R. 10755)
The Method in Brief		
Uses Social Security financing, plus general revenue financing for uninsured aged who are subject to an income test unless past age 72. (Prior to amendment, all under 72 were subject to income test.) Beneficiary selects among (a) short-term benefits with no deductible, (b) longer-term benefits with deductibles or (c) payment of up to $100 toward premiums for approved private health insurance policy.	Uses Social Security financing and benefits, identical to King-Anderson, in combination with (1) a cash option for individuals having private insurance of specified requirements and (2) "Buying-in" for the Government plan benefits through a Kerr-Mills-type program for aged not eligible under Social Security.	Financed entirely from general revenues. Provides for an income tax credit (or certificate for purchasing insurance) of up to $125 a year for private medical insurance of specified types purchased by or on behalf of persons 65 and older.
Eligibility		
Persons 65 or over who are eligible for OASI benefits or who meet income test—i.e., have income of no more than $3,000 ($4,500 for a married couple)—or are age 72; but excludes anyone receiving "medical aid" under a federally supported assistance program.	Same as King-Anderson and in addition, would cover aged persons who meet State means tests and are brought in through State action.	Any person 65 and over who is a beneficiary of a qualified private insurance policy.
As amended, estimated to cover 16 million in mid-1963.[3]	Includes 15 million eligible for OASI or railroad retirement benefits in 1964 plus an unknown number who might be covered by States which "buy-in."	Potentially includes the total population 65 and over (17½ million as of 1963) but actually would be limited to those aged who are acceptable risks to private insurance carriers.

COMPARISON OF HEALTH INSURANCE

Administration bill Anderson (S. 909), King (H.R. 4222)	*McNamara (S. 65)	*Holland (H.R. 94) [1]
Benefits		
Hospitalization: Inpatient hospital services for up to *90* days per benefit period, with $10 per day deductible required for first 9 days, with a minimum deductible of $20. *Nursing Home:* Skilled nursing home services after transfer from a hospital, for up to *180* days per benefit period. *Maximum* on combination of hospital services and nursing home services: 150 units of service with one "unit" equalling 1 day of hospital service or 2 days of nursing home service. *Home Health Services:* Intermittent nursing care, therapy, and homemaker services for up to *240* visits a year. *Outpatient Hospital Diagnostic Services:* As required, but subject to $20 deductible for each diagnostic study. *Drugs:* All drugs used in hospital or nursing home.	*Hospitalization:* Inpatient hospital services for up to *90* days a year. *Nursing Home:* Skilled nursing home services after transfer from a hospital, for up to *180* days a year. *Home Health Services:* For up to *240* days a year. Includes therapy and homemaker services; medical social work, etc. *Maximum* on combination of hospital services, nursing home services and home health services: 90 units of service with 1 "unit" equalling 1 day of hospital service, 2 days of nursing home services or 2⅔ days of home health services. *Outpatient Diagnostic Services:* Necessary laboratory tests and X-rays in a hospital. *Drugs:* All drugs used in hospital; for outside hospital, a portion of such drugs when prescribed generically. Precise amount and kinds of coverage to be determined by Secretary of HEW, after study, and within actuarial limits. *Research:* Research and demonstration projects to improve quality and efficiency of health services.	*Hospitalization:* Inpatient hospital services for up to *60* days a year. *Nursing Home:* Skilled nursing home services after transfer from a hospital for up to *120* days minus the number of days of hospital services. *Surgical Services:* Full payment of fees for surgery provided in hospital, or for emergency or minor surgery in outpatient department of hospital or in doctor's office. *Drugs:* All drugs used in hospital.

See footnotes at end of table, pp. 6 and 7.

PROPOSALS FOR OLDER PERSONS, 1961–62

Javits (S. 2664 as amended May 2, 1962)	Lindsay (H.R. 11253)	Bow (H.R. 10755)
Benefits		
Eligible individuals may choose 1 of 3 options of which the first 2 are Government plans: (1) Preventive short-term illness benefits consisting, during the calendar year, of (a) 21 days of hospital care (except that the individual could request substitution of skilled nursing home services at a rate of 3 days for 1 day of hospital care); (b) physicians' services for 12 days; (c) up to $100 of ambulatory diagnostic laboratory or X-ray services; and (d) 24 days of organized home health care services; *OR* (2) Long-term and chronic illness benefits, providing payment of 80 percent of the cost in excess of $125 incurred by the beneficiary during the calendar year of (a) 120 days of hospital care; (b) surgical services provided in a hospital; (c) skilled nursing home services after transfer from a hospital; and (d) organized home health care services; *OR* (3) Payment to an insurance carrier of premiums up to $100 per year on a renewable private health insurance policy that provides benefits which the Secretary of HEW determines to be of a value not less than the value of benefits under options (1) or (2).	Eligible individuals have option between: (1) coverage under the "Government plan" which provides the same benefits as the King-Anderson bill; *OR* (2) monthly cash payment if covered by a qualified private health insurance policy or health benefits plan which has an actuarial value equal to that of the Government plan; (cash payment is to be $8 per month initially, but after 2 years of operation could be varied according to age to take account of adverse selection of risks against the Government plan). To qualify, a private health benefits plan must be "guaranteed renewable for life." A plan may qualify even though it has a range of benefits different from the Government plan so long as (a) its benefits in the categories covered by the Government plan have a value of at least 60 percent of the Government plan and (b) its benefits for all categories combined have an actuarial value at least equal to that of the Government plan. Beneficiary choosing option (2) may assign his cash payment to a carrier.	A tax credit (or certificate for purchasing insurance) up to $125 a year on a guaranteed renewable insurance policy, the minimum benefits of which are either of the following two options: (1) (a) Hospital room and board up to $12 per day, and up to $1,080 in a calendar year; (b) up to $120 in a calendar year for ancillary hospital charges; (c) convalescent hospital room and board up to $6 per day, and up to $186 in a calendar year, following confinement in a general hospital; and (d) surgical charges according to a fee schedule with a $300 maximum; *OR* (2) A plan with up to 25 percent coinsurance and subject to a deductible and lifetime maximum (either a deductible of not more than $100 in a calendar year with a lifetime maximum of not less than $5,000, or a deductible of not more than $200 in a calendar year with a lifetime maximum of not less than $10,000) which provides more extensive benefits of the type under option (1) plus physicians' and nurses' fees and drugs and related requirements.

COMPARISON OF HEALTH INSURANCE

Administration bill Anderson (S. 909), King (H.R. 4222)	*McNamara (S. 65)	*Holland (H.R. 94)[1]
Financing		
Increase of ¼ of 1 percent in social security tax for employees and employers (⅜ percent for self-employed) and increase in amount of earnings taxable from $4,800 to $5,000.[4]	(a) For Social Security eligibles, increase of ¼ of 1 percent in social security tax for employees and employers (⅜ percent for self-employed); additional increase of ⅛ of 1 percent in 1971. (b) General revenue financing of benefits for uninsured.[5]	Increase of ¼ of 1 percent in social security tax for employees and employers; ⅜ percent for self-employed.
Costs (First year)		
$1¼ billion.	$1.1 billion.	$1.4 billion.
Administration		
Under established Federal OASDI system, with States and accrediting bodies used in determining eligibility of providers to participate, etc. Providers could use nonprofit agents to represent them.	Generally same as King-Anderson. Secretary of HEW may use public agencies and nonprofit organizations for appropriate tasks.	Generally same as King-Anderson. Secretary of HEW may use nonprofit organizations for appropriate tasks.

*These bills were introduced early in 1961 before the most recent amendments to the Social Security Act. The estimates of the number of Social Security eligibles and of costs have not been revised to reflect these amendments; they are shown as originally developed in order to coincide with the financing provided in the bill.

[1] H.R. 94 is the same as the Forand bill (H.R. 4700) of the 86th Cong.

[2] The bill provides that Congress should take action as soon as possible to make available to railroad retirement and civil service annuitants a program under which they can obtain the same type of services as those made available to OASI beneficiaries.

[3] Prior to the amendment which eliminated the income test for persons eligible for OASI benefits, the sponsor's summary of the bill stated: "Out of an estimated 16 million persons 65 and over, 12.3 million would be eligible. Excluded are 2.2 million on old-age assistance; over 1 million have earnings over $3,000; and more than ½ million are covered under other Federal programs." The sponsor's estimate of costs based on the estimate of 12.3 million eligibles was $1¼ billion.

PROPOSALS FOR OLDER PERSONS, 1961–62

Javits (S. 2664 as amended May 2, 1962)	Lindsay (H.R. 11253)	Bow (H.R. 10755)
Financing		
(a) For Social Security eligibles, increase of ¼ of 1 percent in social security tax for employees and employers in 1963 (⅜ percent for self-employed); additional increase of ⅛ of 1 percent in 1972. (b) General revenue financing of benefits for uninsured.	(a) Same as King-Anderson for Social Security eligibles; (b) General revenues of States and Federal Government for uninsured; Federal share—55 to 85 percent of expenditures in State.	Financed from general revenues.
Costs (First year)		
As amended, estimated at $1.6 billion.[3]	Amount by which cost would exceed King-Anderson would depend on effect of option. Cost of buying in for uninsured could exceed cost of present Kerr-Mills programs.	If all qualify, total cost about $2.1 billion in 1963. Allowing for savings in public assistance funds and offset of medical deductions on tax returns, net cost could exceed $1¾ billion.
Administration		
States make payments for health services. Other functions Federal except as may be delegated to States.	Generally same as King-Anderson. State insurance commissioners would determine whether private insurance plans qualified under the option for cash payments toward premiums, and State agencies would determine if uninsured meet means tests.	Treasury Department would administer.

In relation to the estimates for the bill as originally introduced, however, it should be noted that the population 65 and over will be about 17½ million (not 16 million) in mid-1963 when the proposal would be effective. The amendment was not accompanied by the sponsor's estimate of coverage and costs. An estimate by the Department of Health, Education, and Welfare places the number of eligibles under the amended bill at about 16 million, and the annual rate of benefit outgo at about $1.6 billion, assuming no old-age assistance recipients eligible (estimates would be higher to the extent that States took advantage of this program rather than providing "medical aid" under the assistance programs).

[4] Administration has recommended increasing the taxable earnings base to $5,200 instead of $5,000. The tax resulting from the increase in earnings would also finance an increase in monthly benefits to the earners involved.

[5] Estimates developed at the time the bill was introduced indicated a cost for the noninsured of $290 million, part of which is already being spent; approximately $265 million in Federal funds is now expended for OAA, MAA, and other Federal medical programs for aged; net new cost estimated at about $25 million.

LIST OF HEALTH INSURANCE BILLS

Other health insurance bills introduced in the House of Representatives of the 87th Congress through May 10, 1962, are listed here, classified according to the Legislative Calendar of the Committee on Ways and Means:

Health insurance benefits for social security beneficiaries through OASI	Federal grants to States to provide health insurance for aged with limited incomes	Credit against income tax for medical care insurance premiums
H.R. 195—Ashley. 676—Gilbert. 1765—Dulski. 2407—Dingell. 2443—Roberts. 2518—Rabaut. 2762—Gilbert. 3448—Kowalski. 4111—Halpern. 4168—St. Germain. 4222—King. 4309—Dingell. 4313—Karsten. 4314—Machrowicz. 4315—Green (Pennsylvania). 4316—Ullman. 4447—McFall. 4534—Pucinski. 4921—O'Neill. 7793—Santangelo. 11390—Bennett (Michigan). 11641—Daniels.	H.R. 4731—Curtis (Massachusetts). H.R. 4766—Stafford.	H.R. 10981—Bow.* 11039—Harsha. 11043—Berry. 11053—Derwinski. 11064—Kearns. 11065—Knox. 11066—MacGregor. 11075—Schenck. 11087—Collier. 11089—Ellsworth. 11091—Harrison (Wyoming). 11092—Hiestand. 11095—King (New York). 11096—Michel. 11097—Miller (New York). 11098—Nelsen. 11101—Bass (New Hampshire). 11105—Johansen. 11106—Lipscomb. 11107—May. 11109—Van Pelt. 11110—Shriver. 11114—Clancy. 11116—Harvey (Indiana). 11119—Hosmer. 11120—Mailliard. 11139—Moorehead (Ohio). 11189—Glenn. 11194—McDonough. 11203—O'Konski. 11276—Mosher. 11466—Barry.

*Differs from Representative Bow's H.R. 10755 primarily through addition of a statement of purpose.

Senate bills:

In the Senate, the earlier Javits bill (S. 937) was cosponsored by Mr. Cooper, Mr. Scott, Mr. Aiken, Mr. Fong, Mr. Cotton, Mr. Keating, Mr. Prouty, Mr. Saltonstall, and Mr. Kuchel.

S. 909 (Anderson) is cosponsored by the following Senators: Mr. Douglas, Mr. Hartke, Mr. McCarthy, Mr. Humphrey, Mr. Jackson, Mr. Long of Hawaii, Mr. Randolph, Mr. Engle, Mr. Magnuson, Mr. Pell, Mr. Burdick, Mrs. Neuberger, Mr. Morse, Mr. Long of Missouri, Mr. Moss, and Mr. Pastore.

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