# BLUE CROSS AND OTHER PRIVATE HEALTH INSURANCE FOR THE ELDERLY

## HEARINGS

BEFORE THE

## SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

## SPECIAL COMMITTEE ON AGING

## UNITED STATES SENATE

EIGHTY-EIGHTH CONGRESS

SECOND SESSION

**PART 1**

WASHINGTON, D.C.—APRIL 27, 1964

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

33-420 WASHINGTON : 1964

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C., 20402 - Price 20 cents

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NOTE.— Three hearings on Blue Cross and other private health insurance were held as follows:
Part 1— Washington, D.C., April 27, 1964.
Part 2— Washington, D.C., April 28, 1964.
Part 3— Washington, D.C., April 29, 1964.
Part 4A—Appendix.
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# BLUE CROSS AND OTHER PRIVATE HEALTH INSURANCE FOR THE ELDERLY

MONDAY, APRIL 27, 1964

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE ELDERLY
OF THE SPECIAL COMMITTEE ON AGING,
*Washington, D.C.*

The subcommittee met at 10:10 a.m., in room 4232, New Senate Office Building, Senator Pat McNamara (chairman of the subcommittee) presiding.

Present: Senators McNamara, Williams, Neuberger, Muskie, Dirksen, and Fong.

Present also: Jay B. Constantine and Frank C. Frantz, professional staff members; Patricia Slinkard, chief clerk; Toby Berkman, research assistant; and John Guy Miller, minority staff director.

Senator MCNAMARA. The hearing will be in order.

Unfortunately, we have to start with an apology, because there was a quorum call the first thing and several of the Senators will be here in the next few minutes, we hope. They are responding to the live quorum.

This morning, we begin 3 days of public hearings on a matter of great interest and importance both to the public and the Congress, the health needs of the 18 million Americans who are 65 years of age or over.

Actually, the hearings will focus on just one phase of this broad problem. We will be concerned with the cost, coverage, and benefits of health and hospital insurance protection available to the elderly from private insurance companies and the Blue Cross plans.

As everyone here knows, there is a continuing public discussion over the need, or lack of it, for a social security-financed system of hospital insurance for the aged.

On the one hand, there are those who say the private insurance industry, plus existing Federal, State, and local programs, can do the job adequately. On the other hand, there are those who say they can't, and that additional legislation is necessary.

It is important, I believe, to a fuller understanding of this public issue, to define as precisely as possible, the present and potential role of the private insurance industry, and Blue Cross, in meeting the health needs of the elderly.

A number of serious questions have been raised in recent months over the ability of the private insurance industry and Blue Cross to meet these needs. Doubts have been concentrated in three major areas, the actual number of older persons who have some form of health insurance policy; the quality of that coverage in terms of benefits, and the cost of the protection.

A fourth area we hope to explore is the availability of this protection to those who do not now have it.

Finally, we hope to develop enough factual information, so that interested persons, including the Congress, can make objective judgments on the central question, which is:

Is there adequate health insurance protection available from private sources for people over 65 at a price they can afford?

To that end, the Subcommittee on Health of the Elderly has invited the major health insurance companies in the field; the industry's associations; officials of the Blue Cross plans; representatives of appropriate Government agencies, including experts on medical economics; representatives of labor and consumer groups; and other interested and knowledgeable persons to testify.

It is a pleasure to note that all of those invited have accepted, and have stated their intention to cooperate with the subcommittee in developing the necessary information.

This includes not only the formal testimony being presented today, but also answers to questionnaires submitted several weeks ago to several of the largest insurance companies offering special policies to senior citizens.

We have asked all of our witnesses to limit their oral testimony to about 5 minutes, which will be a summary, with the understanding that the full text of their statements will be placed intact in the permanent record of these hearings.

We are doing this so that members of the subcommittee, who have had an opportunity to study the statements in advance, will have more time for questioning, to develop additional pertinent information.

Our first witness this morning is a representative of the Social Security Administration, Dr. Ida C. Merriam, Director of the Division of Research and Statistics.

Senator DIRKSEN. Mr. Chairman.

Senator MCNAMARA. Senator Dirksen.

Senator DIRKSEN. At the beginning of the hearing may I submit a statement?

Senator MCNAMARA. Senator Dirksen has a statement to be submitted for the record, and without objection it will be included at this point in the record.

(The statement referred to is as follows:)

STATEMENT BY HON. EVERETT MCKINLEY DIRKSEN, U.S. SENATOR FROM ILLINOIS

It is our aim that medical care be available to all Americans under a system providing—

1. Greatest possible freedom of choice;
2. Minimum financial burdens;
3. Optimum personal dignity; and
4. Maximum flexibility for continued efficient growth of the world's finest medical care.

In achieving this purpose, there is a role for government. Most appropriately it should give priority, in order, to local, State, and Federal assistance. The late President Kennedy noted this when he said "Effective public health measures and medical care depend, in the last analysis on action at the community level."

The role of government should be held to the minimum practical if the primary role of individual responsibility with freedom is not to be usurped. If excessive tax burdens are to be avoided, government's role should be limited to supplementation of private initiative, both corporate and individual. The role of the

individual and family, which years ago stood almost alone as the medical care bulwark along with voluntary charity agencies, remains preeminent.

That the freedom and dignity which are coadunated with individual responsibility should be destroyed is unthinkable to most Americans. During the last 30 years, however, we have seen emergence of a new force in provision of medical care—voluntary health insurance. Its acceptance by the American people has given unparalleled evidence of their determination to continue exercise of intelligent, individual initiative wherever possible.

Necessitated by increasing complexities in society which have been more than matched by new developments in medicine, this new force is a product of American corporate initiative.

Health insurance, under consideration today with special reference to older people, constitutes a remarkable demonstration of the responsiveness of America's singular talent for corporate initiative, both profit and nonprofit. It will be interesting to review the way in which it is responding to the need of older Americans. Use of the present tense in reference to its effort on behalf of older people is especially appropriate because these are truly new developments.

Health insurance accomplishments to be reviewed during these hearings have almost all occurred in the last 5 to 10 years. Major experiments have been undertaken during the last year or two. More may be expected.

I recognize that the story which will unfold will reveal some mistakes. Blue Cross and the insurance industry can no more be expected to make progress without mistakes than can an individual.

They made mistakes 30 years ago. The voluntary health insurance system which evolved, however, has taken a permanent place in our national life. From what we already know, we may be sure the story of health insurance for older people will be dramatic. It will demonstrate again that when new demands develop, the American system responds effectively.

The willingness of the insurance industry and Blue Cross to appear here voluntarily reflects their desire to find answers to problems which are still emerging. This spirit of cooperation can only bode well for the Nation and its older people. Pursuing the facts in a spirit of good will should result in addition of important information.

I am confident all look forward to such a result with the hope that new knowledge will accelerate the magnificent beginning made by voluntary health insurance on behalf of older people.

Senator MCNAMARA. We are very glad to have you here this morning, Dr. Merriam. We would like you to proceed.

## STATEMENT OF DR. IDA C. MERRIAM, DIRECTOR OF THE DIVISION OF RESEARCH AND STATISTICS, THE SOCIAL SECURITY ADMINISTRATION

Dr. MERRIAM. Thank you, Senator. I have with me, Mrs. Lenore Epstein, Deputy Director of the Division and the person who has carried the major responsibility for our 1963 survey of the aged. I am here to present data from that survey. This survey was undertaken by the Social Security Administration with the Bureau of the Census acting as its agent in collecting and tabulating the information. This is the most comprehensive survey of the aged ever undertaken in the U.S. Government.

It utilizes a representative multistage area probability sample of the entire civilian aged population of the United States. Thus it covers both beneficiaries and nonbeneficiaries of social security. It includes the institutionalized as well as the noninstitutionalized.

Within the past 60 days, we have released the first of our findings, concerning income of the aged in 1962. The analysis of earnings and work experience in that same year has now been completed and we are preparing to release this material within the next few days.

Your committee staff has asked me to focus these remarks on our findings with regard to health insurance, hospital utilization, and medical care costs. We have completed a great deal of work in these areas and are prepared at this time to discuss what we have learned up to the present. Much work remains to be completed, however, and data from later tabulations will be analyzed and released over the next few months.

The basic result of the survey on the extent of health insurance is that about 9 million persons aged 65 and over, or 51 percent of the aged persons in the United States at the end of 1962, had some form of hospital insurance. Another 1 percent had coverage for other types of medical expense but without having hospital insurance. Forty-three percent had surgical insurance: But at least 8⅓ million aged persons were without any type of health insurance protection.

The insurance coverage figures do not in any way reflect the effectiveness of the coverage. An aged person who has hospital insurance which would pay $5 a day for 30 days is counted along with the person who has insurance that would pay all of his expenses in a semiprivate room for 180 days. I shall return to this question of effectiveness of coverage in a few moments.

I am sure you are interested in knowing who among the aged have the insurance and who do not have it. Our survey shows those most likely to be covered are people in good health and with relatively high incomes; the least likely to have it are those in poor health, the very old, those not employed, and those with low income.

The chart to the far left shows the relationship of health status and health insurance coverage. It shows that, of persons 65 and over who say they are in relatively good health, 61 percent had insurance, and 39 percent had none. Of those in fair health, the respective proportions were 53 and 47 percent. Of aged persons claiming to be in poor health, only 37 percent had health insurance while 63 percent were unprotected.

Chart 2 shows the income and insurance relationship. In the upper income third of the aged population—we divided the aged population into three groups—in the upper income group, 80 percent of the couples had coverage for one or both members of the family.

Among the nonmarried individuals in this income group—widows and widowers, the divorced, and the never married—64 percent of the men and 66 percent of the women were covered. But in the lowest income third, one or both members of couple families had insurance in only 42 percent of the case. For individuals, the proportion with insurance dropped to 31 percent for women and 15 percent for men.

Between ages 65 and 72, inclusive, 58 percent had hospital insurance. At 73 and over, 43 percent were covered.

Among the 2¾ million aged persons who are still employed, two-thirds had health insurance. Among the 14½ million not employed, less than half had insurance. One reason for this difference may be that many aged persons drop their previously held coverages when they stop working, perhaps because at a time when their incomes decline, their premium costs increase if they must convert to an individual policy or if the employer's contribution is terminated or reduced.

The present survey is the third we have made of the extent of health insurance coverage of the aged but is the first to include the

institutionalized and thus all of the aged. The first survey in 1952 found that 26 percent of the noninstitutional population 65 and over, had insurance.

The next survey 4½ years later in September 1956, showed the proportion of aged with insurance had increased by two-fifths to 37 percent. To latest survey, 6 years after the second, shows the proportion of aged with some insurance against hospital expense again had increased by two-fifths. The latest period, of course, witnessed intensive efforts by the insurance industry and the nonprofit organizations to cover the aged.

But we should not overlook the opposite side of these data, that is the number of persons without insurance. Despite the increases in the number who have insurance, there remain between 8.3 to 8.5 million aged persons with no coverage.

It is estimated that 9.7 million aged, including persons in institutions, had no coverage in 1952. Thus, during the period March 1952 to December 1962, the number of aged persons without health insurance has dropped only about 1¼ million or 12 percent.

Our survey has one significant measurement of the effectiveness of the coverage in force for the aged. It has produced data on the percentage of hospital costs met by insurance for those couples and nonmarried men and women who have hospital insurance. I would like to stress that the figures I am giving you relate to people who have insurance.

These data suggest wide variance in the effectiveness of the coverage. For example, one-third of the insured married couples with hospital stays reported their insurance paid 90 percent or more of the costs. For one-fifth, their insurance met 75 to 89 percent of costs. In another one-fifth of the cases, insurance met 50 to 74 percent of costs. But one-fourth of the couples with hospital stays and with insurance reported their insurance paid less than 50 percent of the hospital expenses.

The data for nonmarried men and women show a similar picture. It should be noted 10 percent of those with hospital insurance found that their insurance paid no part of their hospital costs. Previous extended illnesses may have exhausted their benefits, the specific situation may not have been covered by their policy, and in a few cases the insurance may have been taken out after the hospital stay.

Mr. Chairman, I have some figures here on hospital utilization, but in the interest of time perhaps I should not read those now. Let me read just one or two of the important ones.

The high cost of hospital care presents special problems to the aged because of the large bills they often face. Our survey discloses that the mean average cost of general hospital stays in 1962 was close to $600 for married couples and almost $540 for the nonmarried who knew the cost of their care and received no public assistance or other agency help. The total medical care costs of the hospitalized aged who received no public assistance or other help averaged $1,200 in 1962.

The average stay of aged persons discharged from general hospitals was 15.1 days. When readmissions were taken into account, the average was 17.7.

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In addition to their high rate of utilization of short-stay hospitals, the aged fill most of the beds in long-stay hospitals and nursing homes. About 750,000 persons aged 65 and over received care in psychiatric, tuberculosis, chronic disease, and other long-stay hospitals and nursing homes in 1962. The average stay in the long-term facilities was 37 weeks.

When aged persons in short-stay and long-stay medical facilities in 1962 are combined, more than one out of every six aged persons in the United States still living at the time of interview was in some medical facility during 1962. The figures would be higher if we could include dependents.

Among the wealth of data from our survey is another statistic that may be meaningful in the context of your hearings. The statistic is this: we found that among all the aged married couples, more than two-fifths of the spouses were "nonaged." That is to say, they were under 65, although the husband, or occasionally the wife, was over 65. Frankly, we were surprised that the proportion was so high.

We assume that in a number of cases, hospital insurance coverage for the person aged 65 or over derived from the employment of the younger member of the couple. We know the income of such couples was higher because of the earnings of the younger spouse.

In conclusion, I would like to thank the committee for giving us an opportunity to present these results of the 1963 survey of the aged. The problem of aging is a many faceted problem. It is important to define its dimensions and to identify, as fully as possible, the special characteristics of the aged population.

I hope this brief presentation, and any additional information we can make available to you, will help the committee in its task.

Senator MCNAMARA. Thank you very much, Doctor, I am sure your presentation will be very helpful to the committee.

You use the term hospital insurance in your survey. How do you define this?

Dr. MERRIAM. Hospital insurance is defined to include any insurance which pays all or part of the hospital bill for the hospitalized person. It does not cover the doctor's or surgeon's bill or the bill for special nurses, but normally includes the cost of other services, such as operating room, laboratory costs, as well as room and board. I think that is a fairly standard definition.

Senator MCNAMARA. Thank you.

I see your survey indicates 9 million aged have some form of hospital expense insurance at the end of 1962. Now, the health insurance companies show a total of 10.3 million, I believe, covered at the close of 1962.

Do you have any explanation as to the cause of the difference in these figures?

Dr. MERRIAM. Well, I do not think any one knows all the reasons. We would be the first to say that in any survey there is a question of sampling variability. However, there are 9 chances out of 10 that if we had a complete count of all the aged, the figure would not vary more than about 250,000 above or below the 9 million—it could be below as well as above.

So far as the insurance industry figures are concerned, I believe the estimate is based on reported data for companies which cover certainly

less than 100 percent, something like 70 percent of the business. However, the great unknown really is the extent of duplicate policyholding. All any one company can report is the number of policyholders and I believe that the estimate of duplicate policyholding used by the industry is based on a relatively limited number of cases in a study made several years ago.

It is really difficult to get accurate figures on this. We have thought of trying to do it and wondered how it could be done better. That is one reason why we think that the more important figure rather than the number covered is the proportion of the medical costs covered by insurance.

Senator McNAMARA. Thank you very much.

Do you have any comments or questions, Senator Dirksen?

Senator DIRKSEN. No, sir.

Senator McNAMARA. Senator Muskie?

Senator MUSKIE. Dr. Merriam, there has been a great deal of discussion about the quality of hospital insurance coverage and particularly for the aged. If you were to discuss the quality of coverage, what elements would we be interested in?

Dr. MERRIAM. Well, by quality of coverage, I think one means essentially, what proportion of the bill would it meet? I mean, a policy paying $5 a day for 20 days is low quality simply in the sense that it is not going to meet the risk.

That is why I gave the figures on the proportion of the bill that is met as being, I think, the best measure.

Senator MUSKIE. We would be interested in the length of stay covered by the policy, the amount per day payable by the policy.

Dr. MERRIAM. That is right, and I think you would be interested in the cost as well, although the better the quality the higher the cost inevitably.

Senator MUSKIE. I see, and this combination which is part of quality, that is the cost and the amount of service that is provided, the combination of these two elements is likely to hit the group which is not covered the hardest.

Dr. MERRIAM. The group which is not covered will not have any. There is a relation between high income and adequacy of protection. Those with higher incomes are more likely to be covered, and more likely to have more extensive coverage than those with low income. The latter are unlikely to be covered at all, but if they have health insurance they are likely to have a less adequate type of coverage.

Senator MUSKIE. In other words, in your statement you said that the least likely are those who are in poor health, the very old, those not employed, and those with low income.

Dr. MERRIAM. In general they have no coverage.

Senator MUSKIE. But to the extent that they or the group just above them have coverage, the quality of the coverage is likely to be low, because of these very factors?

Dr. MERRIAM. By and large, yes. There will be some who are in fortunate circumstances.

Senator MUSKIE. Have you had occasion at all to examine bankruptcy records to evaluate the impact that health costs have upon bankruptcies?

Dr. MERRIAM. No; we have not.

Senator MUSKIE. I would like to recommend it to your attention. We have had some casual look into this problem in the Maine bankruptcy records and it is quite clearly evident that medical costs by and of themselves are the factor often which tip a person into the bankruptcy courts, and very often because of the health costs of dependents and of aged dependents.

I think that the total social cost of medical care ought to include a study of this particular factor.

Dr. MERRIAM. Our Bureau of Federal Credit Unions has made several studies of the reasons why people have to borrow from the credit unions and medical care always stands out. I do not remember the precise figures, but it is always a very important factor there.

Senator MUSKIE. Does your survey give us any late data on the income of the aged?

Dr. MERRIAM. Income of the aged? Yes; we do have data, and I would be glad, if you would care to have it in the record, to submit the article which gives great details on income.

For the entire aged population, the average median total money income for married couples was $2,875 and for nonmarried, it was $1,130. We have this broken down separately for those who are beneficiaries of old-age survivors and disability insurance and those that are not.

Senator MUSKIE. Do you have any judgment on what it would cost an individual over 65 to get reasonable quality insurance coverage?

Dr. MERRIAM. That varies very greatly depending on the community. We do know that at the time we made a study last year of the special nongroup coverages for the aged which Blue Cross put out had a median cost of $112 a year per person. There was a substantial range.

Senator MUSKIE. But what are the elements of the program that would buy?

Dr. MERRIAM. I am not sure I can attach a median cost to a median policy quickly.

Senator MUSKIE. I appreciate the problem. I am interested in getting it if you have it, but I am not interested in posing a problem here.

Dr. MERRIAM. I suspect that what this came close to was, oh, say 70 days of hospital benefits, not necessarily a service benefit.

Senator MUSKIE. Seventy days of hospital benefits?

Dr. MERRIAM. Seventy days probably in a year, not necessarily of service benefits, but as I say, this is a little difficult. There are many different—as you know, 77 different Blue Cross plans with 77 different sets of benefits, and when I give you the median dollar figure, it does not necessarily take into——

Senator MCNAMARA. Will you yield?

Senator MUSKIE. I will be happy to yield.

Senator MCNAMARA. May we have a copy of the material you are referring to for the subcommittee record?

Dr. MERRIAM. Certainly.

Senator MCNAMARA. Will you see that it is submitted to the sta?[1]

[1] Blue Cross-Blue Shield Nongroup Coverage for Older People," research report No. 4, U.S. Department of Health, Education, and Welfare. Single copies available upon request of Publications Branch, Division of Research and Statistics, Social Security Administration, Washington, D.C., 20203. Copy on file with subcommittee.

Senator MUSKIE. One other question.

Senator MCNAMARA. Go right ahead.

Sentaor MUSKIE. To what degree are the policies available to the elderly cancelable or noncancelable?

Dr. MERRIAM. I am afraid I cannot answer that with great assurance. Many of them are cancelable, of course. I would assume the majority, but I do not have any facts on that.

Senator MUSKIE. That is all, Mr. Chairman.

Senator MCNAMARA. Senator Fong?

Senator FONG. Yes. Dr. Merriam, you stated that the cost of hospitalization in 1962 was $600 for married couples and almost $540 for the nonmarried, single persons. Is that the average mean cost?

Dr. MERRIAM. That was the average cost, yes, the mean. Let me emhasize that this was for people who knew their costs and who had no help from public assistance or any other agency. You see, if the public assistance agency pays most of the bills, then the patient usually does not know the cost. We left those out. These are the people who knew their costs and either they or their families or insurance paid the bill.

Senator FONG. So you found that for an aged person who was sick, at some time during 1962, it would cost him on the average around $600, is that right?

Dr. MERRIAM. That is right, the average hospital cost in the case of persons who went into short-stay hospitals. This leaves out the long-stay hospitals, those people were in 37 days on the average, as compared with 17 for the short stay. For short-stay hospitals this was the average.

Senator FONG. These are the people who went in and came out?

Dr. MERRIAM. Right.

Senator FONG. Now, you have a figure of $1,200 for people who are hospitalized. Would you explain the difference?

Dr. MERRIAM. That is their total medical costs. The first figure was what they had to pay the hospital. The $1,200 includes what they paid for doctors, dentists, if they had any, drugs, and so forth.

Senator FONG. So, it would cost another $600 for the other costs, other than hospital costs?

Dr. MERRIAM. Right.

Senator FONG. So the total cost for an aged person who was sick in 1962 was an average of $1,200?

Dr. MERRIAM. For a person who was sick enough for a short hospital stay.

Senator FONG. Do you have any idea what it costs insurancewise to take care of a bill like that? What would the premium be for a year, so that the insurance company could make a profit, or break even?

Dr. MERRIAM. I do not think I could answer that, Senator. Maybe the insurance companies could. This would be a combination of a hospital plus a complete coverage; to cover the whole bill?

Senator FONG. Yes.

Dr. MERRIAM. You would have a hard time buying that much insurance.

Senator FONG. It would be a very high premium?

Dr. MERRIAM. Yes, and not generally available except through group prepayment plans or through multiple coverage.

Senator FONG. Now, you stated that there are also approximately 8⅓ million people who are without insurance. How many of this 8 million are presently not working?

Dr. MERRIAM. I would assume the great majority of them are presently not working.

Senator FONG. Of the 17 million aged people, what percentage would you say are not employed?

Dr. MERRIAM. Well, about 2¾ million are working, part time or full time. The majority of those who are not covered, tend to be older, they tend to be in poor health, they tend to have less income, and therefore, there will be fewer working in that group.

Senator FONG. There are approximately 14½ million people who are not employed, is that correct, out of 17 million?

Dr. MERRIAM. That is right.

Senator FONG. Of that 14½ million people, how many could pay for their insurance costs?

Dr. MERRIAM. Well, I think this depends on how much of your income you think you can afford to pay for insurance as against food and other things.

I don't want to load you with figures, but let me go back to your question about the differences in income between those who did and those who did not work. Of those who worked in 1962—that is the 2¾ million aged—for the beneficiaries, the average income of couples was about $4,000 a year. For couples who were not getting OASI, it was about $6,000 a year. But for those who did not work, the total income for the year was $2,400 in the case of couples who were drawing benefits, $1,800 in the case of these who were not.

Now, take even the more fortunate of the nonemployed group, those who are getting OASI benefits—with an income of $2,400 a year, if your hospital insurance alone costs on the average $112 per person, $224 for the couple, and then you bought surgical insurance and had to take out major medical to cover physicians and nursing care and drugs and all the other things, it would get up to be quite a sizable proportion of your income.

Senator FONG. Under those circumstances, a couple who makes $2,400 is unable to buy any insurance; almost?

Dr. MERRIAM. Well, it would take a very sizable proportion of their income to buy even limited coverage. It would take 10 percent of their income to buy hospital insurance alone, which would leave all the rest of their bills uncovered.

Senator FONG. How many of the 14½ million people are under old-age assistance?

Dr. MERRIAM. Old-age assistance?

Senator FONG. Yes.

Dr. MERRIAM. About 2 million, a little over 2 million. Two and a third million.

Senator FONG. How many of them would qualify under the Kerr-Mills law?

Dr. MERRIAM. Actually, the Kerr-Mills bill applies to people who are slightly above the old-age assistance level, as well as providing some additional funds to help those on assistance. Theoretically, all of those under old-age assistance should get some help with their medical bills, though the amount of it varies greatly.

Senator MUSKIE. Will the Senator yield?

Senator FONG. Yes.

Senator MUSKIE. Not all States have adopted Kerr-Mills.

Dr. MERRIAM. No.

Senator MUSKIE. When you talk about those who are not eligible under Kerr-Mills you would have to exclude that portion of them who live in States which have not yet enacted Kerr-Mills legislation.

Dr. MERRIAM. Yes. Only about two-thirds of the States have adopted medical assistance to the aged programs.

Senator FONG. If the Kerr-Mills program were enacted in every State, with the benefit at the minimum which the States now having Kerr-Mills programs give to their people who need medical care, how many of these 14½ million people not on OAA or 8⅓ million people without health insurance would be taken care of?

Dr. MERRIAM. Senator, I am sorry, I do not have that figure. I would be glad to try to get some kind of an estimate and put it in the record.

Senator NEUBERGER. Will the Senator yield on that point?

Senator FONG. Yes.

Senator NEUBERGER. But, also, every State has variations in the benefits. For instance, what does Hawaii do under Kerr-Mills?

Senator FONG. Hawaii has very liberal benefits. So long as the medical indigent is unable to pay for his medical bills, Hawaii is very, very liberal.

Senator NEUBERGER. It would behoove someone who is in that income bracket to move to Hawaii, New York, or Pennsylvania, wouldn't it, besides being good places to live. [Laughter.]

Senator FONG. Is it possible for you to work out some figures for this committee showing what I am trying to bring out? I am just trying to get the picture.

Dr. MERRIAM. I am sure, Senator, we can get for you figures, first on the number of people who have had some assistance under Kerr-Mills, and then what you are asking is, supposing every State did have it at some level, what would the scope of the program be? One can always suppose. We will submit an estimate for the record.

Senator FONG. Thank you.

Senator NEUBERGER. It is very nice of you to do that, but it seems so hypothetical. It would be like, What would be the average weight of everybody who eats 2,000 calories a day? It is so intangible with the great variations.

Senator MCNAMARA. Well, if you will, furnish for the record the answer to the Senator's question to the best of your ability. Will you do that?

Dr. MERRIAM. I will.

(The information to be furnished follows:)

The attached table indicates the number of persons receiving medical assistance for the aged and the amount of the payments in February 1964, in the 35 States with programs in operation. It is estimated that if all States had medical assistance programs for the aged equal in scope and services to the best existing programs the additional cost would be between $1.8 and $2 billion a year.

TABLE 4.—*Medical assistance for the aged: Recipients and payments for recipients, by State, February 1964* [1]

| State | Number of recipients [2] | Payments for recipients | | Percentage change from January 1964 | |
|---|---|---|---|---|---|
| | | Total amount | Average | Number | Amount |
| Total | 161,274 | $31,770,975 | $197.00 | +2.9 | +2.7 |
| Alabama | 250 | 69,810 | 279.24 | −17.2 | −22.4 |
| Arkansas | 2,560 | 139,588 | 54.53 | +16.2 | +6.1 |
| California | 22,262 | 6,402,475 | 287.60 | −8.1 | −2.5 |
| Connecticut [3] | 5,383 | [4] 1,142,698 | 212.28 | | |
| District of Columbia | 515 | 145,567 | 282.65 | −6.7 | +19.7 |
| Florida [5] | 369 | 150,923 | 409.01 | +14.2 | +23.5 |
| Guam [6] | 106 | 1,730 | | | |
| Hawaii [5] | 453 | 114,180 | 252.05 | −22.2 | −21.3 |
| Idaho | 1,833 | 253,379 | 138.23 | 0 | +9.7 |
| Illinois [5] | 835 | 389,317 | 466.25 | +3.9 | +26.0 |
| Iowa | 1,505 | 77,399 | 51.43 | (7) | (7) |
| Kansas | 1,090 | [4] 147,573 | 135.39 | (7) | (7) |
| Kentucky [5] | 6,178 | 221,989 | 35.93 | +73.7 | +114.3 |
| Louisiana | 455 | 75,218 | 165.31 | +14.6 | +26.9 |
| Maine [5] | 348 | 88,001 | 252.88 | −29.7 | −32.3 |
| Maryland [5] | 9,559 | 339,946 | 35.56 | +8.0 | +8.1 |
| Massachusetts | 25,282 | [4] 4,312,867 | 170.59 | +2.7 | +4.3 |
| Michigan | 5,453 | 2,008,999 | 368.42 | +14.4 | +16.2 |
| New Hampshire | 761 | 34,051 | 44.75 | −28.5 | −67.7 |
| New Jersey | 4,769 | [4] 969,433 | 203.28 | +2.1 | +5.4 |
| New York | 32,142 | [4] 9,850,424 | 306.47 | +.4 | +2.9 |
| North Dakota | [8] 1,076 | [4] 235,276 | 218.66 | +3.2 | +14.1 |
| Oklahoma [5] | 1,083 | 174,927 | 161.52 | +25.3 | +35.0 |
| Oregon | 3,352 | 459,699 | 137.14 | −1.9 | −6.7 |
| Pennsylvania | 7,637 | 1,773,284 | 232.20 | +4.9 | +4.4 |
| Puerto Rico | 2,563 | 81,102 | 31.64 | +2.8 | +15.6 |
| South Carolina | 718 | 87,978 | 122.53 | −37.8 | +55.5 |
| Tennessee | 4,491 | 250,091 | 55.69 | +35.4 | +44.6 |
| Utah | 2,051 | 246,872 | 120.37 | +4.0 | −2.5 |
| Vermont [5] | 114 | 38,976 | 341.89 | (9) | (9) |
| Virgin Islands | 114 | 1,208 | 10.60 | −.9 | −55.9 |
| Virginia | 94 | 24,581 | 261.50 | | |
| Washington | 9,143 | 1,326,273 | 145.06 | −2.8 | −6.3 |
| West Virginia | 6,715 | 126,493 | 18.84 | −23.8 | −59.8 |
| Wyoming | 15 | 8,648 | (9) | (9) | (9) |

[1] All data subject to revision.
[2] Persons for whom vendor payments were made during the report month.
[3] Data for January: February data not available.
[4] Includes money payments not subject to Federal participation as follows: $811 in Connecticut, $6,054 in Kansas, $99,498 in Massachusetts, $11,087 in New Jersey, $48,146 in New York, and $2,299 in North Dakota.
[5] Represents medical assistance for the aged under program for aid to the aged, blind, or disabled and medical assistance for the aged.
[6] Estimated.
[7] Program initiated in January 1964.
[8] Includes an unknown number of cases receiving only money payments.
[9] Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients.

Senator MCNAMARA. Are you through?

Senator FONG. Yes.

Senator MCNAMARA. Senator Neuberger, do you have any questions or comments?

Senator NEUBERGER. No.

Senator MCNAMARA. Again, Doctor, we want to thank you very much for your help.

Dr. MERRIAM. Thank you.

Senator McNAMARA. Our second witness this morning is Dr. Forrest E. Linder, Director of the National Center for Health Statistics, U.S. Public Health Service.

## STATEMENT OF DR. FORREST E. LINDER, DIRECTOR, NATIONAL CENTER FOR HEALTH STATISTICS, U.S. PUBLIC HEALTH SERVICE; ACCOMPANIED BY THEODORE D. WOOLSEY, DEPUTY DIRECTOR; AND DR. PHILIP S. LAWRENCE, CHIEF, HEALTH INTERVIEW STATISTICS DIVISION, NATIONAL CENTER FOR HEALTH STATISTICS

Senator McNAMARA. You may proceed.

Dr. LINDER. I have with me today Mr. Woolsey, who is the Deputy Director of the Center and in charge overall of the technical aspects of our work and Dr. Philip Lawrence, who is directly in charge of the Health Interview Survey which, in our organization, produces the kind of material that we will present today.

Senator McNAMARA. Thank you.

Dr. LINDER. I am very pleased to be able to come before you and give you a few figures from our surveys on the extent and adequacy of hospital insurance coverage among the older people.

The most recent information on health insurance coverage from the health interview survey is based on data collected as a supplementary item to the health interview during the period July 1962 to June 1963. While information was obtained on three types of coverage—hospitalization, surgery, and physician services—this presentation, in the interest of brevity, will be restricted to statistics pertaining to hospital insurance.

Approximately 54 percent or 9,100,000 of the 17 million persons 65 years and older living in the civilian, noninstitutional population have some form of hospital insurance, according to our figures. This estimate is in contrast to 72 percent coverage among people under 65 years of age, and 70 percent for the population of all ages.

Hospital insurance is defined in the survey as any plan, either group or individual, specifically designed to pay all or part of the hospital expenses for the insured person. The plan must be a formal one with defined membership; the premiums may be paid by the individual, his employer, a third party, or a combination of these.

Specifically excluded from our figures are plans limited to specific "dread diseases"; those that pay only for accidental injury; free care provided by public welfare, veterans' facilities, care given to dependents of uniformed service personnel, crippled children's programs, and the like; and plans which pay only for loss of income.

Among persons 65 years and older, the rate of insurance coverage ranged from 39 percent of the 6 million living in families with less than $2,000 income to 73 percent of the 1 million in families with annual income of $10,000 or more.

A comparable range for the insurance coverage of persons under 65 was from 32 percent in the low-income group to 89 percent for those in families where the income was in excess of $10,000.

In all income groups, the rate of coverage was appreciably higher for those 65 to 74 years of age than that for persons 75 years of age and over.

About 11 million, or roughly two-thirds of the older group are in the age group 65 to 74; and their rate of hospital insurance coverage is 61 percent. The remaining one-third of this group, 75 years and older, have an insurance coverage rate of 41 percent.

Of the 129 million people in the country covered by hospital insurance, approximately 10 percent have more than 1 hospital insurance plan. However, among persons 65 years and over, the rate of multiple coverage is estimated at 13½ percent.

Similar to the pattern for the total population, the rate of multiple insurance coverage among persons 65 years and over increased with amount of income from 10 percent among families with income less than $2,000 to 17 percent for those with income $10,000 or more.

Even though the extent of hospital insurance coverage provides a broad measure of the protection afforded the population against the hazards of illness, a more definitive measure is the availability and adequacy of this protection when hospital services are needed.

Based on data collected during the period, July 1958 to June 1960, some portion of the hospital bill was paid by insurance for 68 percent of the discharges that had been hospitalized overnight or longer in short-stay hospitals.

Included in this percentage were 51 percent that had three-quarters or more of the bill paid by insurance.

Among persons over 65, approximately 51 percent of the discharges had some portion of the bill covered by insurance, while a comparable proportion among persons under 65 was 70 percent.

For both young and old people, the percentage of discharges that had any part of the bill paid by insurance increased with amount of family income.

Among persons 65 and older, the proportion with some part of the bill covered was 43 percent for those in families with less than $2,000 income. Included in this percentage were 24 percent of the discharges for which insurance paid three-quarters or more of the hospital bill.

This presentation has been a summary and in a report which we have provided for the committee, we have given more detailed information and, of course, we would be glad to supply other facts that we have that would be of interest to the committee.

Thank you, Mr. Chairman.

Senator McNAMARA. Thank you very much, Dr. Linder.

I notice that your definition of hospital expense insurance excludes policies which only provide coverage for specific dread diseases.

Could you tell us why such policies are not included?

Dr. LINDER. Well, these are policies such as those which were very popular a few years ago in which you could take out a brief policy for poliomyelitis or something like that.

These are probably very limited and probably not very numerous, so these have not been included in our definition.

Senator McNAMARA. They are not of sufficient number to give a great deal of weight to your testimony.

Dr. LINDER. That is our impression.

Senator McNAMARA. On the basis of insurance company reports to the subcommittee, it would appear that your estimate of the number of older persons who have more than one hospital expense policy may be lower than actually is the case.

Do you recognize that point?

Dr. LINDER. Well, our estimate of the number of older people with more than one policy, is, as I said, 13.5 percent, and it is, of course, recognized that in interview-type surveys, there is likely to be some underreporting and there is an item which could be somewhat underreported. We feel that the underreporting of this item is very substantial.

Senator MCNAMARA. Do you have any information in your report dealing with hospital expenses of aged persons compared with those under 65?

Dr. LINDER. Well, in the survey activity test of our organization we collect information on a large number of things and among these we are collecting information on the costs of hospital care by age groups, and so on.

As a matter of fact, we have in the Government Printing Office at this very time, a rather comprehensive report entitled, "Medical Care, Health Status, and Family Income," and this report does include some figures on the relative hospital costs of people by age.

We also have in the planning stages what we consider a very important survey which will collect information on individual cases, a sample of individual cases from a sample of hospitals, and this hospital discharge survey which we have in the planning stages should result in very detailed and very accurate information on the nature of the hospital charges, the amount by age, by length of stay, by disease, and by who paid the bill.

Senator MCNAMARA. Will you see that we have a copy of that report for the record?

Dr. LINDER. This report that is in the Government Printing Office we will submit to you.[1]

Senator MCNAMARA. I want to say that we do have a quorum call and I expect some of us may have to leave.

Do you have any questions, Senator Neuberger?

Senator NEUBERGER. No.

Senator DIRKSEN. Dr. Linder, I have a question.

You are familiar with the report of the insurance industry that roughly 60 percent of our aged now have coverage? You shake your head, but the record cannot get a nod of your head.

Dr. LINDER. Yes.

Senator DIRKSEN. Your report would indicate about 54 to 56 percent of the aged have health insurance coverage?

Dr. LINDER. Yes. Our report would be about 54 percent and as you say, the insurance figures are approximately 60 percent. There is a difference of 5 to 6 points between our two estimates.

Senator DIRKSEN. Would you regard that as a significant difference from the administrative standpoint? Would you explain the difference as a result of difference in methodology?

Dr. LINDER. Well, the two figures are collected by entirely different methods and both methods are subject to technical variation and technical error. As a matter of fact, we regard the correspond-

[1] "Medical Care, Health Status, and Family Income," U.S. Public Health Service Publication No. 1000—Series 10—No. 9, U.S. Government Printing Office, May 1964. For sale by the Superintendent of Documents, Washington, D.C., 20402—price 55 cents. Copy on file with subcommittee.

ence between our figure and the insurance figure as very satisfactorily close, with one factor of the difference being this still undetermined knowledge about the extent of multiple coverage.

I think it is pertinent to say that if the insurance figure is 60 percent and if that is based on the multiple-coverage estimate of 13.5, then if the true multiple-coverage figure was as much as 22, the insurance figure would correspond exactly with ours.

So, I think we can say with some degree of confidence and that the amount of coverage is someplace between 54 and 60 and on the amount of duplication, multiple coverage, is someplace between 13 and 22.

Senator DIRKSEN. Well, then, we can firmly identify at least this one result springing from either of these surveys that at least over half of our people presently have coverage in this field?

Dr. LINDER. Have coverage to some extent, yes. That is correct.

Senator DIRKSEN. I think that is all.

Senator MCNAMARA. Thank you.

It appears that the other members of the subcommittee have gone to respond to the quorum call.

We thank you again very much for your testimony. I am sure it will be very helpful to the subcommittee.

The next witness is the Continental Casualty Co., Mr. Walter M. Foody, Jr., vice president.

Mr. Foody, we are very pleased to have you here this morning. I see you have a gentleman accompanying you. Will you identify him?

## STATEMENT OF WALTER M. FOODY, JR., VICE PRESIDENT, CONTINENTAL CASUALTY CO., CHICAGO, ACCOMPANIED BY PAUL SINGER

Mr. FOODY. Yes. This is Paul Singer, who is also an officer of the Continental Casualty Co.

Senator MCNAMARA. Thank you.

You may proceed in your own manner.

Mr. FOODY. We are happy for the opportunity to appear here and I will try to keep my comments as brief and general as possible.

In your letter inviting us to testify, you suggested that the subcommittee had particular concern at this time with the following topics:

"The Availability and Cost of Insurance."

"The Number of Older People Covered by Health Insurance and the Adequacy of That Coverage."

"The Ability of Older Persons To Retain Health Insurance Once Secured."

And I would like to address myself to these.

The availability and the permanence of health insurance seem to me to be aspects of the same problem: Is health insurance at hand for those who need it, when they need it?

Historically, health insurance was available to the public in two major forms: individual and group insurance, each with its own characteristics of availability and permanence. In each, the aged were at a disadvantage by comparison with younger lives, although for different reasons in each form.

Physical underwriting was the barrier to freely obtainable individual insurance. Most such insurance was of the "commercial" type, issued on a year-to-year basis and renewable at the option of the company.

For the aged, this physical underwriting approach meant obvious hardships. Many in impaired health could not qualify at all; others might be covered for a time but were likely to fall below the standards for continuation, and found individual health insurance hard to get and hard to keep.

Group insurance does not require individual physical underwriting, either for issue or for renewal. It does require membership in an eligible group. Obviously, the retired person has no such affiliation, and the elderly worker loses his membership status upon retirement.

Here, as in the case of individual insurance, access to and retention of health insurance was far more difficult for the aged than it was for the young.

However, today this picture is completely changed. Modern health insurance underwriting has not only developed solutions for these problems, but has gone on to provide new insurance mechanisms to meet the special needs of the aged.

It is now almost literally true that any aged person who wants health insurance can purchase it. The underwriting approaches which have made overage insurance so freely available today would have been unknown and unthinkable 10 years ago.

The most striking of all the developments in this area has been the extension of the group underwriting philosophy into fields where it previously had been thought inapplicable.

Beginning with the underwriting of associations of retired persons, such as the NRTA (National Retired Teachers' Association), and the other groups, these on the basis of voluntary participation, this has culminated in the mass-enrollment programs, pioneered by Continental Casualty and adopted by other companies and by the State-65 plans, which now make health insurance available to every person over age 65 in the United States. The early history of these developments I mentioned to your subcommittee when I was here 4 years ago, Senator, and I think most of you are aware of them.

With respect to health insurance, it seems to me that there is some misunderstanding as to what is involved in this.

Actually, the gross cost of health insurance consists of two major parts and only the smaller part of this is the cost of insurance. The larger part by far is simply the cost of health care itself—care which is needed in any event and must be paid for somehow.

This major part of the total cost of insurance is the insured's average share in the aggregate cost of health care, which might be financed in other ways but which cannot be avoided.

The remainder of the premium represents the actual cost of the insurance process: administrative and marketing costs, taxes, costs of paying the benefits, and a risk charge or profit.

When the "cost" of health insurance is seen for what it really is—an average cost of health care which the insureds must pay anyway, plus a small charge for protection against disastrous fluctuations in that cost—the fact that some of the aged cannot afford health insurance takes on a new meaning.

What this group of the aged cannot afford is in fact the average cost of health care. It must be said frankly that for this group there is no help in the insurance industry. Insurance is not a device for the creation of wealth; it is a means of protecting existing or potential wealth from destruction by chance.

For those millions of the aged who have the modest means required for their needs, insurance can afford invaluable protection against unusual medical expenses. For those who cannot afford the average costs of medical care, we must seek other solutions.

While the health care portion of the total cost of health insurance presents a problem primarily to those who cannot afford average care, the insurance cost included in the total premium is significant to those who can.

They must decide whether the service insurance provides is worth the cost it involves. Each individual must make this decision in the light of his own wants and needs. Some will insure; others will not; those who choose to insure will purchase a variety of benefits which reflect their differing circumstances.

The result is a pattern, among those who can afford these various choices, of insuring more or less of total medical expenses. Each one buys, ideally at least, those benefits which in his case justify the cost of the insurance process; he retains as his direct responsibility those health care costs which he finds not worth insuring.

This is the type of economic behavior that makes the concept of the adequacy of health insurance elusive to estimate. Any aged person with sufficient funds could purchase in today's market insurance benefits of unquestionable "adequacy" in the sense of being very comprehensive.

Probably such a purchase would be ill advised. A truly adequate program for such an insured would exclude the benefits he could afford to budget—and would save the cost of insuring them. In this case, the more economically adequate program would cover a lesser portion of total medical expenses.

The individual election of benefit combinations, limits, and deductibles appropriate to the individual situation poses problems for the statistical analysis of the adequacy of health insurance benefits in general. It simply is not true that the best program is the one which pays the greatest portion of medical expenses.

Such considerations of the cost of health care and of the cost of insuring it should lead us to classify the aged into two groups—those who have the means to provide for their own health care and who can be greatly aided by proper insurance, and those who lack the means to pay the average cost of health care, for whom insurance is not appropriate.

If this latter group were large and growing, we might seriously question whether voluntary health insurance can meet the needs of the aged.

Fortunately, the opposite is true. The financial status of older Americans appears, from all the indications available through studies by the Social Security Administration and others, to be improving yearly.

We can look forward, apparently, to an ever larger population of older persons for whom health insurance is both necessary and highly practicable. The relatively dependent aged seem to be decreasing in number both relatively and absolutely.

Those who cannot benefit from health insurance and for whom aid must be found in other ways will present a more limited problem in the future than they do today.

One measure of the effectiveness of our voluntary health insurance system is the extent to which it actually provides coverage for a significant part of the population.

Despite the many differences in the detailed findings of studies devoted to determining the numbers so covered, we know with certainty enough to indicate a very high level of effectiveness: The number of aged persons covered by health insurance is acknowledged to be very large and to be increasing rapidly.

The aggregate figures now available are reasonably accurate and very impressive. It is unfortunate that their significance sometimes has been obscured by disputes about detail and methodology.

We think it very gratifying that most of those engaged in this work are now agreed on the general conclusions which can be drawn from it: That voluntary health insurance has succeeded in a relatively short time in extending its benefits to a majority of elderly Americans, with constant rapid increases in the number covered and in the adequacy of their coverage.

Thank you.

Senator McNAMARA. Thank you very much, Mr. Foody.

In this statement you have submitted to us, you say that you are providing health care insurance for about 1 million aged; is that correct?

Mr. FOODY. That is right.

Senator McNAMARA. I was interested in this figure. Does this mean 1 million individuals or 1 million policies?

Mr. FOODY. I think we are getting to the subject of the number covered. I am going to ask Mr. Singer to talk on these, Senator.

Senator McNAMARA. Very well.

Mr. SINGER. I think as best we can estimate it, Senator, we probably insure about 900,000 or 910,000 different persons. However, it is very difficult to verify the amount of duplication. In arriving at this, we have eliminated all duplication within such programs as our golden 65, where there are three different policies. Here we have eliminated all the duplication. There may still be some between different branches of our operation, but our present estimate is about 910,000.

Senator McNAMARA. About 910,000?

Mr. SINGER. Persons.

Senator McNAMARA. Senator Dirksen, do you have any questions or comments at this point?

Senator DIRKSEN. I do not believe so.

Senator McNAMARA. Senator Neuberger?

Senator NEUBERGER. There has been a great deal of advertising of the golden 65 policy. Many people are concerned with preparing for their old age and the reason I think they have not done it sooner is because they just did not have the money to keep up these premiums.

They could not keep up these premiums, but last summer, I think, the Continental Casualty Co. sold a good many policies, to 105,000 people or so, but these policyholders, have very limited coverage during the first 6 months of their policy; is that true?

Mr. FOODY. No. During the first 6 months, Senator, they have full coverage. The limitation that I believe you would be referring to is with respect to preexisting diseases. They have full coverage for everything except those diseases which were preexistent during the first 6 months. After 6 months, they are covered for even the preexisting conditions.

Senator NEUBERGER. Then, are they given a complete physical examination at the time they take out their policy?

Mr. FOODY. No. They are not.

Senator NEUBERGER. Who determines that it is a preexisting?

Mr. FOODY. The definition in the policy is one for which they have had previous medical treatment or advice. In other words, that they have been to a doctor or been in a hospital.

Senator NEUBERGER. But it is possible they could have had a condition which they did not know about and this would not void their policy if they had not had any treatment?

Mr. FOODY. That is correct.

Senator NEUBERGER. Then, as soon as that 6 months' waiting period is over is there any change in the premium rate?

Mr. FOODY. No.

Senator NEUBERGER. There has been no increase?

Mr. FOODY. We have had an increase now, Senator, in this year, but regularly speaking, no. This was an unusual——

Senator NEUBERGER. It was about 30 percent, was it not?

Mr. FOODY. Yes. But now let me differentiate; this was a general increase, not for the people who just had the policy for 6 months; this was for all the people, some of whom have had it for 6 or 7 years for one of the policies or others who have had them for 18 months.

Senator NEUBERGER. Did these people who came in on the 6-month waiting period receive any notice that they might have an increase?

Mr. FOODY. At the beginning, no. They did not, Senator, because we did not know that there was going to be one.

Senator NEUBERGER. You obviously found you could not supply the coverage at what you had hoped to do it for, is that correct?

Mr. FOODY. That is the case.

Senator NEUBERGER. What was the rate, then, for the complete golden 65 package for older persons?

Mr. FOODY. It would be——

Senator NEUBERGER. What is their rate per year?

Mr. FOODY. Well, it would be roughly around $300.

Senator NEUBERGER. For a couple, it would be $600 a year?

Mr. FOODY. Yes.

Senator NEUBERGER. This would include basic hospital insurance and what about major medical expenses?

Mr. FOODY. Well our $10,000 reserve policy would pay three-quarters of the hospital bills in excess of $500. It comes in over the basic program.

Senator NEUBERGER. And is there a maximum amount that you will pay per day for hospital?

Mr. FOODY. Yes.

Senator NEUBERGER. $10?

Mr. FOODY. No. That is $25 in the $10,000 reserve policy.

Senator NEUBERGER. The one that costs $612 a year for a couple?

Mr. FOODY. Yes, $25. Now, when you get the $600—the price that you are talking about where you have the complete package, the limit would be $25 a day.

Senator NEUBERGER. Well, in view of the fact that 50 percent of the people in the United States who are over 65 have an annual income of less than $3,000 per year, does not the cost of this limit their participation then?

Six hundred dollars a year out of an average of $3,000, leaves $2,400 for rent, food, clothing, all other expenses. So, it would seem that we could say that this protection would cost about 20 percent of the annual income of half of the population 65 and over.

And what about the cancellation? Suppose this couple is in the hospital and begin to use up quite a lot of their coverage. Is there an indefinite continuation of the golden 65?

Mr. FOODY. Yes. Our program with the 65, the golden 65 program, is about the same as group insurance everywhere. We look on all the people within a State as being members of a group and the individual has as much protection with this policy as he would if he were working for an employer.

The concept of group insurance is carried over into these policies. There is no individual cancellation involved.

Senator NEUBERGER. It seems like a wonderful idea if these people could be trained to participate in insurance, know the value of insurance, but suppose the day comes that they cannot meet the premium and we have not provided anything else to care for them, the day they do not meet a premium then the insurance policy is canceled; is it not?

Mr. FOODY. That is right.

Senator NEUBERGER. So, the only way to assure that these people would have coverage is some sort of a plan based on their social security or Kerr-Mills because the minute they fail on a premium then it is as if they never carried any insurance.

Mr. FOODY. Well, that is true, but we do not find that the people lapse these policies very fast, Senator. Our experience has been, I think, very good, considering the aspect of death, and there is a high rate of mortality in this age group, I would say the lapsation of these polices is less than we get with individuals insured under age 65, so that the maintenance of the coverage has been quite good.

Senator NEUBERGER. Well, I know, of course, they probably feel that that is the security they need, they must be scared to death of what happens if they do not have any.

How much a month is that for a couple?

Mr. FOODY. About $50.

Senator NEUBERGER. $50 a month a couple has to pay, and if they only have $3,000 a year income?

Mr. FOODY. Well, Senator, you use the maximum program. I wonder if people are very well advised in most instances to buy the entire program—depending on what else they have, depending on their own financial resources. I do not think we get too many people who buy the entire package.

Senator NEUBERGER. I am glad you brought that up because I know in your remarks you said that the maximum was not always the best. What alternative would you suggest for people of this low income then?

Mr. FOODY. I think basically anybody is better off buying a deductible policy simply because the possibility of budgeting the first part or of borrowing or of taking it out of liquid assets is much greater.

I think, generally speaking, all of us should protect ourselves against the catastrophe of a major claim.

This is my advice to my friends who ask me what I think their parents should do.

Senator NEUBERGER. I am very eager to have you outline what you would consider a good plan, then, because your golden 65 is advertised nationally so much.

Mr. FOODY. Well, I think that here we have a question of some people supplementing their programs. Now, you have to recognize in various areas of the country the price levels are quite different. Although there are some comments all the time about what good is a $10 room and board policy, there are many areas of the country where you can get a semiprivate room today for $12, so that everybody does not live in the areas where you need coverages up to $25, as the golden 65 plan.

So, that in some areas a person is well advised to buy a simple, basic, little form. In other areas, I think they are well advised to buy something that gives them fuller coverage.

Since we are going nationwide with these programs, we have to try and present each of them, and, of course, our feeling, then, is that the individual with whatever help he needs from advisers, whether they be family or professional insurance people, should select what fits their program the best.

Senator NEUBERGER. Can you quickly give us the cost per year of a deductible plan that would be suitable for a rural couple living where hospital costs are not as great? I mean just roughly indicate how much would they save over this $600 a year?

Mr. FOODY. I think for most rural couples, talking about a low-cost area, I think our little 65-plus policy does a very, very good job—it costs them $96 a year, say $100 a year.

Senator NEUBERGER. For a couple?

Mr. FOODY. Oh, $200 a year for a couple. I am sorry.

Senator NEUBERGER. Thank you.

Senator MCNAMARA. You were discussing your golden 65 policy. According to your statement, you have around 400,000 individuals covered by these policies. Is that a figure we got from your statement or not?

Mr. SINGER. No, Senator, there are about 400,000 policies issued in this program to about 250,000 persons.

Senator MCNAMARA. 250,000 persons. That is because some people have more than one policy?

Mr. SINGER. That is correct, sir.

Senator MCNAMARA. Do some policies cover more than one person? Can a policy cover a couple?

Mr. SINGER. These are individual policies, a couple buys two policies.

Senator MCNAMARA. What is that figure you gave—400,000?

Mr. SINGER. At the end of 1963, we had approximately 395,000 policies in this program on a little over 256,000 individual persons.

Senator MCNAMARA. Thank you very much.

Senator Fong?

Senator FONG. Yes.

Why is it when a man has a multiple policy he only gets paid under one policy? Actually he is paying for another policy which he never gets much protection from?

Mr. FOODY. I wish that were always true, Senator. It is one of the great problems in the insurance industry today, what we call duplication of coverage, that we are trying very hard to solve.

We would prefer that people do not make a profit on their insurance because this induces or we are afraid it induces malingering in the hospital or extra stays and hence does increase the overall cost of care.

But a determination of what is overinsurance is quite difficult to get at. When a person goes in the hospital there are frequently other expenses entailed with the illness other than those which are reimbursed under the hospital forms.

Also, among young people you will find that if mother goes in the hospital, they have somebody in to take care of the children, or child, so that these people may have double coverage.

Under certain policies, certain combinations of policies, we attempt to limit the double coverage if we can avoid it, but a clear, sharp, definition is very difficult to get at, as to what is duplicate coverage and what is not.

Senator FONG. The industry is working on that trying to give the full premium benefit? Many times I find that my costs are only taken care of partly by one policy and the other policy does not pay for the balance of the cost.

Mr. FOODY. I do not understand, Senator.

Senator FONG. Well, I do not recover 100 percent of the cost of my medical sickness even though I have two policies?

Mr. FOODY. Well, we probably prefer in a sense that you do not recover 100 percent of your cost and I think that could well be a situation where you would be overinsured.

Senator FONG. At least, I think, a big percentage of the cost should be covered if you are going to be covered by two insurance companies. I do not think the company should be allowed to get away with a windfall.

Mr. FOODY. Excuse me, you are talking about where you would have two policies that would overlap?

Senator FONG. Yes.

Mr. FOODY. I am not aware of circumstances like that. The clauses that we are working on to solve this problem in the industry would pay up to the limit of your eligible expenses. That is the two companies would get together and you would be reimbursed up to the limit of your eligible expenses, under the various parts that were insured. This is what we are working on to get to.

Senator FONG. In your answer to the question propounded by Senator Neuberger, you stated that a reasonable policy could be purchased for about $100 a year per person, is that correct?

Mr. FOODY. The Senator's question had to do with the rural area as I understand it, sir.

Senator FONG. Now, $100 can buy you a pretty good policy?

Mr. FOODY. Well, what I was describing was our 65-plus program, which costs about $100, and I would say that the people in the rural areas generally have found this very satisfactory. Now, it does not cover their complete costs.

Senator FONG. I understand that.

How does that compare with the King-Anderson bill's coverage?

Mr. FOODY. Well, as I understand the King-Anderson bill—and I am sure others around here know it better than I do—they have three options.

Basically, it is a service-type program in the hospital, depending on the option selected no deductible——

Senator FONG. The option which is closest to your 65 paying $100 a year?

Mr. FOODY. Well, the policies cannot be compared very easily.

Senator FONG. I understand.

Mr. FOODY. In the rural area I imagine that the value of the King-Anderson approach would not be too dissimilar from that. In the metropolitan area it would be quite different.

Senator FONG. Would your $100 a year policy give more coverage than the King-Anderson?

Mr. FOODY. No, sir.

Senator FONG. How much less would it give?

Mr. FOODY. I would say on the basis of nationwide averages, and I do not have an exact number to come up with, but I would say the King-Anderson would be about two and a half times.

Senator FONG. Two and a half times coverage?

Mr. FOODY. Yes.

Senator FONG. Then, it would cost $250 a year?

Mr. FOODY. I do not know if I can——

Senator FONG. I want to tell you that I received a figure from the Blue Cross of Hawaii, stating that they could give the King-Anderson package in Honolulu for the price of approximately $85.20 a year. Would you say that was reasonable?

Mr. FOODY. I do not know what the hospital costs per day are in Hawaii, Senator.

Senator FONG. Approximately the costs here.

Mr. FOODY. What does a semiprivate room run in the islands?

Senator FONG. I do not know.

Mr. FOODY. This is the difference. For example, in California, where the prices are much higher than they are, say, in Mississippi, or rural Wisconsin, the price varies quite a bit.

Senator FONG. Could you work out from your company's actuarial figures as to what the King-Anderson full benefits policy would cost?

Mr. FOODY. In Hawaii?

Senator FONG. Say, in the District of Columbia. Are you able to work on that?

Mr. SINGER. I believe we could prepare such an estimate, Senator.

Senator FONG. Would you prepare for this committee what that package would cost?

Mr. SINGER. I would be glad to.

Senator MCNAMARA. Senator, are you including everything in this?

Senator FONG. Whatever it would be.

Senator McNAMARA. Doctor's fees as well as hospitalization?

Mr. FOODY. No.

Senator McNAMARA. You were talking about King-Anderson and I was talking about Kerr-Mills. This would be hospitalization. Thank you. This figure would make sense if you could provide it for us.

(The information to be furnished follows:)

CONTINENTAL CASUALTY CO.,
*Chicago, Ill., May 8, 1964.*

Hon. HIRAM L. FONG,
*U.S. Senate,*
*Washington, D.C.*

SIR: In accordance with your request during my testimony before the Subcommittee on Health of the Elderly, Special Committee on Aging, this letter will provide you with a cost estimate for the King-Anderson proposal. This estimate has been prepared by the Actuarial Department of Continental Casualty Co.

The approach used was to estimate the cost of a policy which offered the same benefits as the King-Anderson proposal and which would be sold by a private insurance company using the mass enrollment technique of marketing. The estimate reflects the experience Continental Casualty Co. has had with its golden 65 program. Probably the most significant characteristic of such an insured population versus the general population is that the former has a much higher incidence of hospital confinement, however, at the same time a shorter duration of hospital stay is observed. The age distributions for the two populations are very similar.

The estimate was adjusted so that it would specifically reflect the cost levels peculiar to the District of Columbia. Furthermore, the estimate was projected to 1966 cost levels. The estimated costs of these benefits, taking into consideration all of the aforementioned factors, is $198 per person per year. This figure does not include any expense loadings for the cost of administering such a program or paying premium tax.

It should be pointed out that this estimate is somewhat higher than that which the Health Insurance Association of America presented to the Ways and Means Committee of the House of Representatives on November 22, 1963. The main point of disagreement between the two estimates is the expected cost of the nursing home benefit. This is not surprising since this benefit was considered to be one of the most difficult to evaluate. Our estimate of the cost of this benefit was approximately three times HIAA's estimate. In making our estimate it was assumed that adequate skilled nursing home facilities would be available to the residents of the District of Columbia. I also want to reiterate that this estimate was adjusted to the District of Columbia cost levels, while HIAA's estimate was countrywide.

Senate bill 880 provided three specific options which an insured covered under the program may elect. The option that was used for the estimate provided above was 90 days of hospital confinement coupled with a $10 daily deductible for the first 9 days subject to a $20 minimum per hospital confinement. It is estimated that the cost of the other two available options would exceed the one presented by approximately 2½ percent. Due to inflationary effects it is anticipated that if such a program were offered at the rate suggested above a rate revision would be required by 1968.

I hope that this letter provides the information which you requested. If you have any questions on any of the data contained herein, please feel free to call on me.

Very truly yours,

WALTER M. FOODY, Jr.

Senator FONG. What would be the rule of thumb as to what percentage of a person's income should be used for health insurance?

Mr. FOODY. I could not answer that. I think that some of the people in the Department of Labor or some of the economists could do a better job than I. I do not know that. This depends so much on what other assets the individual has. It is not simply a question related to income, I do not believe, particularly with older people. I would prefer not to answer that.

Senator FONG. You stated that your health insurance can only take care of those who can afford it. You cannot provide anything for those who cannot afford it, is that correct?

Mr. FOODY. That is right.

Senator FONG. To those who can afford it, what would you say would be the premium that you are talking about?

Mr. FOODY. I am sorry, Senator.

Senator FONG. I mean how much premium are you asking from these people who can afford it?

Mr. FOODY. Again, the policy I would recommend most highly costs about $150 a year.

Senator FONG. This is the type of policyholder you are referring to?

Mr. FOODY. That is right.

Senator FONG. Approximately how many people can afford $150 a year for insurance—that is the group within age 65 and over, these 17 million people that we are talking about?

Mr. FOODY. I don't know how many can afford it. We know more than half from the things that were said earlier today, do have insurance, so that we are getting at least half the population covered.

Now, I do not say they are all paying $150, but I would say that the average is probably over $100.

Senator FONG. Now, of the 50 percent you said that are covered, what is the minimum premium?

Mr. FOODY. I imagine policies are available, more limited policies, down to about $5, $6 a month, I suppose. It is possible, you see, with individual policies, to grade these down all the way.

Now, I think an individual who did not have any other coverage probably would be ill advised or poorly advised if they purchased a policy for $5 a day today anywhere in the country, because the coverage would be too small.

Senator FONG. Of the 51 percent that are being covered, would you say that a majority of them are covered pretty reasonably?

Mr. FOODY. I believe so.

Senator FONG. You are not talking about those who would pay for a premium of $5 a day?

Mr. FOODY. Pay a benefit of $5 a day——

Senator FONG. I see. What would that cost?

Mr. FOODY. Depending on the other benefits included, ancillary benefits or surgical benefits, I would say that you would buy $5 a day for—let me make sure before I state it. I don't know, $15 or $20 a year, depending on what your markup costs go to. Now, that is just for room and board.

Senator FONG. In your company's experience, how many persons of your 51 percent are being covered by that type of policy?

Mr. FOODY. Well, I wish we had 51 percent of the population; we do not. You mean within the industry?

Senator FONG. Yes, within the industry.

Mr. FOODY. That would be very, very small, I think. We have no indications. I do not believe that we have many policies, if any, that go back that far.

Now, you have a peculiar circumstance here where some people have had policies for years and they purchased them back in the early 1940's,

let us say, and they are good luck charms and you cannot get people to give them up. They still have them and they think this is what has kept them out of the hospital. These are frequently people who would have a second policy, though.

Senator FONG. Let us go back to the question of cancellability. You are advertising that you now sell a policy to anyone who can afford it, is that correct?

Mr. FOODY. That is right.

Senator FONG. Is this a relatively new type of coverage?

Mr. FOODY. Well, we introduced this policy on a mass enrollment basis to the general public in 1957, starting in the State of Iowa, on a one-State experiment. We were nationwide by 1959.

Senator FONG. So, you have only had about 7 years of experience?

Mr. FOODY. That is correct.

Senator FONG. I see. Would 7 years of experience be a long period of time in the industry?

Mr. FOODY. Well, it is a long period of time in a sense on the basic coverages that we have offered. But, in terms of the job that still has to be done, I do not know that it was a long period of time.

Senator FONG. From time to time you will still be modifying your policies, and your premiums will change, is that correct?

Mr. FOODY. I would hope we are constantly modifying the benefit structures as well as the type of policies that we have, and I suppose the premiums are going to change.

Senator FONG. Would you say the premiums will go up or down relative to cost paid?

Mr. FOODY. In the whole medical area, and particularly hospital, I certainly think for the next few years we are going to see continued increases in hospital prices. Was that your question?

Senator FONG. I am saying, if you paid a patient, for example, $300, would that premium go up or go down? I am not talking about whether this is in relation to the cost of a hospital. I am talking in relation to the cost or amount.

Mr. FOODY. In relation to premium dollars?

Senator FONG. Yes.

Mr. FOODY. I think that it is constantly going up. I think the cost of benefits to the dollars taken in is constantly going up.

Senator FONG. For example, if you offered to pay $1,000 for a sickness?

Mr. FOODY. Yes.

Senator FONG. Would the premium go up or would it go down, that $1,000 being constant?

Mr. FOODY. Oh, I think it would go down, if I understand you properly, sir.

In other words, the way I am interpreting your question is, Will the administrative expenses go down for handling hospital insurance?

Senator FONG. Well, I do not know whether the administrative expenses would be a big item in this program, or not. What I am saying is if you were to have a policy which today says, "Well, we will give you so much for every day you are in the hospital," and say that it would amount to $100.

Mr. FOODY. Yes.

Senator FONG. In the future, when you give him $100, will he be required to pay more premium or pay less?

Mr. FOODY. If we are talking about a blanket policy, Senator, one that is open, let us say that there is available to the claimant $5,000 for any hospitalization, I would expect that cost to go up in the—for a while yet, yes. I would expect it to go up.

Senator FONG. You anticipate there would be a time when it would be on a plateau?

Mr. FOODY. I think it has to reach a plateau sometime because if we continue at the rate of increase in hospital coverage that we are today, in hospital rates, the charges would reach an impossible situation. Nobody could pay that.

Senator FONG. I am not talking about your payment in relation to the cost of hospitalization. I am talking in relation to the amount of money paid out by you.

Mr. SINGER. Do I understand your question, Senator, to be what do we think is going to happen to the premium for a fixed set of benefits?

Senator FONG. Yes.

Mr. SINGER. We believe that the premium for a fixed set of benefits probably will increase for a time in the future primarily because older people are showing more disposition to accept this kind of care than they did in the past.

They are more interested in hospitalization where previously they were afraid of hospitals. So, that they are making more use of the facilities and consequently a specified set of benefits will be made use of more often by them and the premium will have to be a little higher.

Senator FONG. Are these policies cancelable by you?

Mr. FOODY. No.

Senator FONG. That is, if I had a policy and I were confined in a hospital say, for 3 or 4 years, and you paid me some every year and I paid you my premium, you will continue it forever. Is that correct?

Mr. FOODY. We will continue it so long as we continue all of the policies of your kind in your State.

Senator FONG. If I bought a policy from you and I continued to pay my premiums and you continued to issue that type of policy to the general public, you will not cancel my policy?

Mr. FOODY. That is correct.

Senator FONG. Are the insurance companies making any profit on these types of policies?

Mr. FOODY. Well, I do not know. I can only speak for my own. We are in the black at all times on this form of coverage, and it is our belief that these policies should stand on their own.

Senator FONG. How many companies are selling health insurance policies?

Mr. FOODY. I guess of all the companies, there are probably 800 or 1,000 companies selling hospitalization policies.

Senator FONG. So, this is a very competitive business, is it not?

Mr. FOODY. Extremely.

Senator FONG. So, if you charge too much premium, you are going to lose policies?

Mr. FOODY. That is true.

Senator FONG. So, in time, you will work out to a point where the company can expect a certain profit and still be able to get the number of people coming to them?

Mr. FOODY. We hope and believe this is true.

Senator FONG. Thank you.

Senator MCNAMARA. Senator Neuberger, do you have any further questions?

Senator NEUBERGER. I would like to clarify one thing. I made a hypothetical case about somebody in a rural community. What I was thinking of was that the Government makes a contribution to a good many rural hospitals through the Hill-Burton program, and usually because of the really more limited care in some of these community hospitals the rates are cheaper.

That was particularly why I selected the rural area, but if the patient going there finds he needs some treatment not offered, he has to move somewhere else. The Senator from Hawaii brought out a point that I was thinking about, and your reply that people are using the facilities more makes me think of one of the great advantages of the King-Anderson bill, where the coverage is provided through social security. King-Anderson provides for quite a long stay in nursing homes. Sometimes people might not need to be hospitalized if they could have nursing home privileges, but when they have hospitalization coverage only, they will go to the hospital. I think that is a definite advantage over the other.

Mr. FOODY. Well, we include nursing home benefits in our policies. I will grant that we are still very much in the development stage of this, but with the policies that we have underwritten for retired groups, the National Retired Teacher's Association, for example, and the American Association of Retired Persons, we have had nursing home benefits for some years now, and these benefits are constantly being broadened in terms of what we offer.

Originally, if I recall the policies, our first attempt at this was nursing home benefits which were available after a period of hospital stay. For example, 5 days, if I recall correctly, you could go into a nursing home. Subsequently, in our 10,000 reserve policy, we have a benefit available to go in a nursing home directly without hospitalization.

Now, the benefit is not $10,000, it is $1,000, but we are experimenting with this to see what can be done in this area and we are taking the first steps, really, to get into this field.

Senator NEUBERGER. Thank you.

Senator MCNAMARA. You mentioned group plans and you specifically mentioned a couple of groups. Do you have individual plans as well as group plans under this golden 65 program?

Mr. FOODY. Technically speaking, the golden 65 policies are individual policies because there is no master policyholder, as such.

Senator MCNAMARA. And you treat the whole group over 65 on a sort of group plan?

Mr. FOODY. Yes, and that is the essence of this program.

Senator MCNAMARA. Do you have a minimum number for these select groups that you mentioned, such as retired teachers?

Mr. FOODY. No. They were on a voluntary basis, that is, people had an option to buy. When we started out talking to the association, we did discuss some minimum number that we would want before we thought the plan would be feasible, but it was a very low number.

Senator MCNAMARA. A very low number?

Mr. FOODY. Yes.

Senator MCNAMARA. Your experience has indicated that your $5,000 medical plan paid out a much lower percentage of premiums than your hospital insurance plans did. Do you conclude from this that the real problem here from a health insurance standpoint, lies more in providing hospital care than medical care?

Do you put the emphasis on that or do you figure otherwise?

Mr. FOODY. We really do not know as yet, Senator, because in the medical area, this is a new policy and we find that by and large the people have to become accustomed to their coverages before you really know what the end result is going to be in terms of utilization of the policy.

So, it is a little early to say. I believe that from national figures that the dollars spent in hospital certainly is the largest single item in the total medical bill. I think that is true.

Senator MCNAMARA. The hospital bill?

Mr. FOODY. Yes.

Senator MCNAMARA. Senator Muskie?

Senator MUSKIE. We have had three figures this morning on the percentage of people over 65 who are covered by insurance. Dr. Merriam stated 51 percent. Dr. Linder's, I think, was 54 percent. Senator Dirksen suggested one of 60 percent. Which one do you consider to be accurate?

Mr. FOODY. I am not a demographer, I am afraid, Senator. I do not know what the answer would be. Our association's number is close to 60 percent. From what I have seen of their work, in terms of the statistical analysis that they use, it looks quite competent to me. I am not aware of the statistical techniques that are used in the Government sources, but I——

Senator MUSKIE. So, the figure you use is 60 percent?

Mr. FOODY. I have no reason to disagree with the figure, Senator.

Senator MUSKIE. Now, what proportion of that 60 percent has adequate coverage, in your judgment?

Mr. FOODY. Adequate is an elusive term.

Senator MUSKIE. Adequate by whatever standards you would use. Then we will get those standards on the record.

Mr. FOODY. Pardon?

Senator MUSKIE. Adequate by whatever standards you use and then we will get your standards on the record.

Mr. FOODY. I think this is very much an individual choice, depending on the person's income, asset position. I think it depends so much on where he or she lives.

Senator MUSKIE. Let me put it this way: There is a great deal of controversy as to whether or not we should cover the health care costs of the aged through other insurance, so we are interested in knowing whether or not private insurance is providing adequate coverage.

Now, if you prefer first to establish your definition of what would be adequate coverage that is fine; because, after all, you have to argue, or your industry has to argue, with people who say that private insurance cannot provide adequate coverage.

If you will give me your definition of what is adequate coverage for people over 65, then I would be interested in knowing what percent over 65 has adequate coverage.

Mr. FOODY. I recognize the problem, Senator. Let me say it a different way—that there are programs in the industry that certainly provide adequate coverage. I think if we are talking in the hospital field that the adequate coverage certainly consists of our $10,000 reserve policy and 65-plus.

This would cover a majority of the bill.

I think really that our 10,000 reserve policy by itself provides adequate coverage. It would protect an individual against a disastrous claim.

Senator MUSKIE. Now, what does it provide?

Mr. FOODY. Well, it provides——

Senator MUSKIE. It has a high deductible feature, does it not?

Mr. FOODY. It has a $500 deductible.

Senator MUSKIE. In other words, no benefits are paid until $500 in bills have accumulated?

Mr. FOODY. That is right.

Senator MUSKIE. And that first $500 has to be met by the policyholder out of his assets?

Mr. FOODY. That is right.

Senator MUSKIE. What proportion of the other policyholders are covered by insurance as good as that?

Mr. FOODY. I don't know.

Senator MUSKIE. Then, you are not in a position to say that the 60 percent are covered adequately or inadequately by insurance?

Mr. FOODY. No. I am not, but I am in a position to say that the industry has offered to people adequate coverage.

Senator MUSKIE. Well, whether or not it is adequate depends upon whether the policyholder thinks so, does it not?

Mr. FOODY. That is right.

Senator MUSKIE. If 60 percent of these people over 65 had bought that kind of insurance, then you can say at least they buy it and they may find it adequate.

Now, I am interested in knowing what proportion of the 60 percent have a policy as good as the one you have described.

Mr. FOODY. I have no way of knowing because I have no way of determining what the other companies have sold.

As far as our program in this area, whether they be through the Association of Retired Persons or through our golden——

Senator MUSKIE. I am trying to pinpoint the fact whether or not these 60 percent have adequate coverage. Now, I happen to be for the King-Anderson bill and I happen to be for it because I say private industry is not taking care of the problem, and I constantly get this figure of 60 percent thrown at me.

They say 60 percent of the people over 65 have insurance from private companies. I am interested in knowing whether in your judgment that 60 percent is adequately covered by private insurance.

Mr. FOODY. I think, Senator, we can say that certainly not all of the 60 percent of these people have adequate coverage in terms of looking at the policies from the standpoint of setting down and analyzing what proportion of the bill they would pay.

Senator MUSKIE. No. But, you said that in your judgment it would be adequate if the policyholder were forced to pay the first $500 himself.

Now, I am saying by that test, using your test, what percentage of the 60 percent is adequately covered?

Mr. FOODY. And I do not know.

Senator MUSKIE. Then, it is not fair for those who argue that private industry can take care of the problem to use the 60-percent figure as an argument, is it?

Mr. FOODY. You asked me for a particular policy that I thought would be adequate. I do not think that you can name any policy or any set of provisions that you can stipulate that this is adequate coverage.

Senator MUSKIE. I asked you to set your own standard of what adequate coverage is and then tell me what proportion of the 60 percent has adequate coverage by your standard. Now, you picked up this policy as an illustration. I did not.

Now, if you can suggest some other standard of adequacy which would be more illuminating to us, I invite you to do so. But, I would like to have some judgment from you, if you have such a judgment, as to whether or not these 60 percent are adequately covered by insurance today.

Mr. FOODY. I have no figure to give you as to how many of the people——

Senator MUSKIE. Do you have a judgment?

Mr. FOODY. Pardon?

Senator MUSKIE. Do you have a judgment as to whether or not they are adequately covered? Any impression, the vaguest kind of impression as to whether or not they are adequately covered?

Mr. FOODY. I believe that the majority of them are adequately covered because they have the opportunity to buy——

Senator MUSKIE. Would you give us some facts to support your opinion?

Mr. FOODY. The only way that I can do this is to say that we have made coverages available to the people——

Senator MUSKIE. I am not talking about what is available; I am talking about what they have. I am talking about these 60 percent that you people are saying are covered by insurance now.

Mr. FOODY. And I am saying, Senator, that I don't know.

Senator MUSKIE. So, you do not have a statistic?

Mr. FOODY. I have no statistics or values which show how many people have what type of coverage, no.

Senator MUSKIE. So, you cannot have any judgment as to whether or not the insurance they have is adequate, is that right? I mean, if you have no facts, and you say you have none, how can you have a judgment as to whether they are covered adequately?

Mr. FOODY. Because I don't know what the words "covered adequately" mean.

Senator MUSKIE. But you said a little while ago that it was your impression that they were adequately covered. If you have no facts upon which to base such a judgment, no standard of adequacy, then why form a judgment in the first place?

Mr. FOODY. Only because the people have purchased what they want out of the various policies that are available, and I have to assume that the majority of them know what they are doing and have purchased policies that in their standards and in their areas are reasonable or in their minds adequate.

Senator MUSKIE. Do you think that every one of these 60 percent have bought policies which they think are enough to do the job?

Mr. FOODY. Of course not every one of the 60 percent.

Senator MUSKIE. This is the point I am getting at. I am taking your figure of 60 percent, and we have had three this morning, two of which are lower, I want to know, and you can answer the question very briefly—(1) whether in your judgment these people or what proportion of them have adequate coverage, and, (2) if you have a judgment, what are the facts upon which you base it?

These are simple questions.

Mr. FOODY. We keep getting the words, "adequate coverage."

Senator MUSKIE. I have asked you to give a standard.

Mr. FOODY. I can't.

Senator MUSKIE. So, you have no judgment?

Mr. FOODY. If you want to say it that way, yes.

Senator MUSKIE. If you want to say it differently——

Mr. FOODY. I have tried, Senator, to say this is a problem that the individual must solve himself as to what he believes he should have, of all the different types of coverage available to what he purchases. This is a function of many things.

Senator MUSKIE. I have so many dollars of life insurance, but I have five children and I know my insurance coverage is not adequate; but it is all I can afford.

Now, if these 60 percent were buying health insurance, I assume some proportion of them could use more if they could afford it. So, I am trying to find out how many of them have less than they ought to have, for whatever reason; whether because they could not afford it or because it is not available. Do you have a judgment on that?

Mr. FOODY. No, sir.

Senator MUSKIE. Now, of the 40 percent who are not covered, what percentage would you say can afford to be covered by private insurance in accordance with your standards of adequate coverage?

Mr. FOODY. Well, we know quite well, or we will assume that those on OAA certainly cannot afford insurance, I would think——

Senator MUSKIE. People on OAA—are you talking about the old-age assistance coverage, the charity cases?

Mr. FOODY. We assume they cannot afford to buy insurance.

Senator MUSKIE. Yes.

Mr. FOODY. The number might be twice as great. Maybe there are 5 or 6 million that cannot. It might be that high. I do not know.

Senator MUSKIE. Now, the figure we had this morning from Dr. Merriam was that there were 8-million-plus people not covered by insurance. I quote from the statement:

> These are likely to be those in poor health, the very old, those not employed and those with low incomes.

Notwithstanding that description, you are saying that of the 8-million-plus, in your judgment, two and a half to three million could afford insurance?

Mr. FOODY. I really have no way of knowing, but if we get——

Senator MUSKIE. If you have no way of knowing why say that?

Mr. FOODY. I was going to get to the point, Senator, that we know we have some 60 percent of the people apparently who have

some form of insurance, adequate or inadequate, so, we go below the $3,000 mark; I do not think you can ignore the presence of family in purchasing of insurance.

Senator MUSKIE. What percentage of that eight and a half million have families that could purchase insurance?

Mr. FOODY. I don't know.

Senator MUSKIE. Then, you have no judgment.

Mr. SINGER. May I offer a comment, Senator?

Senator MUSKIE. Yes.

Mr. SINGER. Obviously, we are not in a position to estimate how many of the uninsured can afford to purchase insurance, but I think that we can set certain minimum values based on Dr. Merriam's figures.

You will note, for instance, that among the married couples in the high-income brackets, 20 percent do not have insurance. This represents about 7 percent of the married couples, who are persons in the top third of the income bracket and who do not have insurance. I think it is fairly evident that these, for example, could purchase insurance.

There are many others; I am not in a position to work up a complete compilation for you at the moment.

Senator MUSKIE. But you agree that there is some proportion of people over age 65 who cannot afford to buy insurance?

Mr. FOODY. Absolutely.

Senator MUSKIE. You said that in your statement.

Mr. FOODY. We also said that 4 years ago, Senator.

Senator MUSKIE. You are not in a position now to pinpoint and tell us how many there are?

Mr. FOODY. That is right.

Senator MUSKIE. If you had time, would you be able to give——

Mr. FOODY. We could give you impressions.

Senator MUSKIE. I do not want impressions. What I would like for you to do is set some standards.

Personally, I think to force a policyholder over 65 to pay the first $500 is pretty stiff, but if that is your measure of adequacy—I would like to have you give us some measure of adequacy, if you have it, say so, some measure of the people over 65 who could meet those standards out of their own pockets.

Mr. FOODY. I said that the policies I described would be adequate to persons who bought it.

Senator MUSKIE. All right, it might be adequate for someone who is earning an income and in my age bracket, but I say, in my judgment for the people over 65, most of whom are not working, that that $500 is a little stiff.

As a matter of fact, it would be a little stiff for me if the truth be known. I am sure it would be for people over 65, but that is your standard of adequacy.

Now, using that as a standard of adequacy, I would like to have some judgment, if you are in a position to give it, of the number of people in the 60-percent group who now have that kind of coverage, those people over the 60-percent group and the 40-percent group who do not have it and who can afford it.

As what income level—what would be the break-even point on income at which you think people ought to be able to afford $150 a year in premiums on health insurance?

Mr. FOODY. Well, income, of course, in this age group is a tough test. I suppose as a general rule——

Senator MUSKIE. If you are over 65 and you are earning $x$ number of dollars, how many dollars would you think you ought to have as income from whatever source to be able to afford $150 a year in health premiums?

Mr. FOODY. Well, apparently, from what was said earlier, if I understand it all, and the aircraft has affected my ears so I did not hear everything that was said, some figure of $2,400 was given as a reasonable income for a family. Did I hear that correctly? For a couple?

Senator MUSKIE. I am darn sure I didn't use it. [Laughter.]

Mr. FOODY. Well, I am sorry then. But, if you figure that the Department of Labor standards come in this area somewhere——

Senator MUSKIE. Correct me, if I'm wrong. You said that a premium of $150 a year would provide reasonable coverage. I don't know whether it is reasonable or adequate or what it was, but a policy that you would recommend to people over 65.

Incidentally, if you could provide that policy, for the record, it would be very useful so we could see exactly what it would provide. For that policy, how much income should an individual have, in your judgment, to be able to afford that premium?

Senator MCNAMARA. Let me say, for the benefit of the Senator, that the staff has such a policy; it was submitted by the company.

Senator MUSKIE. But you have no judgment as to what the income ought to be in order to afford that policy?

Mr. FOODY. No.

Senator MUSKIE. Whether it should be $10,000, $2,000, $3,000, or $1,000, you would not have any judgment on it?

Mr. FOODY. No.

Senator MUSKIE. Might I ask one question? Continental Casualty does participate in the Connecticut 65 program?

Mr. FOODY. Yes.

Senator MUSKIE. In the November 1963 edition of Business Week, Mr. Lee Farmer, a vice president of your company, said that Continental Casualty was basically negative about the State's 65 plan. Would you care to comment on that?

Mr. SINGER. I would like to.

Mr. FOODY. Go ahead, Paul.

Mr. SINGER. Perhaps I should because I am on the executive committee of Connecticut 65, Senator, and I know what Continental's position with regard to the State 65 plans is.

We did join Connecticut 65 and we have continued to be active in it and to participate in it. Our reasons for joining it at the time were that we felt that the Connecticut 65 program was making a definite contribution in an experimental area and we were anxious to participate in it and contribute to it.

Connecticut 65 was really offering the first major medical coverage to the aged on a mass enrollment basis.

At that time our company's program, for example, did not include such benefits, so, we were anxious to participate in it and do our share in it.

Subsequently, we and other individual companies have broadened our benefits so that this kind of coverage is now generally available outside the State 65 programs.

Consequently, we have not participated in other State 65 programs since that time.

Now, this position is not necessarily one that would be adopted by a company which was not active in the field of the aged and wished to participate by way of one of these plans.

Senator MUSKIE. In other words, if I understand your answer, you are not active in the State plans because you, as a company, are able to offer something comparable?

Mr. SINGER. Yes.

Senator MUSKIE. I want to say this in closing my questioning: I do not want to appear critical of the efforts of the private insurance industry to develop programs for the aged. I am interested in my questioning in trying to determine the extent to which you are able to meet the problems of the aged and the problems described by Dr. Merriam, those with low incomes and the rest.

It seems to me that this committee has a problem to try to identify that group, find out how big it is, who they are, where they live, what their health needs are.

Until we have done it, I do not think you people in private industry have been able to evaluate your capacity to meet their problem.

That is why I maybe hit a little hard in trying to get those facts if you have them.

Senator MCNAMARA. Thank you, Senator. We have the honor now of being joined by Senator Williams who has taken a great interest in the work of the subcommittee.

I know he has gone over some of the statements that have come in from the various companies. Do you have any questions or comments at this point, Senator Williams?

Senator WILLIAMS. Not at this point, thank you.

Senator MCNAMARA. I want to thank you very much, Mr. Foody. Your testimony, as well as that of your associate, is very helpful for the record. We appreciate it very much.

The fourth witness this morning is Mr. Edward J. Kelly, first vice president of the Bankers Life & Casualty Co. Mr. Kelly.

Senator MCNAMARA. Mr. Kelly, I hope you will identify your associates for the record and then you may proceed in your own manner.

## STATEMENT OF EDWARD J. KELLY, FIRST VICE PRESIDENT, BANKERS LIFE & CASUALTY CO., CHICAGO; ACCOMPANIED BY MISS ZITA STONE, ASSOCIATE GENERAL COUNSEL; AND J. F. KELLEHER, PUBLIC RELATIONS DIRECTOR

Mr. KELLY. Thank you, Mr. Chairman. My name is Edward J. Kelly, I am first vice president of Bankers Life & Casualty Co. of Chicago. I have with me this morning Miss Zita Stone, our associate counsel, and Mr. James Kelleher, an executive on our public relations staff.

Since our answer prepared in response to the subcommittee's recent questionnaire completely summarizes our company's experience in voluntary health insurance programs for persons over 65, we have not availed ourselves of the subcommittee's invitation to submit a detailed statement prior to today's hearing. However, I will briefly review that experience here, if I may.

Prior to World War II, health insurance was virtually unknown to vast segments of our population. A depressed economy, coupled with increased costs naturally associated with more intensive and extensive medical techniques, left much of our hospital capacity unutilized. Blue Cross and similar group programs arose in response to these needs.

Group insurance, in turn, created an awareness of need and a demand for health protection among millions ineligible for group protection. Sporadic, abortive prewar efforts of various companies to fill this gap proved unsatisfactory.

Our company entered the field in 1945. There existed no body of experience upon which to predicate underwriting of individual health insurance, in contrast to more than a century of accurate mortality statistics in the life insurance field.

Early policies were obviously modest. They were limited in protection and cancelable. Their limitations stemmed from sound underwriting principles which relate premium cost to the insured risk. And 20 years ago we knew almost nothing of the risks involved.

Now we know a great deal more. We have accumulated considerable experience in just 20 years regarding the entire health insurance field including the elderly.

Our policies have evolved with our experience—from cancelable through renewable at company option, to the guaranteed renewable at certain ages, and, more recently, to guaranteed renewable for life. As applicable experience accumulates, we hope to continue to broaden coverage and expand benefits.

Parallel with the pattern of developing ever-increasing coverage to an ever-broadening segment of the population at an ever-higher age level has been our effort to keep in mind an appeal to those of limited means.

From the first we have offered the convenience and budgeting ease of monthly premium payments. As a result, our policies have appealed particularly to middle and lower income groups. We have developed a plan of mass marketing and advertising carefully designed to bring interested applicants to State-licensed local resident agents.

Certainly, persistency here is lower than among those able to pay annual premiums. But to many in a restricted budget situation, it puts some health insurance within reach.

Today, based on the best available statistics, we have 666,856 policyholders over 65 whom we insure under various hospital benefit plans. Another 433,488 policyholders are insured against illness under medical-surgical and hospital indemnity plans of various sorts.

As pointed out in our submission, we know that obviously some duplication exists among policyholders with both types of policies but we are unable to accurately estimate the degree of duplication.

Among the elderly, more than among younger persons, hospital indemnity policies and the like have a direct bearing on their health insurance. With fixed incomes from pensions, social security and so forth, the older policyholder is not as likely to have his regular income interrupted by a hospital stay as is the younger patient forced to leave his job.

Thus, an indemnity policy paying a flat rate per week to a hospitalized policyholder over 65 is much more likely to contribute directly to his hospital expenses.

And we are constantly improving our offerings, as indicated in our submission. We will continue to do so. But in this field, with a bare 20 years' experience behind us, an enormous number of variables still exist.

Medical costs rise steadily—at the rate of 6 percent or more per year—reflecting constantly improving services available to the ill. Hospital labor costs, technological breakthroughs, diagnostic techniques and rising building costs all have a bearing on health insurance and its future for our expanding aging population.

Administrative and sales costs play a role, too. We take some satisfaction in the low administrative cost level we maintain, and plan to continue that pattern of operation.

But the income level of the older potential policyholder in relation to the foregoing is also a factor—and one over which we exercise no control. So is the body of debilities inevitably associated with aging.

We take considerable pride in our role in the evolution of the private, voluntary health insurance industry. But we are realistic and practical as well.

There simply does not exist sufficient information, in the face of shifting variables, to document a definitive conclusion regarding comprehensive health insurance for all persons over 65 for the indefinite future. But we do have sufficient information to reach some tentative conclusions.

We know costs—all costs—are rising. We know our company and others have made enormous strides in this field in a relatively short span of years. And we know millions of the elderly have been relieved from at least a substantial part of the nagging worry growing from the uncertainty of their future health.

But while we also frankly acknowledge we do not have the answer for everyone, we believe we can continue to make real progress for many in line with sound business and underwriting principles as outlined in our earlier submission. Yet, at the same time, we face the fact that there are realistic limitations to our potential—as a company—which will affect the individual's ability or opportunity to continue to obtain health insurance coverage when he reaches 65.

I cannot and will not pretend that I can precisely delineate those limitations. Perhaps after this subcommittee has an opportunity to study and analyze the data being made available to it, some further conclusions can be reached.

Thank you.

Senator McNamara. Thank you very much. Mrs. Neuberger, do you have any questions or comments?

Senator Neuberger. Well, this does not give me very much information about this company. I know Mr. Kelly is in the insur-

ance business and I know that you have some 665,000 policies which provide hospital coverage. What are the limitations?

Mr. KELLY. The limitations as to benefits, do you mean?

Senator NEUBERGER. How much hospital coverage do you pay for those policyholders?

Mr. KELLY. That is the benefits you are referring to.

Senator NEUBERGER. Suppose the hospital bill is $57 a day, do you pay $57 a day?

Mr. KELLY. No ma'am.

Senator NEUBERGER. What is the limitation?

Mr. KELLY. The maximum daily room benefit would be $22 a day.

Senator NEUBERGER. You will pay for $22 under these policies?

Mr. KELLY. Under some of those policies, ma'am, not all of them. They vary.

Senator NEUBERGER. Do they vary because of the premium they pay or the deductible?

Mr. KELLY. The premium, the plan that is selected by the insured.

Senator NEUBERGER. Well, that injects another thought. These 665,000, what are most of them? Do most of them carry the minimum, the $10 a day?

Mr. KELLY. Well, these policies, go back for many years and some of them had a range of anywhere from $4 a day up to, as I say the maximum is $22 a day. The older policies have been upgraded over the years, but I have no way of—I cannot tell you, give you a breakdown as to the benefits provided by these policies.

Senator NEUBERGER. But you would say, then, that many of them provide quite a lot less than $10 a day; is that it?

Mr. KELLY. No ma'am, I would not say that. I would say that most of them would probably be around $10 a day.

Senator NEUBERGER. But if they provided any less than that it would just be practically no coverage. It would be a deductible plan, would it not, because what is the average cost of a hospitalization, two-bed ward?

Mr. KELLY. It varies by area all over the country.

Senator NEUBERGER. I did not ask for the maximum and minimum, I just asked for the average.

Senator MCNAMARA. I think the staff has that figure.

Senator NEUBERGER. A $20 average, the staff tells me. So if your policy for that large group averaged $10 then they really have a deductible policy. It only pays 50 percent of it then.

So, do you give them the premium rates as if they had a deductible policy?

Mr. KELLY. No; our premium rates are in proportion to the benefits provided.

Senator NEUBERGER. I do not know anything about your company or what it provides. What is the cost per year for a policy that only pays $10 a day in hospital?

Mr. KELLY. One of the plans provides a $10 a day room rate with the cost, at age 65, of approximately $60 a year.

Senator NEUBERGER. $60 a year. But if the average cost of the hospital room is $20 then the beneficiary, so-called, would have to have quite a bit of money put aside to pay that difference. Does that $60 premium include anything else besides the hospital day?

Mr. KELLY. Yes; it includes benefits for miscellaneous ancillary services and surgery.

Senator NEUBERGER. Any X-rays——

Mr. KELLY. Yes, ma'am.

Senator NEUBERGER. Thank you for the moment.

Senator MCNAMARA. Senator Fong?

Senator FONG. Mr. Kelly, your company, the Bankers Life & Casualty Co. is one of the largest companies in this health insurance field?

Mr. KELLY. Yes, sir.

Senator FONG. You write approximately 11 percent of all the premiums written or policies written?

Mr. KELLY. I could not answer that question offhand.

Senator FONG. I understand there are approximately 9 million who are insured and you write about a million; would that be correct?

Mr. KELLY. That would be on that basis, yes, sir.

Senator FONG. And are you the largest?

Mr. KELLY. No, we are the largest stock company.

Senator FONG. I mean the number of policies written?

Mr. KELLY. Well, I have not seen any data on it by policy, it is generally by premium.

Senator FONG. How do you fare in the matter of premiums?

Mr. KELLY. We are the largest stock company.

Senator FONG. You are the largest stock company that writes this type of insurance?

Mr. KELLY. That writes hospital, medical, surgical insurance.

Senator FONG. When you compare your company to all companies, not only including stock companies, how do you rate yourself?

Mr. KELLY. Well, I would believe we are in the top 10. The only figures I have, Senator, break down the companies on the basis of premiums for hospital and medical expense as to stock companies and mutual companies, and we would appear to be fifth among both categories.

Senator FONG. When you say you are fifth, are you very far behind first?

Mr. KELLY. Yes, sir, we are quite a way. If you include Blue Cross.

Senator FONG. If you include Blue Cross you are far behind?

Mr. KELLY. Yes, sir.

Senator FONG. Where do you stand with other insurance companies if you eliminate Blue Cross?

Mr. KELLY. Then we are second.

Senator FONG. Whatever you do would have a very, very strong impact on this industry?

Mr. KELLY. Yes, sir.

Senator MCNAMARA. May I interrupt to ask, were you in business before the Blue Cross plan was born? Are you one of the oldest companies?

Mr. KELLY. I said we entered the business in 1945.

Senator MCNAMARA. Then Blue Cross was in existence by that time?

Mr. KELLY. Yes, sir.

Senator MCNAMARA. Thank you. I did not mean to interrupt. Go ahead.

Senator FONG. You have this policy you call the guaranteed renewable.

Mr. KELLY. Yes, sir.

Senator FONG. How old is that policy?

Mr. KELLY. Well, I believe it is about 4 years old.

Senator FONG. Do you anticipate that there will be any radical change in the guarantee factor in that type of policy?

Mr. KELLY. No, sir.

Senator FONG. What I mean is this, does your company foresee doing away with the guaranteed feature of such policy?

Mr. KELLY. No, sir.

Senator FONG. So far as the industry is concerned, would you say that policy is here to stay?

Mr. KELLY. Yes, sir.

Senator FONG. How many other companies write that kind of a policy, guaranteed renewable policy?

Mr. KELLY. I have no exact figures, Senator, but I am sure there are literally hundreds of them.

Senator FONG. Mr. Foody indicates there are approximately 800 companies that are in the health insurance field. Would that be approximately correct?

Mr. KELLY. I believe that is approximately correct.

Senator FONG. And how many companies would you say write this guaranteed insurance?

Mr. KELLY. I do not know how many write it, Senator. I think that there is a very, very large number that do, but I do not know.

Senator FONG. Would you say the majority of them write it?

Mr. KELLY. I would say probably the majority of them write it.

Senator FONG. Then, so far as the guaranteed renewable feature is concerned, that type of policy will stay in the industry?

Mr. KELLY. That is my opinion, sir.

Senator FONG. The premiums may go up and they may go down, but the likelihood of that policy remaining so far as the insurance business is concerned is very good. Is that correct?

Mr. KELLY. Yes, sir.

Senator FONG. So, any person buying a policy today, from a reputable company, can expect that he will have it guaranteed him when he wants it?

Mr. KELLY. Yes, sir.

Senator FONG. Do I understand, Mr. Chairman, that we have the premium rates for various types of policies?

Senator MCNAMARA. The staff has much information on that.

Senator FONG. Would your actuary work out for this committee, Mr. Kelly, the cost that you could package the King-Anderson bill with the Javits modification as it was voted on by the Senate in 1962? Would you work that out for us? What would that cost an individual?

Mr. KELLY. I would be happy to do everything we could to arrive at that, Senator.

Senator FONG. I would like to have those figures if you could work them out for us.

Mr. KELLY. Yes, sir, we will try to do that.

Senator FONG. Thank you.

(The information referred to follows:)

BANKERS LIFE & CASUALTY CO.,
*Chicago, Ill., June 2, 1964.*

Hon. PAT MCNAMARA,
*Chairman, Subcommittee on Health of the Elderly,*
*U.S. Senate,*
*Senate Office Building, Washington, D.C.*

DEAR SENATOR MCNAMARA: Reference is made to the request which Senator Fong made to me during the course of the subcommittee hearing as to the cost of hospitalization under certain specified plans.

Attached hereto as table 1 is the 1966 estimated net annual claim costs for inpatient hospital services under the King-Anderson and Javits bills. These figures assume an average rate for hospital room and board of $23.16 per day, with maximum miscellaneous hospital benefit of $1,000. The 90-day plan assumes a deductible of $10 per day for the first 9 days (minimum deductible $20). The 180-day plan assumes a deductible equal to 2½ days hospital care based on an average room and board cost of $23.16 with maximum miscellaneous hospital charges up to $1,000.

The figures on table 1 do not reflect any additional charge for the expense of administering and paying claims, general company expense, taxes, or profit. The projected cost appearing on table 1 is based on our experience on underwritten risks and may not be entirely adequate to cover the entire population over age 65 without regard to individual medical history.

We have not included any estimate of the cost of providing skilled nursing facilities or home health service, as we have no comparable experience upon which to base estimates. Neither have we included the estimated cost of outpatient services contemplated under King-Anderson. While some of our policies include certain scheduled outpatient benefits, we do not have sufficient data available at this time to be able to furnish an estimated cost figure for the outpatient services contemplated.

We trust the attached information will be useful along whatever lines Senator Fong has in mind, as well as being helpful to the subcommittee in its study of problems connected with health care of the aging. If we can be of further service, please advise.

Yours very truly,

EDWARD J. KELLY, *First Vice President.*

Enclosure.

TABLE 1.—*1966 estimated net annual claim costs for inpatient hospital services under the King-Anderson and Javits bills* [1]

| Age and sex | Cost of miscellaneous benefits, $1,000 maximum | Room and board cost ($23.16 per day) | | | Cost of deductible | | Total 1966 net annual claim costs—In hospital benefits [1] | | |
|---|---|---|---|---|---|---|---|---|---|
| | | 45-day plan | 90-day plan | 180-day plan | 90-day plan | 180-day plan | 45-day plan (2)+(3) | 90-day plan (2)+(4)−(6) | 180-day plan (2)+(5)−(7) |
| (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) |
| Male: | | | | | | | | | |
| 65 to 69 | $83.61 | $73.16 | $79.23 | $83.12 | $23.17 | $36.26 | $156.77 | $139.67 | $130.47 |
| 70 to 74 | 83.61 | 85.25 | 92.32 | 96.85 | 23.17 | 36.26 | 168.86 | 152.76 | 144.20 |
| 75 to 79 | 107.72 | 97.00 | 105.05 | 110.20 | 23.17 | 36.26 | 204.72 | 189.60 | 181.66 |
| 80 and over | 107.72 | 161.92 | 126.62 | 132.83 | 23.17 | 36.26 | 224.64 | 211.17 | 204.29 |
| Female: | | | | | | | | | |
| 65 to 69 | 65.05 | 63.57 | 67.35 | 70.30 | 20.82 | 30.36 | 128.62 | 111.58 | 104.99 |
| 70 to 74 | 65.05 | 76.95 | 81.52 | 85.09 | 20.82 | 30.36 | 142.00 | 125.75 | 119.78 |
| 75 to 79 | 94.04 | 94.01 | 99.59 | 103.96 | 20.82 | 30.36 | 188.05 | 172.81 | 167.64 |
| 80 and over | 94.04 | 119.44 | 126.53 | 132.08 | 20.82 | 30.36 | 213.48 | 199.75 | 195.76 |

[1] Assuming maximum miscellaneous benefit of $1,000.

Senator McNAMARA. Good. Senator Williams, do you have any questions?

Senator WILLIAMS. One or two, Mr. Chairman.

Mr. Kelly, when you were in the exchange with Senator Fong, you were talking about guaranteed renewable policies. Now, you have guaranteed renewables in age groups, at specific ages as well as guaranteed renewable for life. Is that right?

Mr. KELLY. Well, the policies to which we were referring are guaranteed renewable for life.

Senator WILLIAMS. How many of your many hundreds of thousands of policyholders do hold that guaranteed renewable for life?

Mr. KELLY. I would say approximately 200,000.

Senator WILLIAMS. Are most of your new policies that you now are writing guaranteed renewable for life?

Mr. KELLY. Yes, sir; they are.

Senator WILLIAMS. Most, not all.

Mr. KELLY. Not all, but most of them.

Senator WILLIAMS. I have some figures here on the standard monthly premium. Do these sound right? They range from $6.30 at age 65 to $9.15 at age 85?

Mr. KELLY. Yes, those are the premiums, I believe, for one of our policies.

Senator WILLIAMS. They are what?

Mr. KELLY. That is the monthly premium rate for one of our policies.

Senator WILLIAMS. Some States can go higher, though, than that. Is that true, depending on the risk?

Mr. KELLY. On other policies; yes, sir.

Senator WILLIAMS. What is the maximum premium that you have found necessary in some cases?

Mr. KELLY. The very outside maximum, I would think, would be approximately double.

Senator WILLIAMS. In other words, at age 65 it would be a little better than $12, at 85 a little better than $18?

Mr. KELLY. Well, that would be the very maximum.

Senator WILLIAMS. Under the guaranteed renewable for life, does the company have any protection within the policy to cancel for any cause at all?

Mr. KELLY. The only provision of the policy is that rates can be changed as a class, not for an individual.

Senator WILLIAMS. But no matter what, the policy cannot be canceled?

Mr. KELLY. No, sir.

Senator WILLIAMS. That is all I have.

Senator McNAMARA. Mrs. Neuberger?

Senator NEUBERGER. Yes. It bothers me that you said a lot of people have policies that may only provide $4 or $5 a day toward hospital care. Of course, this is the fault of all insurance policies.

You probably have a lot of people that have not even looked at the amount their hospitalization coverage pays, they are going to come up short some day and find $10 a day does not go very far in paying a hospital bill. That is not your fault. They bought it, but they are included in this class of people that seem to have coverage.

On page 3 in your testimony, I do not quite understand the third paragraph.

Thus an indemnity policy paying a flat rate per week to a hospitalized policyholder over 65 is much more likely to contribute directly to his hospital expenses.

In other words, you evidently have a policy of supplementary coverage which pays the beneficiary like an unemployment insurance, is that it, while he is in the hospital?

Mr. KELLY. We have a policy which provides a weekly benefit while confined to a hospital.

Senator NEUBERGER. And that is separate from hospital insurance policy? He could have both, in other words?

Mr. KELLY. Yes, he could.

Senator NEUBERGER. So you could pay him to pay his own hospital bill, but if he were properly covered he would receive an indemnity payment along with hospital insurance? You would allow him to carry both?

Mr. KELLY. Yes, ma'am.

Senator NEUBERGER. And how much per month would that cost him for average hospital care, to have both? Now I am assuming he is over 65, how do you figure what his weekly benefit is.

Mr. KELLY. $50 a week.

Senator NEUBERGER. $50 a week?

Mr. KELLY. Yes, ma'am.

Senator NEUBERGER. All right, he is in the hospital 2 weeks, he would get $100?

Mr. KELLY. Yes, ma'am.

Senator NEUBERGER. And then if he had another policy paying $10 he would have an additional $140——

Mr. KELLY. Or to say it another way, he would have $17 a day.

Senator NEUBERGER. Yes; so that would still make him $3 short on paying the average hospital room and board bill, would it not?

Mr. KELLY. Well——

Senator NEUBERGER. But how much does this cost him in premiums? To carry both of those that would pay him $17 a day? You told me awhile ago $60 in premiums about paid the $10.

Mr. KELLY. Well, it would cost approximately $6.78 or $7.60.

Senator NEUBERGER. A month for both?

Mr. KELLY. No——

Senator NEUBERGER. To get the $17 a day you just cited, how much a month would it cost him?

Mr. KELLY. It would be $9.35.

Senator NEUBERGER. $9.30, and you are still short $3 a day on the hospital room and board bill. Now, the other question I have really concerns me. It is reported that Bankers Life recently reported to the Health Insurance Association of America that you had over a million health insurance policies covering persons age 65 and over. Is that right?

Mr. KELLY. The figure we had was 1,100,344.

Senator NEUBERGER. Well now, did you not modify that later by subtracting some surgical-medical policies?

Mr. KELLY. Yes, ma'am, we did.

Senator NEUBERGER. How many surgical-medical policies were there?

Mr. KELLY. There were 337,118 medical-surgical policies, and 96,370 hospital indemnity policies.

Senator NEUBERGER. These indemnity policies we were talking about, there were how many of those?

Mr. KELLY. 96,370.

Senator NEUBERGER. So, actually, then, we are back to that figure—I am mixed up. So then you have how many really basic hospital expense policies in force on older people?

Mr. KELLY. Well, we have, according to the request from the committee we broke that 1,100,000 figure down into 666,856 policyholders over 65, whom we insure under various basic hospital plans.

Senator NEUBERGER. So the Health Insurance Association of America is using which figure, the million figure or the——

Mr. KELLY. I do not know.

Senator NEUBERGER. Thank you.

Senator MCNAMARA. Senator Williams, do you have further questions?

Senator WILLIAMS. Yes, one or two, Mr. Chairman, thank you.

Mr. Kelly, you have estimated that there are some 800 companies in the health insurance——

Senator MCNAMARA. That was somebody else's figure, I believe.

Senator WILLIAMS. Is that a reasonable figure?

Mr. KELLY. I believe that is reasonable, I really could not tell you exactly how many there are.

Senator WILLIAMS. I know, of course, your company is a company of excellent reputation. I wonder if a reputable company such as yours has any evidence or heard complaints of companies that do not have the reputation for reputability who are perhaps claiming more coverage than in fact exists, and in other ways misrepresenting the policy of coverage that they are issuing?

Mr. KELLY. I do not really have any information on that, Senator.

Senator WILLIAMS. None at all?

Mr. KELLY. No, sir.

Senator WILLIAMS. I just wonder if the King-Anderson approach to the coverage is enacted what the effect would be on a company such as yours, the risk obviously is greater, the older people get, is that not right, and this is reflected in your premiums?

Mr. KELLY. Yes, sir.

Senator WILLIAMS. If a substantial amount of coverage were to be assumed using the King-Anderson approach and the social security as the means, would this have an effect of removing some of your high-risk cases? Would this make it possible for you, perhaps, to broaden your coverage for younger people perhaps at a better rate?

Mr. KELLY. Well, of course, it would have some effect on it, I am sure. But the history and success of our company illustrates imaginative flexibility in my opinion, and I believe that we could continue to be of considerable service to many people over 65 as well as to people under 65.

Senator WILLIAMS. But more specifically for those under 65, do you think you could perhaps write a better policy without a dramatic increase in the premium rate?

Mr. KELLY. No, sir.

Senator WILLIAMS. You know by definition many of your highest risk cases might be covered through the King-Anderson proposal?

Mr. KELLY. But that would not have any effect on the under 65.

Senator WILLIAMS. That is all.

Senator MCNAMARA. Senator Fong?

Senator FONG. Mr. Kelly, I want to ask you two questions. This $60 a year premium, you say, pays $10 a day?

Mr. KELLY. Yes, sir.

Senator FONG. How much is deductible before you pay that $10?

Mr. KELLY. I beg your pardon?

Senator FONG. How much deductible before you pay that $10?

Mr. KELLY. No deductible.

Senator FONG. For anyone going to the hospital, you pay starting the first day on that?

Mr. KELLY. Yes, sir.

Senator FONG. How long would you continue to pay that?

Mr. KELLY. Under that policy I believe we would pay for 31 days. We have other policies that pay up to 100 days.

Senator FONG. I beg your pardon?

Mr. KELLY. We have other policies which pay up to 100 days.

Senator FONG. What would the 100-day policy cost?

Mr. KELLY. For example, the $15 daily benefit at age 65 would be $8.90 a month.

Senator FONG. $8.96 a month?

Mr. KELLY. $8.90 a month.

Senator FONG. For 100 days?

Mr. KELLY. Yes, sir, that would also include additional benefits besides the room rent, of course.

Senator FONG. I see. Now, the $17 per day you said cost $9.30.

Mr. KELLY. Yes, sir.

Senator FONG. That would run for 31 days?

Mr. KELLY. Yes, sir.

Senator FONG. What would it cost if it ran for 100 days?

Mr. KELLY. I could not answer that question, because we have not computed rates on that basis for that particular policy.

Senator FONG. Now, after the 30 days then the second year comes around when you guarantee that this person will be able to buy that same policy?

Mr. KELLY. Yes, sir.

Senator FONG. And the third year and the fourth year?

Mr. KELLY. Yes, sir.

Senator FONG. You do not cancel that?

Mr. KELLY. No, sir, that is a guaranteed renewable policy.

Senator FONG. Thank you.

Senator MCNAMARA. Thank you very much, Mr. Kelly, I am sure your testimony is very helpful to us. I want to say for everybody's information that we do appreciate your patience and we know we are running through the lunch hour. Our next witness has a lengthy statement which we are going to put in the record, then we are going to ask him, considering the fact that it is the lunch hour, to be brief. We hope we will be able to finish.

Thank you, everybody.

Senator McNAMARA. The next witness is Mr. Nelson Cruikshank, director of the Department of Social Security, AFL–CIO. We are delighted to have you here, Mr. Cruikshank.

Mr. CRUIKSHANK. Thank you, Senator.

Senator McNAMARA. Would you like to identify for the record, the young lady who is accompanying you?

## STATEMENT OF NELSON H. CRUIKSHANK, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AFL–CIO; ACCOMPANIED BY MISS LISBETH BAMBERGER, ASSISTANT DIRECTOR, DEPARTMENT OF SOCIAL SECURITY

Mr. CRUIKSHANK. Yes, Senator. I am accompanied by Miss Lisbeth Bamberger, the assistant director of the Department of Social Security of the AFL–CIO. The formal statement indicates that I was also to be accompanied by Mr. Fair, but he had to leave for another appointment.

PREPARED STATEMENT OF NELSON H. CRUIKSHANK, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AFL–CIO

My name is Nelson H. Cruikshank. I am director of the Department of Social Security of the AFL–CIO, and I am appearing here on behalf of that organization. I am accompanied by Miss Lisbeth Bamberger, assistant director of our department of social security.

Mr. Chairman, this committee is to be congratulated on the great public service it is rendering in holding these hearings to inquire as to the adequacy of private health insurance coverage for the aged.

It is a matter of regret to many Americans that private insurance cannot meet the need of financing health care in old age. In testimony on the King-Anderson bill President George Meany of the AFL–CIO spoke on this point last January:

"Speaking for myself, and I am sure for the great majority of Americans, I would be delighted if these private plans could meet the need. We do not want a Federal plan for its own sake. We do not have any ideological stake in extending the operations of the Government. On this issue, as on others, we press for Government action only when other means have proved to be inadequate.

"Such is the case here. I am willing to assume that the insurance companies have made a sincere effort; but the actuarial facts doomed them to failure. The nature of the problem (that the aged get sick oftener, and for longer periods of time; that they require much more institutional care; and that they have much less money to meet the costs of illness) makes it impossible for any commercial insurance carrier or nonprofit health plan to devise a policy that will adequately protect the aged, at a cost they can afford to pay."

That is what we told the House Committee on Ways and Means. Now this committee is spelling out the precise dimensions of this problem. This will be a significant contribution. We sincerely hope that insurance carriers and nonprofit health plans will cooperate by providing the information needed to bring us a clearer understanding of existing difficulties. For our part, we believe we can be most helpful by addressing ourselves specifically to two issues with which we have the most experience: (1) The health coverage through collective bargaining of active workers over 65, and (2) the extension of coverage to retired workers by private insurance through group arrangements.

As this committee is aware, our interest in this problem is much broader than that. In the matter of financing health care in old age the AFL–CIO has assumed the role of spokesman for many more Americans than its 13½ million members. The officers and membership of organized labor have worked, and worked hard, to obtain the passage of legislation that would permit people to contribute, while they are working, toward paid-up health insurance at age 65.

We are cognizant of the problem faced by all Americans, not just our own members, when they reach retirement age and face the fear of high and sudden medical bills that can wipe out their resources. We are concerned

about the plight of all Americans, not just our members, when they are confronted with the hard choice between paying an aged parent's medical bills or helping their children get an education.

We are appalled at the inadequacy of the health insurance that is being sold to the elderly. The policies sold on an individual basis to people over 65 at prices they can afford provides only severely limited protection. Benefits rarely cover more than a small fraction of expenses. Where insurance is available that provides reasonable protection it is so costly as to be out of the reach of the vast majority of the aged, and even those rates are being increased sharply. We agree with the Wall Street Journal's conclusion from its survey of the scene (April 6, 1964) that the purpose of much of the insurance industry's activity in offering new policies to the aged is avowedly political. Insurers may have some hopes of obtaining protection against legislation in this way, but the aged can have little hope of obtaining meaningful protection against the high costs of needed health care.

Not only are the plans that are being sold woefully inadequate, but those of the aged most in need of insurance have none at all. Among the aged in families with incomes of less than $2,000, among the aged with chronic disabilities, among the aged over 75—less than one-third have any health insurance, adequate or inadequate.

As we discuss our experience with collectively bargained health insurance coverage for active workers over 65 and for retired workers, it is essential to keep in mind that the segment of the aged that we are talking about is made up, by and large, of the more fortunate among the aged. These are the workers who are or were working under a union contract at union wages and who enjoy the fruits of seniority.

We are addressing ourselves to a narrow spectrum of this problem, then, not because our interest is narrow but because we believe that our special experience with health insurance that is tied to the employer-employee relationship will make out testimony in this sphere most meaningful to this committee.

## COVERAGE FOR ACTIVE WORKERS OVER 65

As we began a thorough review, in preparation for these hearings, of the question of health insurance coverage for active workers over 65, we were aware of the rosy picture that had been so frequently presented with respect to this segment of the problem, particularly by the Health Insurance Association of America.

*Number of older workers in active employment*

Twenty-seven percent of men over 65, and 7 percent of women over 65, the HIAA stated in testimony in November 1963,[1] are in full-time active employment and, therefore, enjoying in substantial part the health coverage available to most active employees. Past experience taught us to be wary of the HIAA when it comes bearing figures, but we were still shocked when we found that these figures were for 1950, and were taken from a 1951 Census Bureau publication (rather than a 1961 publication as their footnote alleged).

Undaunted, we proceeded to a further examination of the HIAA's description of the health insurance situation of the working aged. We found an HIAA memorandum which stated:

"In 1961, 4.1 million aged persons and their dependents received money income from employment. For those of these 4 million aged who are employed in industries where there is group insurance, these persons currently have health insurance protection with all or a large portion of the premium paid for by the employer. Although it cannot be definitely established as to the exact number of these who are so protected, it is known that in excess of three-quarters of the total working population and their dependents are insured through the group insurance mechanism." [2]

The HIAA thus was suggesting that at least 3 million people (three-fourths of 4 million) were covered by health insurance as part of an actively employed group. (This is apparently also the figure that is used by the HIAA as part of its estimate that 60 percent of the aged now have insurance.)

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[1] P. 1129, Ways and Means Committee hearing on medical care for the aged, 1964, pt. 2.
[2] "An Estimate of the Extent of Private Health Insurance Coverage of the Aged as of Dec. 31, 1962," Health Insurance Association of America, July 1963.

We were somewhat less reassured when we pursued the matter a little more closely. Only 2.3 million persons over 65, it turned out, were employed full time in 1962. Now it is among these people, and not among the 4.1 million with any money income from employment, that health insurance coverage through active employment is likely to be widespread.

*Proportion of active older workers with health insurance*

Then comes the question of just how widespread it is apt to be. The HIAA, in its estimates, blithely assumes that health insurance is as widespread among working people over 65 as among those under 65. When it does so, it ignores entirely the following facts:

A. The proportion of persons who are self-employed and, therefore, vastly less likely to have health insurance, is more than 2½ times as high among the aged as among the rest of the population. These are the figures: In 1960 only about 1 in 12 (8.7 percent) of all persons under 65 had taxable self-employment income, but nearly 1 in 4 (24 percent) of those 65 and over had such income.

B. The availability of coverage through the place of employment diminishes with the age of the worker. The Health Information Foundation reports that among uninsured persons in the labor force, "the proportion reporting that coverage was not offered through their work rose from 72 percent at age 18–24 to 93 percent at 65 and over." The HIF hypothesized that "this rise may be associated in some way with a change in the nature of the jobs held by most people as age rises."

It is clear then that among the 2.3 million persons over 65 who are in full-time work, the proportion covered by health insurance is substantially less than three out of four as claimed by the insurance industry.

*Trends*

The outlook is that a steadily decreasing portion of the aged will have health insurance coverage as active employees. An examination of available facts and figures again runs counter to the rosy predictions of the insurance industry. Only about three-fourths as high a proportion of men over 65 had any work experience in 1962 as in 1950. The proportion of full-time year-round workers decreased by nearly one-half. In this 12-year period the percentage of men over 65 with any work experience during the year decreased from 49.3 to 38.4. The percentage of such men having full-time year-round work decreased, in the same period, from 25.8 to 14.5. All indications, including projections of the Department of Labor and Department of Commerce, point to a continuance of this trend.

### 2. HEALTH COVERAGE FOR RETIRED WORKERS UNDER COLLECTIVE BARGAINING

Unions have tried to obtain health insurance coverage for retired members through collective bargaining for over a decade. Organized labor began its efforts in this direction before legislation was introduced that would provide health benefits through social security. It has continued its efforts while at the same time working for the Forand bill, and the King-Anderson bill in more recent years. We have worked on the collective-bargaining front because we must do what we can to meet the immediate need of our retired members and of persons who are now retiring. We have worked on the legislative front because we know that the health insurance we can obtain for the retired aged through collective bargaining is and will be hopelessly inadequate to the dimensions of the need. To attempt to meet the problem of financing health care in old age through collective bargaining is like using an eye dropper and a sieve to bail out a sinking battleship.

Private plans extend benefits only to retirees with records of long and continuous service; they are of no avail to the majority of workers who—willingly or unwillingly—change jobs during their working lives. They serve the fortunate minority, who work continuously for a single forward-looking employer and belong to a strong union. Furthermore, what protection these plans provide is available only during the retiree's lifetime, excluding his widow; they typically set a ceiling on total lifetime benefits; they make no provision for disability before 65; and they cut off workers who lose their jobs before retirement because of technological unemployment or other reasons.

While unions pushed for health insurance for their retired employees, employers and insurance companies sharply resisted demands for such coverage, especially during the early 1950's. According to one large union:

"At the earliest stages of our efforts to enroll retirees, the carriers often refused to make coverage available and, in effect, instructed their field agents to discourage actively any moves to include retiree coverage. * * * Almost without exception, employers were initially unwillinging to assume responsibility for direct contributions."

More recently, as an apparent consequence of pressure for a legislative solution to this problem, ideological resistance on the part of employers toward coverage of their retired workers became less intense, but there was little change in their unwillingless to put up the amounts of money required if retired persons were to be covered under reasonable eligibility requirements and with an adequate scope of benefits. Even an appeal by the chamber of commerce to selected employers had little effect. Several years ago the chamber wrote to a number of companies that had refused to extend private health insurance through union negotiations and advised them, in effect, to do for political reasons what they would not do for humanitarian reasons. Despite such appeals and the glowing reports of the insurance industry, little progress has been made. The number of retired persons protected through group coverage remains small, benefits remain inadequate, and there is no reason to believe that this situation will change for the better.

While comprehensive figures on the coverage of retired workers through collectively bargained plans are not available, we were able to obtain for this committee some indication of the current situation by requesting reports from a representative number of the major unions affiliated with the AFL–CIO. Information obtained from these reports and from several published studies follows:

*A. Most companies still do not extend health insurance coverage to retired workers*

Even among the 100 major plans studied most recently by the Department of Labor, only 63 of them extended coverage to retired employees. Among 300 plans studied by the Department of Labor, only 115 extended benefits to retired workers.

The smaller the plan, the less likely it is to provide coverage to retired workers. One study in Ohio found that of firms with health insurance plans, less than 20 percent of the firms with fewer than 100 workers, 31 percent of those with 250 to 499 employees, and 44 percent of those with 500 or more employees, provide health insurance for retired workers.

But even many large companies continue to resist the extension of health insurance to retired employees. One union which negotiates contracts with some of the largest corporations in the country writes: "We have found a general reticence on the part of companies in our jurisdiction to provide retiree insurance. This is true even when we are willing to agree to a contributory plan."

Several of the unions reporting indicate that only between 3 and 5 percent of their members will become eligible at retirement for health insurance obtained through collective bargaining. Many unions write of their frustrations in negotiating such coverage. "The demand for hospital, surgical, and medical program coverage for retired employees and their dependents," writes the president of one union, "has been an unsuccessful issue in several recent significant negotiations."

The unions in the railroad industry, to cite another example, are among the many that have not been able to secure employer participation in covering retired workers.

"Nearly all railroads are parties, with the unions, to [a contract] which provides health insurance for nonoperating employees in active service and their dependents * * *. It was necessary, however, that the unions themselves negotiate [with the carrier] to provide health insurance for furloughed and retired employees because of the repeated refusal of the railroads to join with the brotherhoods in setting up a health insurance program for these workers * * *. The entire monthly payment is made by the furloughed or retired employee."

*B. Many workers are not eligible for health benefits at retirement because they do not have the required length of service to qualify, or because of other eligibility restrictions*

Most plans, especially those to which the company makes a substantial contribution, have high eligibility requirements. Ten or fifteen years of service is typical; a 20-year service requirement is frequent; a 25-year requirement is not

exceptional, and 30-year requirements can also be found. With today's industrial mobility, such service requirements eliminate an enormous number of working people from coverage.

Since eligibility for health insurance in retirement is usually tied to pension eligibility (while, of course, only a fraction of firms with pension plans also have health plans for retired persons), one can get an idea of prospects for future eligibility for health benefits at retirement from estimates of eligibility for pensions. According to Senator Paul Douglas, who recently reviewed the data on this point, "only from one-third to one-half of those ostensibly covered, and from whom contributions are made, will actually benefit at journey's end" from existing pension plans.

One union, more successful than most in obtaining health protection for its retireees, writes of the situation that prevailed for its members until 2 years ago, and that is still usual elsewhere.

"For a number of years, there were no employer contributions for retirees and the underwriting rules were very strict. The retirees were offered a single lifetime opportunity to become enrolled. A worker not covered by Blue Cross-Blue Shield at the time of retirement, or one who retired without a pension was unable to obtain group coverage. A retired worker who, for any reason, missed a month's or quarter's premium was permanently removed from the group. If for any reason the actively employed group ceased to be enrolled in Blue Cross-Blue Shield, the retirees were stranded. A number of retired groups have lost coverage when plants moved or were permanently shut down. Others have been continued under precarious arrangements at the sufferance of the carriers with the possibility of discontinuance always present."

The same union comments further that it still has a substantial number of retired members without any health insurance. In addition to those workers who retired from an establishment without a pension plan, others are without health protection in retirement for any of the following reasons, as cited by this union:

(1) The workers may lack the required 10 years of pension service credits to qualify for any company financed pension benefit. Hence they are barred from participating in hospital-medical coverage after retirement for lack of an acceptable source of payment.

(2) Although covered under a pension plan from which they may eventually collect some benefits, their employment (and coverage) was terminated by a permanent layoff—because of their jobs being abolished through automation, business failure, transfer of operations, etc.—prior to retirement.

(3) Their coverage is canceled because they are retired from establishments that have been permanently shut down (or that have been drastically curtailed) and there is no longer any actively employed group (or a very small one) by which the excess claim costs of the retired group can be absorbed. Among those cut off in this way are retired employees of the former Hudson Motor Co. of Detroit, of the former Electric Auto-Lite (now Eltra Corp.) plant in Toledo, and of the South Bend operation of Studebaker.

(4) They die and their survivors, having no continuing pension, are not permitted to continue coverage. Naturally, this occurs most frequently among the older retirees.

*C. Costs to retired workers often prohibitive*

Plans arranged for or negotiated by the union may be out of reach of the retired person, and entail severe financial sacrifices—even where there is an employer contribution. Most plans of health coverage for retired employees require some contribution from the retired worker; often the retired person must pay the entire amount; where the employer does contribute, his payment is usually limited, and often the retired person must bear the cost of any increase in premiums.

According to a survey of the Health Information Foundation, nearly one-third of persons without insurance who were formerly insured had to drop their coverage because "they could not afford to make the payments, or found them too expensive."

One union that has obtained group coverage for its retired members finds that the fact that the entire cost must be paid by the retired person keeps the great majority of members from being able to enroll.

"The benefits * * * are not adequate, but they are the best that could be obtained for the premiums paid. It has been necessary to keep the monthly payments as low as possible in view of the reduced income of our retired members. Nevertheless, many of them have been unable to take advantage

of the protection of [this] policy. * * * The health insurance coverage presently available to [our members] is very inadequate, both from the standpoint of benefits and the number of retired workers who are able to avail themselves of this protection. The situation is brought to our attention repeatedly by letters from our retired members who either have been financially unable to participate in the plan or, having enrolled, find that they are still required to pay a substantial portion of the hospital, medical, and surgical expenses they have incurred."

Even where there is an employer contribution, the cost problem is severe. Here is the description provided by one large union:

"The average retiree, even with employer contributions, has out-of-pocket costs for coverage now that are almost as high as they were a few years ago when the retiree paid the full cost himself. In Michigan, for example, retirees enrolled in Blue Cross-Blue Shield, with the employer paying half the cost, now have premium payments to make that are approximately 75 percent of the amounts they had to pay for identical coverage in 1959 when there was no employer contribution. Nor can it be overlooked that people who were retired at that time have had increases neither in OASDI nor in their pensions.

"Currently the typical pensioner pays about $5 a month if he is single, and about $12.50 if he is married. On the average this means that an elderly couple would have to spend about 15 to 20 percent of their negotiated pension benefits for health insurance. For some, particularly those still paying unaided the full cost, the amounts spent for health insurance are more than half of the pension. The best that we have been able to achieve is a continuance of group coverage and group benefits for retired workers. The cost of coverage, in addition to any employer contributions, comes from deductions from pension benefits, authorized by the retiree."

*D. Benefits for retired employees are almost always reduced from those available to active workers, and are usually inadequate*

"It is painfully obvious," writes one union official, reflecting the conclusions of the majority of those reporting, "that these private plans do not begin to cover our retirees in serious illness.

"Program coverage for retired employees is universally inadequate," begins another. "This is true regardless of the hospital, surgical or medical benefit analyzed. Realistic benefits in terms of present-day costs are not provided. In this regard our examination of the programs on file indicates that in every case program benefits for retired employees are less than those for active employees."

"Hopelessly inadequate," "benefits startingly reduced," are the phrases that reflect the tenor of every one of these reports.

*E. Plans that provide conversion rights to individual enrollment after retirement are of very little value*

One union, which has a large concentration of membership in New York State—the only State which requires insurance companies to provide conversion rights for those covered previously by group insurance—writes us:

"The costs of insuring persons over 65 years of age for hospitalization and surgical benefits individually are so high that very few retired * * * members can afford to buy such individual health insurance policies. Less than 1 percent of retired members * * * who were eligible to convert to individual policies have converted their group health insurance to individual health insurance policies * * *."

## CONCLUSION

In the light of experience of the kind we have cited, what is the practical possibility of providing health benefits for aged persons through collective bargaining?

It is clearly evident that no national program can be based on a projection of limited success among a relatively small number of the more fortunate workers. Even though people who belong to AFL–CIO unions are among those most likely to have benefits made available through collective bargaining, and despite our best efforts for more than a decade to bring these plans in line with the protection our members need, we are absolutely convinced

that the social security method offers the only practical solution. We came to this conclusion because:

A. The aged with potential access to negotiated health benefits do not constitute a typical segment of the over-65 population. They are among the best off of the Nation's elderly. Their incomes are substantially higher than those of the rest of the aged population, as the following table shows:

*Median total income of persons aged 65 and over in 1962*

| | Married couples | Nonmarried persons |
|---|---|---|
| All persons | $2,875 | $1,130 |
| Persons usually working | 4,670 | 2,790 |
| Persons receiving pensions | 3,400 | [1] 2,200 |

[1] Estimated.

Though people with potential access to negotiated coverage are not, by and large, getting the kind of health insurance they need, they are sufficiently better off than those not having such access to make them quite unrepresentative of the total aged population.

B. There are inherent limitations to extending covering to the aged through collective bargaining.

As we have shown, the proportion of persons over 65 in regular full-time work is decreasing and can be expected to continue in a downward trend. This means that in the future a smaller segment of persons over 65 will be receiving health benefits as active workers.

While there may be an increase in the number receiving negotiated benefits in retirement, this number is severely limited by the limitations of collective bargaining itself. These limitations are reflected with most serious consequences in the strict eligibility requirements under collectively-bargained plans. A mobile society such as ours simply cannot tie a basic minimum retirement benefit to continuous service with one employer. But the mechanism of collective bargaining cannot go beyond the individual employer-employee relationship. Only a Government program can do that.

C. Attempts to extend coverage of private insurance plans to the aged have confronted the plans with irreconcilable conflicts. If the premium rate, adjusted to include the high-cost experience of the elderly, is spread over the entire group then the costs to others under the plan become, if not prohibitive, impracticable in a competitive insurance market. If separate rates for different groups under the plan are set to reflect the high-cost experience of the elderly, and the lower costs for the younger groups, they are definitely prohibitive for most of the aged. The stresses and strains of these hard facts have simply proven too much for the private plans.

The question of whether the health bill of the aged shall be paid is not up for discussion. The only question is how. The problems the aged face in paying for their own care, the difficulties they encounter when they must turn to their children for help, the serious drawbacks of using State and Federal public relief funds is a matter of record. Here we would like to comment only on the problem of these costs being shared and often subsidized by others who are insured.

Indications are that a considerable proportion of the rate increases in plans that retain an element of community rating come as a result of the high cost of coverage for persons over 65. Now we wish to make it plain that we are in favor of persons who are in active employment sharing in the high cost of coverage of the aged. But we want this sharing to be equitable. That is why we advocate sharing through social security contributions. We do not believe that the sharing should be limited to those Blue Cross subscribers who happen still to belong to a community-rated plan. Nor do we believe that sharing should be limited to those who belong to plans where the high cost of over-65 coverage can somehow be kept hidden, and charged surreptitiously to the actively employed.

We have long maintained, and every bit of additional evidence confirms our position, that the best that could happen to private health insurance plans, both the commercial carriers and the nonprofit plans is the enactment of health benefits for the aged through social security. With basic protection assured under social security hospital insurance, aged persons could use what funds they have

to supplement their coverage. Supplementary insurance could be sold by private insurance plans to cover items not covered by social security hospital insurance, such as surgery, drugs, physician visits, and dental care. Without the burden of insuring the high-cost aged, Blue Cross, Blue Shield and commercial insurance carriers could hold down their rates and provide health insurance to the working population more successfully.

The pluralistic approach to our major social problems has become in this century the typical American approach. It has worked in the pension field, with basic protection provided under the Government social security program, supplemented by a multitude of private plans. It is the only practical approach to the knotty problem of health care for the aged. With a basic social security plan, private plans can continue and even flourish. But they can never do the job alone.

Mr. CRUIKSHANK. We appreciate the opportunity to appear before this subcommittee, Mr. Chairman, and members of the committee, as we think this is a tremendously important inquiry that your subcommittee has undertaken, one of vital concern to our members and those whose interests we try to reflect.

I will, as you suggested, be as brief as possible in view of the time and the fact you have given us permission to enter into the record the formal statement which we have presented.

I would like to make it clear at the outset, Mr. Chairman, that in our testimony, as in the inquiry of this committee, we are not attacking the private insurance industry or nonprofit plans, the Blue Cross or Blue Shield, we are examining the adequacy of these plans in a situation such as we have now where there is no basic Government plan. The fact that we find these private insurance plans unable to do the whole job does not mean that we feel there is no place for them or that they should be done away with.

Now, our interests, both in terms of the people for whom we are concerned and the range of the subject is broader, much broader than the statement we have presented.

We are, of course, concerned with our own membership, those who we represent directly, but we also are concerned with the people who are not our members—the aged generally, and those who have the aged as a problem within their family.

We are concerned also with the quality of the insurance that people have—its adequacy to protect them against the devastating costs of hospitalized illnesses. But we do not deal with that extensively in this paper.

Others will examine that and already this morning you have gone into it at some length. I could say in an aside that it is interesting to us to see the picture that was suggested by representatives of the insurance industry that people have a great smorgasbord of policies before them and apparently operating with complete freedom to determine what kind and extent of insurance is tailored to their individual needs, and then buy that which is available.

One representative kept insisting that insurance was available to everyone in the country, that everyone over 65 had a policy available to him. Well, this I suppose is true exactly in the sense that every person in the United States has a Cadillac available to him, if he could meet the conditions of the Cadillac agency in his community.

We do, however, deal in our paper with two issues with which we feel we have the most experience, and where we can be the most useful to this committee in its deliberations.

First, health coverage through collective bargaining for those over 65 who are still working. And second, the effectiveness or lack of effectiveness of efforts to extend coverage to retired workers by private insurance through group arrangements.

Now, as to No. 1, health coverage through collective bargaining for older people, who are still working. In gaging the effectiveness of this whole approach we examined the claims of the insurance industry and we find that apparently in an attempt to show that there is no need for a Government program the figures have been distorted and grossly misinterpreted.

The facts are, as we demonstrated at length in our paper, that few older workers have protection. Many fewer older workers have protection than has been claimed. In fact, we understated our case in our paper and I would call attention to two corrections that we have made on the copy that we have filed with the reporter.

On page 3 of our statement in the third full paragraph on line 3 you need to strike out "the year-round," and on page 4 dealing with the same subject, the second line after the end of the quote at the top of the page strike out again "year-round." Both these references are to those who have significant employment but not full year-round employment.

What happened, apparently was that the insurance industry made an estimate of the number of employed people who had some kind of protection under a group policy, then they projected the same proportion into this group of aged employed persons. But the fact is that a much, much smaller proportion of the people age 65 and over have the same type of employment that characterizes those under age 65 so you cannot project this. The estimates that they arrive at on the basis of such a projection are completely erroneous.

Now, No. 2, health coverage for retired workers through collective bargaining. Here in our paper we cite extensively the responses to telegraphic requests we sent to some 30 of our largest and more experienced affiliated unions. The experiences that they cited in response—and these are people who are on the frontline of the collective bargaining efforts to meet the problem of health care for their older workers and retired workers—the experience that they cited in response to our inquiry can be summarized as follows:

(*a*) Most companies do not extend health insurance to retired employees. I do not mean insurance companies, I mean employing companies. Most companies do not extend health insurance to the retired employees. Those that do are usually the larger concerns. We know that while General Motors and the big steel corporations and all are in our minds often when we think of employers, we know that still the vast greater proportion of workers in this country do not work for these giant companies, they work for much smaller companies.

Now the movement, such as it is, to extend insurance to the retired employee has not caught on at all among the smaller employing units that affect such a great number of our people.

Second, many workers are not eligible because the health benefits are tied to the pension plan and many workers do not qualify for the benefits of the pension plan because their employment with one company has not been long enough and therefore do not qualify for the health benefits.

The best estimate we have is that from a third to a half of those covered under the pension plan will have any expectation of having the protection of the health plan after retirement.

Third, the costs are prohibitive. In very few of the plans, while they may extend beyond retirement, does the employer pay the whole cost or a significant part of the cost. So that while the retired worker may have the privilege of extending at the group rate, the costs are prohibitive and many of the people drop out when they go on a reduced retirement income.

And fourth, the benefits to the retired workers are almost always reduced; that is from those provided in the plan. Now, this is particularly significant because we know that when people reach retirement age their need for coverage rises dramatically, but under these plans that extend the protection after retirement the protection drops.

It drops just when it is needed most, and in this respect I would like to call the committee's attention, Mr. Chairman, to a very significant report that just came out last week, in fact it reached our building last Friday, after, under the rules of this committee to get the statement over, our statement was already on the mimeograph—and you know what is on the mimeograph is like the laws of the Medes and Persians, it cannot be changed at that late date. This very significant study, a research report from the National Industrial Conference Board, which is not, need I say to anyone in this room, a labor-oriented research group, but an industry-oriented research group.

They have here in their "Studies in Personnel Policy," No. 190, a study of corporate retirement policy and practices, chapter 6, which deals with the coverage of health insurance and hospital insurance under these retirement policies, and I suggest, Mr. Chairman, that your committee get this chapter 6 and make it a part of the record, but at this time I would like to cite what this industry research group says, and I quote:

> By and large, companies that continue commercial health insurance for retired employees do not extend the full scale of benefits provided by the program that covered the employee prior to retirement. As table 25 indicates, 65 percent of the base plans and 86 percent of the major medical programs in this study reduce coverage at retirement.

Continuing the quotation after skipping two short paragraphs:

> Apparently the reduction of health insurance coverage at retirement is more widespread now than some years ago; at least under base plans, the only type for which data are available. Thus, in the 1955 conference board study only 50 percent of the 71 companies that continued hospital coverage after retirement-reduced benefits as compared with 65 percent in the current study.

In other words, this picture that has been given to us of an onward march—just leave private industry alone; it will take care of the problem—is not supported by one of the most reputable research organizations sponsored by industry itself.

In conclusion, Mr. Chairman, I would say that in the light of our experience—and I submit that our experience is the most extensive in the country with the collective bargaining effort—we concluded that meeting the health costs of the aged through extending collective bargaining provisions is hopeless.

What is needed in this area is clearly the typically American, pluralistic approach, a basic Government plan through social security, sup-

plemented by all kinds of private arrangements, the unilateral plans of employers as well as those negotiated through collective bargaining, and here is where our most basic difference with the insurance industry rests.

It is their contention primarily that they can do the job alone and that no Government program such as that contemplated in King-Anderson, is needed. We make no such contention in support of King-Anderson. We say that King-Anderson as representing a Government program, a basic Government program, like social security, should provide the floor of protection for all of the working people of this country, and that there is a place for insurance. There is a place for private insurance. There is a place for commercial insurance. There is a place for the Blue Cross, the Blue Shield, and the others that have made an important contribution to this problem. But its place is to supplement the basic protection afforded by a Government program of social insurance.

This is a very brief summary, Mr. Chairman, and I thank you for the opportunity of presenting it.

Senator McNAMARA. Thank you very much, Mr. Cruikshank. We appreciate your brevity and we know you could go on at great length. We are sorry the time has caught up with us. You concluded by indicating support for the King-Anderson plan.

There is before the Congress now some thought of increased social security benefit payments. Will these increases that are contemplated, in your judgment, be adequate so that people could buy proper health insurance protection under the private plans now available?

Mr. CRUIKSHANK. Well, if cash benefits were increased, of course, Senator, it is obvious that there are a lot of things retired people could buy. There has been no increase in cash benefits since 1958 and there should be some increase in cash benefits in social security, but this is not the best way to provide the health insurance that is needed, primarily because most of these people would have to buy the individual policies that are available and these are the most wasteful and the most extravagant and the ones that give the least return for the dollar.

The insurance industry itself points out in their publications that these individual policies yield only about 50 cents on the dollar in benefits paid, so this is not the way to meet the problem. The elderly need the improved cash benefits but they should not have to spend them for this kind of wasteful and extravagant insurance.

Senator McNAMARA. These increased benefits would catch up with the increased cost of living to some degree. So it would be less than what is required to do that. Is that your judgment?

Mr. CRUIKSHANK. I am not quite sure I understand you, Senator.

Senator McNAMARA. Actually, you say we have not had an increase——

Mr. CRUIKSHANK. In the cash benefits in social security, I do understand you now. Yes, we do need those to catch up with the increase in the cost of living; yes, sir.

Senator McNAMARA. This probably would not even do that, the proposed increases now before the Congress.

Mr. CRUIKSHANK. There are various proposals. Let us assume for the moment that the increase was commensurate with the rise in the cost of living, then you would have barely kept pace with the real benefit that you had in 1958.

Senator MCNAMARA. You cite some figures in this study that recently came out. We have instructed the staff to see that they get a copy of it as it applies to private employers.

Senator MCNAMARA. Now, is it not true also that Government plans generally reduce the benefits after retirement as well as in private industry? You pointed out that under private companies the benefits are reduced after retirement. That is also true in Government plans, is it not?

Mr. CRUIKSHANK. Well, the Government plan for the retired employees is a different plan basically.

Senator MCNAMARA. Yes, it is a different plan, but they also face the same reduction upon retirement that you made reference to under the private plan? I mean if somebody works for a U.S. Senator, or the Senate, no matter what their level of employment is, when they retire their health insurance benefits are reduced, too.

Mr. CRUIKSHANK. The health insurance program covering those Federal employees that were already retired when Federal employees health insurance legislation was enacted, provides more limited benefits than does the program for actively employed Federal workers. However, Federal employees who have retired from active employment since that time continue to draw the same benefits and make the same contributions as they did while they were working.

Senator MCNAMARA. I see. Now, we are going to ask the members of the committee, in view of the hour and the patience that has been displayed, to be as brief as possible.

Mrs. Neuberger, do you have any questions?

Senator NEUBERGER. This is somewhat of a comment, but through these last three witnesses it was indicated that the best buy for the insured was to buy a deductible policy, and one suggested a $500 deductible with a much smaller premium. I was thinking that actually the fellow who can afford a $500 deductible is the one who is really able to pay a greater premium, and you constantly put the emphasis on the low-income family. In your statement, which you did not read verbatim, you have a point that always bothered me with the private insurance companies, and that is failure to meet the premium.

You say here on page 9 that according to a survey nearly one-third of the persons without insurance who were formerly insured had to drop their coverage because they could not afford to make the payments or found them too expensive. This is the $x$ factor in all these private insurance companies.

We do not know how many people signed up and just could not meet the $9 a month payment or whatever it was. This is, of course, the value of social security being deducted during working years before retirement.

Mr. CRUIKSHANK. The social security approach in effect gives them a paid up policy at the time they become eligible.

Senator MCNAMARA. Thank you, Senator Williams?

Senator WILLIAMS. Just one question, Mr. Chairman. Have you heard reports from people complaining that the coverage they get, in fact, is not equal to the coverage they thought they had bought?

Mr. CRUIKSHANK. Yes, Senator; we have complaints, people write us letters saying that they are oversold, that they thought the policy covered more than it did.

I do not know that we have had any complaints that people did not get the coverage that was actually in the policy, but they have been oversold in these policies. They have been presented as meeting the problem and people buy them and then they find that there is some fine print in the policy.

Senator WILLIAMS. Is this widespread, do you know?

Mr. CRUIKSHANK. It is hard for us to judge. I would say that we have not had a volume of mail and complaints about it that would indicate that there is any great tidal wave of objection. We get a considerable amount of complaint on this kind of thing, but I do not know that you would call it widespread.

The greatest number of complaints we have had relate to the fact that people carry these policies for years and pay premiums on them for a long time, then when they get ill for the first time and make a claim for benefits, the company cancels the policy. This is widespread.

Senator WILLIAMS. Thank you.

Senator MCNAMARA. Thank you very much.

We appreciate your help and I am sure the information you have furnished us will be of great help to the committee.

I want to announce that tomorrow morning we will open the session at 10:15 to give us a chance to answer the first quorum call which we will expect will be the same as today. We will meet in this room.

(Whereupon, at 1:10 p.m., the hearing was recessed, to reconvene at 10:15 a.m., Tuesday, April 28, 1964.)

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