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 3

WASHINGTON, D.C.—APRIL 29, 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 health insurance were held as follows:
Part 1—Washington, D.C., Apr. 27, 1964.
Part 2—Washington, D.C., Apr. 28, 1964.
Part 3—Washington, D.C., Apr. 29, 1964.
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BLUE CROSS AND OTHER PRIVATE HEALTH INSURANCE FOR THE ELDERLY

WEDNESDAY, APRIL 29, 1964

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

The subcommittee met at 10:15 a.m., in room 4232, New Senate Office Building, Senator Pat McNamara (chairman of the subcommittee) presiding.

Present: Senators McNamara, Williams, Moss, Neuberger, and Fong.

Also present: Jay B. Constantine and Frank C. Frantz, professional staff members; Patrica Slinkard, chief clerk; Toby Berkman, research assistant; and John Guy Miller, staff director.

Senator MCNAMARA. The hearing will be in order.

The first witness this morning is Dr. Edwin F. Daily, vice president and medical director, Health Insurance Plan of New York, representing the Group Health Association of America.

Doctor, will you identify your colleagues for the record?

STATEMENT OF EDWIN F. DAILY, M.D., GROUP HEALTH ASSOCIATION OF AMERICA, INC.; ACCOMPANIED BY DR. W. P. DEARING, EXECUTIVE DIRECTOR, GROUP HEALTH ASSOCIATION OF AMERICA, INC.; LOUIS L. FELDMAN, CONSULTANT, GROUP HEALTH ASSOCIATION OF AMERICA, INC., AND UNDERWRITER, HEALTH INSURANCE PLAN OF GREATER NEW YORK

Dr. DAILY. On my left, Dr. W. Dearing, executive director of the Group Health Association of America; on my right, Mr. Louis L. Feldman, underwriter for Health Insurance Plan in New York.

Senator MCNAMARA. You may proceed in your own way, Doctor.

Dr. DAILY. Thank you, Senator. I am very pleased to be here. From the reports of your hearings I have been reading, I gather that the over 65's find themselves in what might well be called a state of medical poverty. The testimony seems to indicate that medical and hospital care are available to the oldsters, but the vast majority of them can afford to buy or insure themselves for only small pieces of it, if any.

The two organizations I represent here today, Group Health Association, GHAA, and HIP, are both dedicated to the provision of prepaid comprehensive medical care through group practice.

These plans have shown one great difference between themselves and other types of health insurance. This is most clearly demonstrated in the report of the U.S. Civil Service Commission analyzing the hospital experience of almost 6 million Federal employees and their dependents in 1962. This report showed that the persons cared for by the prepaid group practice plans had a hospital admission rate 40 percent less than the participating plans offering the fee-for-service type of health benefits.

A similar remarkable difference in the hospital admission rates like this has been demonstrated over and over for the persons covered by group practice programs.

It would appear that in medical groups where the physicians have modern diagnostic equipment available, have ready access to specialist consultation in all fields, and are paid on a salary basis without the incentives of a fee-for-service system, they hospitalize their patients much less often than do doctors in solo fee-for-service practice.

This 40 percent, Senator, if it could have been applied to all of the Federal employees in 1962, would have achieved a saving of 1,800,000 hospital days. As a conservative estimate of $30 per hospital day this would mean a potential overall saving of $54 million in 1962 to employees and to the Government.

I believe the economic advantages of group practice merit the adoption of legislative measures to stimulate its development.

Now, turning to HIP which provides medical care to almost 700,000 people through its 32 affiliated medical groups.

The program provides for comprehensive medical care—home, office, in-hospital, preventative, and curative. It also covers injectible drugs, immunizations, biologicals, home visiting nurse service, ambulance service, some appliances, all of this without any charge to the patient beyond the premium charge.

We now have 45,000 people in HIP over the age of 65. We have had considerable experience in providing medical care to elderly people.

Some 16,000 of the over-65 subscribers pay their premiums for medical benefits directly to HIP and for the most part are also paying premiums to Blue Cross for hospital coverage.

Another 13,500 have their premiums paid by the New York City Department of Welfare and the remainder of the 45,000 come under group enrollment provided by employers or union welfare funds.

It has been our experience that these older people need more medical attention than the other age groups; they have to be seen by doctors much more frequently, and more important than the number and nature of the services provided is the additional time that doctors and their skilled assistants need to care for elderly people. Medically they need more laboratory procedures, they need more X-ray and more physiotherapy.

For example, our over 65 enrollment needs to see doctors at the medical centers and offices about twice as often and in the hospitals three and a half times as often as they did between the ages of 25 and 45. We care for 1,500 of people in nursing homes who are over 65, who receive an average of 20 doctor services per year.

HIP and the New York City Department of Welfare are in the midst of an experimental project to learn how we can better provide

medical care for these older people. We are taking care of 13,500 OAA and MAA recipients.

We have found in the past 18 months that there are some very real problems of providing care for these people, more than just the volume of service.

The physical limitations of these people and their difficulties in using usual methods of travel would normally prevent a great many of them from getting medical care at all. Our medical groups have had to set up special transportation systems for these people in order to get them to the medical centers.

This cost alone of transportation, taxis, and our own transportation systems we have developed for these people, are running between $5 and $7 per old person per year. That is just to get them to the doctor's office for office medical care.

It takes at least one-third more time for these people to go through a laboratory procedure or to have X-rays taken. They are old, they are infirm, they have difficulty in getting about, they have difficulty in giving their histories to the doctor; this is costly because to a doctor time is money.

Let me tell you about the cost of this experimental project. For office and at home medical care for these older people under welfare, the premium is now $72 per year, and for those who reside in nursing homes, the premium cost is now $96 a year. And these amounts are adjustable every 6 months, up or down, depending on experience.

If we were to provide for their medical care in hospitals as well as in their homes and in doctors' office, the annual premium would be at least $130 a year.

Our most recent estimates for hospital insurance for these older people on welfare would be at least $300 a year in addition to the $130 for medical insurance.

In relation to this welfare program I would like to mention this one rather dramatic savings in costs. I told you we are taking care of 1,300 of these older people in nursing homes; that is about one-fourth of the people in nursing homes receiving aid from the New York City department of welfare.

A study reported last week showed that the cost of prescribed drugs in the nursing homes in which HIP provides medical care was 50 percent less than it was in the homes where the patients were being taken care of by sole practitioners under a fee-for-service system. This is a very interesting finding.

Also, we were told by the welfare department that its cost of administration had gone down for our part of its program.

Now, I wish to discuss the costs of insuring people who come into insurance before they are 65 and after they are 65.

The present HIP annual premium rate for its medical care program for a person enrolled prior to 65, is $57.80 and the Blue Cross insurance is $55.80. If that person then remains in HIP-Blue Cross, he pays an annual premium after 65 of $113.60 in order to have both medical and hospital coverage. Now, let me make it clear, these are community rates, and reflect the average costs of young people, middle age people, and old people.

But, the present Blue Cross rates for a person coming in after he is 65, jump up to $129.60 a year. That is Blue Cross alone and is

available only if that person is found medically acceptable. Blue Cross does not take them all, they take a few.

We do not even enroll them. I will come to that later.

I am certain, though, that if we did decide to open up enrollment for people coming into HIP for the first time after age 65 on an individual basis, that our premium rate for medical care would be as high or higher than the $129.60 charged by Blue Cross for hospital care. For a total of at least $260 a year for both coverages.

This cost is beyond the means of most elderly people, and I believe it is going to be beyond the means of practically all of our elderly people.

Here is a good example of it.

We have many enrollees who upon attainment of age 65 become ineligible to continue under group enrollment and no longer have part or all of their premiums paid by an employer or welfare fund. We urge every one of these people to keep their insurance, that this is the time they need it most. Yet at this time, when they need it most, two out of three of these people drop their health insurance. They simply cannot afford to go on at a time when their income is reduced, to pick up the full cost of health insurance which previously had been paid for all or in part by an employer. This really is tragic.

Perhaps we should call these people medically impoverished.

The sensible way would be to pay the hospital costs for the aged by providing for regular contributions during their entire working years. Hospital coverage, if financed through social security, as proposed by the administration, would enable many, if not most of these elderly people who now drop their medical care insurance to continue it through their years of retirement.

Thank you very much.

Senator McNAMARA. Thank you very much for this very helpful testimony.

Has your experience been largely or exclusively in the city of New York?

Dr. DAILY. For the past 15 years; yes, sir, New York.

Senator McNAMARA. That is what I am talking about, what you are describing here today?

Dr. DAILY. Yes.

Senator McNAMARA. We often hear the statement that every one who needs medical care gets it. Is that statement true with respect to the older people in your experience?

Dr. DAILY. In my experience in the geographic areas that I know, medical care, doctors and hospitals, are there. The problem is to get patients to them. Often there will be a means test barrier set up between you and that hospital or that doctor and you cannot get to them, or maybe the rate of payment is set up at this height; you do not have that kind of money to pay for it; or even as I pointed out for elderly people, Senator, it could be just the matter of transportation. Unless there is some organized medical care program, those people are not going to get to see a doctor.

Senator McNAMARA. In view of your long professional experience, what would you consider adequate and necessary benefits in a basic hospital insurance program for older people?

Dr. DAILY. Senator, I have carefully read several times the King-Anderson bill. That has been given a great deal of thought by experts in this field from all over the country. It is my impression that the benefits provided there for hospital care, for nursing home care, and for the out-patient diagnostic services in a hospital, are a good basic program. I would not suggest any changes in it at this time. I think after some experience with that program, there may be a desire to have adjustments up or down, but I think that is a very sound program to start with.

Senator MCNAMARA. We are quite impressed with your statement that two out of three subscribers drop their coverage when they reach age 65. They are given the right to convert from the group to an individual plan.

Dr. DAILY. Yes.

Senator MCNAMARA. You point out that this is primarily based on the fact that they are not able to continue to carry it?

Dr. DAILY. This is what we have been told over and over again; remember, these were employed people retiring.

Senator MCNAMARA. Yes.

Dr. DAILY. And it is when they lose this employment and they lose their group coverage, income goes way down and then they see for the first time how much it is going to cost to pay the full cost of HIP and Blue Cross, which for years in the past had been a payroll deduction with at least half paid by the employer. All of a sudden this bill is in front of them and they say, we simply cannot afford this amount of money—2 out of 3—and that is tragic.

Senator MCNAMARA. We have had some testimony in the last few days that indicates that many older people become eligible for other group plans after 65. Do you find this to be true? Would not a person in the category that you have just described be looking for another group that he might become associated with? Are there such group plans?

Dr. DAILY. I do not know of such groups and I think it would be extremely difficult for a person to find such a group, and the cost, as I have presented to you, is going to be way, way beyond their means. If you become insured again after age 65, the costs are very high.

Senator MCNAMARA. This is largely due to the fact that they are compelled to take out an individual policy and are not able to get the advantage of a reduced premium that would be available if they had group plans for people over 65.

Dr. DAILY. There is just no question that the person after 65, paying the full cost of his medical or hospital care, which you do have to pay when you take an individual policy, certainly cannot afford this. It is certainly well over $300 a year.

Senator MCNAMARA. There are some groups such as teachers who do have a plan after 65, that is a group plan. Do you not find that to be true for retired teachers?

Dr. DAILY. We beg our retired teachers, we have thousands of teachers in HIP, we plead with these people to keep it after retirement. Some of them do. A third of them do, but two-thirds of them just feel that they do not have that amount of money left over.

Senator MCNAMARA. Even when there is a group plan available to them?

Dr. DAILY. They were in a group plan, any teacher in New York can be in HIP if they wish to be today. Many of them are. But when they retire and they have their chance to continue with HIP and Blue Cross, which are companion plans in New York, 2 out of 3 of them drop it, sir.

Senator MCNAMARA. Thank you very much. You can be sure the testimony you have given will be very helpful.

Now, Senator Fong, do you have any comments or questions?

Senator FONG. Dr. Daily, you say you have 45,000 people who are enrolled in this plan over 65 years of age; is that correct?

Dr. DAILY. That is correct.

Senator FONG. I think yesterday we got testimony from the New York 65 that they had figures of approximately 120,000; is that correct? Do you know what their enrollment is for those over 65?

Dr. DAILY. I did not hear the testimony yesterday, Senator.

Senator FONG. I think they have been in existence 18 months.

The New York plan has been in operation 18 months. How long has your plan been in operation?

Dr. DAILY. Fifteen years.

Senator FONG. Then, the New York plan is a better plan than yours from the standpoint of lesser premium and more benefits?

Dr. DAILY. If you are speaking of the Blue Shield-Blue Cross New York plan?

Senator FONG. No, the New York 65.

Dr. DAILY. I believe this is backed by New York Blue Shield, Blue Cross—all right, the commercial groups.

Senator FONG. They have been in operation 18 months.

Dr. DAILY. I would say that the benefits of that plan are vastly lower than the benefits of the HIP plan I have been describing to you this morning, Senator.

Senator FONG. How does the premium compare with yours?

Dr. DAILY. I have not seen the premium of the New York 65 plan.

Senator FONG. What accounts for the New York plan having 120,000 enrollees age 65 and above in a period of 18 months as compared to your plan of 45,000 in 15 years?

Dr. DAILY. Well, I would say that the main reason for this is that the benefits in most of those over 65's that I have seen are a small fraction of the benefits we provide in a combined HIP-Blue Cross coverage. Our coverage for our people is really fully comprehensive medical care, at home, in the office, and in the hospital, by specialists of all types, with all diagnostic tests, X-rays and other things provided; hospital care, full service hospital benefits for at least 21 days. I have seen nothing like such a coverage in any of these over-65 plans that you are describing.

Senator FONG. You stated that the commercial insurance plans are not sufficient to take care of the aged. I think everybody agrees with you there, that the aged need something more than private insurance, and I think they should receive help from the Federal Government, but there is disagreement as to whether the social security approach is the best approach or whether the Government should appropriate the money for the care of these people who cannot afford medical service.

In the State of Hawaii I received the statement that anyone who needs medical care gets it.

Would you say that would be a fair statement for the State of Hawaii, for those who cannot afford it?

Dr. DAILY. In Hawaii?

Senator FONG. Yes. Anyone who needs medical care and is not able to pay for it, gets it?

Dr. DAILY. I have long heard that Hawaii is the paradise of the Pacific. I am delighted to find it is also a paradise for medical care. I have not had personal observation of it, Senator.

Senator FONG. This is the statement I got from the previous administrator of the health program over there.

Would you say that applied to the State of New York? If a person is medically indigent and is unable to provide for his medical bills and his hospital bills, does he or she get it in the State of New York?

Dr. DAILY. I would say in many instances, they do not get medical care; and in many more instances they get totally inadequate medical care, and this we have seen with our own eyes.

Senator FONG. Does the State of New York have a law which says that he is entitled to medical care?

Dr. DAILY. I think that our State has been very enlightened in its legislation endeavoring to provide medical care for the people in the State and in the cities.

Senator FONG. Does the law say that if he needs medical care and is not able to provide for it that he can get it?

Dr. DAILY. They try to legislate this, Senator, but I can assure you that you can have a Kerr-Mills type of legislation, for example, with a great deal of Federal money, more Federal money spent in New York State than was ever spent before for medical care, and it is my impression that not one additional person got medical care than before the Kerr-Mills bill was in existence. It merely meant a shift of money. People who were previously getting their medical care in nursing homes paid for by State or local funds, for example, were all shifted over on to the Kerr-Mills program, thereby largely relieving State and local government of their financial responsibility for those people. The thousands of other older people who also needed medical care were not able to get it under Kerr-Mills because of the means test. These people were not helped with that legislation.

Senator FONG. It refers to these medical indigents, I do not know what the definition of that is in New York. If a person is medically indigent as far as the medical profession is concerned, you understand that, can he or she get medical care free in the State of New York?

Dr. DAILY. With the greatest of difficulty in the areas that I know and I believe sometimes they would find it impossible to get it.

Senator FONG. Why is that?

Dr. DAILY. There are people, for example, under the Kerr-Mills bill, that I am told that in order for them to get any benefit they must declare themselves in a charitable state. The sons and daughters and the other relatives must be also found in an impoverished state. And the people—the person who needs the care is not willing to have his or her relatives go through this demeaning process which is required by law in New York State, and therefore these people, and I am told this by the administrators of the medical care under the welfare department, that these people even though they need care, they will

not apply for it because they have to go through this very demeaning process to get it.

Senator FONG. Is that not a fault of the State law rather than of the Federal law?

Dr. DAILY. I think this is the fault of all grants in aid in medical care programs that we have known for the past 20 or 30 years. If Uncle Sam leaves it to each State to determine how they will provide this care, you will find that in many States you will get little or no benefit out of your grant-in-aid program.

This is why many of us plead for the social security approach where people when they reach age 65 are entitled to have certain medical or hospital benefits, whichever it may be, and they will go in with their chin up knowing that this has been paid for through the years of their employment, they are entitled to it just like they are entitled to the other benefits of social security. This is the American way.

Senator FONG. So, you do not know the answer whether a person in the State of New York, if he or she actually needs medical care, can get it?

Dr. DAILY. I answered your question, Senator, and I said I think that many of them would find it extremely difficult, if not impossible, to get the medical care that they really need.

Senator FONG. Does the law provide for it?

Dr. DAILY. It does not adequately provide for it, Senator.

Senator FONG. When you come to the word adequate, you said the King-Anderson bill is a good bill.

I have been told that the King-Anderson bill only takes care from 18 to 30 percent of the person's medical costs. I think you probably have studied it; is that correct?

Dr. DAILY. It was my impression that the King-Anderson bill was designed primarily to take care of the hospital costs. By the way the bill is completely mislabeled when it is called "Medicare," it is "Hospitcare," if anything. This is a bill to share the cost of hospital bills, diagnostic services in the outpatient department of the hospital, and nursing home costs. As far as I could find there is nothing to pay for physicians' services in the bill. The bill was carefully designed, this way, to take care of this very high cost item that the older people have in paying hospital and nursing home bills. Once you get that one taken care of, I think most of these people will be able to continue with the medical insurance they have had in their working years.

Senator FONG. Your figure of $130 annual premium for a person over 65; does that take care of medical costs or are you just talking of hospital costs?

Dr. DAILY. I gave you the premium for older people entering Blue Cross; this is for hospital insurance only—$129.60 per year, if they come in after age 65, and I said if, in HIP, we should decide to try and enroll these people, I would like to see us do it but I know practically no one could afford to buy it. It would be at least $130 more. So you would have something in the neighborhood of $260 for medical and hospital insurance for these over 65's "medically acceptable."

Senator FONG. When we talk about King-Anderson, we talk about hospital costs; but when we talk about your insurance, we throw in medical costs; do we not? So the figures you have given us takes care of the medical costs?

Dr. DAILEY. Yes.

Senator FONG. If you excluded the medical cost and provided the King-Anderson benefits, what would you have to charge under the HIP plan?

Dr. DAILY. If people came in to HIP for the first time in their lives, after age 65, to provide the medical and related services which we provide in HIP, the cost would be at least $130 per person per year. This excludes hospital costs.

Senator FONG. That $130; that is just for hospital?

Dr. DAILEY. No; that is just for doctors' services in their offices, at home, or in the hospital.

Senator FONG. Well, the King-Anderson bill does not provide for all the doctor bills?

Dr. DAILY. No; it excludes them.

Senator FONG. If your plan was just confined to hospital and nursing homes, what would that cost be?

Dr. DAILEY. If these people become insured for the first time after they were age 65, the experience of Blue Cross in our community has been that they can insure these elderly people for $129.60 per person per year if they are found to be "medically eligible."

Now, the benefits which Blue Cross provides are quite different from the benefits proposed under the King-Anderson bill, so do not let anyone draw a conclusion that these are exact comparisons. I am saying that for the New York Blue Cross plan which provides for 21 days of full service coverage, and 180 days of coverage for half the hospital charges. The current premium afterwards, is $129.60 a year for a single person.

Now, there are different benefits; different lengths of stay; people pay something toward their hospital bill under King-Anderson; you have diagnostic services and you have nursing homes.

Senator FONG. I have a 1962 figure of approximately $85.20 for the King-Anderson package if it were given in the city of Honolulu, a city of approximately 350,000.

Would you say that would be a fair premium?

Dr. DAILY. I would say that this is a question that really should not be directed at me. This is a question for a medical economist or a hospital expert that has given a great deal more time in analyzing these costs than I have. All I have quoted to you is the costs of the New York Blue Cross with which I am familiar. And these are not costs related to benefits under the King-Anderson bill.

Senator FONG. You have proposed that we follow the social security financing under the King-Anderson bill. Originally I thought I would support that. I felt that it was necessary that we take care of our aged and that there are two very basic needs of an individual. One is employment and the other is the medical services when they need them. But the more I study the problem the more I find that I cannot go along with the social security approach, but I feel that there should be an appropriation by the Federal Government augmented by the State, to take care of the aged. By doing that we will be able to give to the aged the best medical care that we can provide. If we give it to too many, we will find that we do not have enough for the man who really needs it.

The argument has been raised that under King-Anderson financing 40 percent of our taxable income will not bear the burden of the medically aged.

In other words, the only people that it would take care of—the medically aged—would be those who are under social security. A man who is in the Navy; a man who is in the Army; a person who works for the Federal Government; taxable income from interest, and dividends—all of this will escape the burden of taking care of the aged.

Do you think that is fair?

Dr. DAILY. Well, I want to quote from my own experience of 15 years of administering medical care in the Federal Government startings in the early days of the Social Security Act where we tried to plan, as you are proposing, a Federal grants-in-aid to the States under some matching formula hoping that this would stimulate States and counties to provide better care for mothers and children, and for crippled children.

I can assure you that it was a heartbreaking task to find that many counties or small communities, or States, did not feel that they had the wherewithal to match these Federal grants. Therefore, in many areas, nothing was accomplished by it. That program was supposed to particularly improve services in rural areas. These are the areas that least could afford to put in the matching funds required by the Federal Government, and it was very disheartening.

I think you will find, because of the great differences in the economic levels of different parts of our country, that if you put medical care on a grants-in-aid basis—in these areas of lower economies, not as well off as some other areas—you will accomplish little, if anything.

Senator FONG. Well, the King-Anderson bill does not accomplish much. The King-Anderson bill only takes care of 18 to 30 percent of the medical care of an individual. This is what I have been told. This has not been disputed. Secretary Celebrezze says it is up to 30 percent. He says King-Anderson will take care of 30 percent of the medical costs. Even taking his figures of 30 percent medical costs, there are still 70 percent that will not be paid for by any plan. So, therefore, you have these medically aged who will not be able to take care of their doctor bills, even if you had King-Anderson enacted.

Dr. DAILY. The King-Anderson bill is not the cure of all ills in the medical world. It is a marvelous step forward and I hope very much that a progressive step like that will at long last be taken in 1964. It should have been taken, Senator Fong, in 1935 when President Roosevelt had it in his original social security legislation. For some reason, which has never been well explained, the medical care portion of the original social security bill was dropped at the last minute. Many of us, who have studied and worried about the health problems of our Nation, have regretted that the start was not made at that time when this magnificent piece of legislation was first enacted.

Senator FONG. You see, when we discuss this King-Anderson problem we usually get very confused but when we talk about insurance, taking care of the aged, we talk about its inadequacies. We know that many of these policies are inadequate unless you are willing to pay a premium of $500, $600, or $1,000 a year. And yet when many talk about King-Anderson, they do not talk about the inadequacies of King-

Anderson. To me the King-Anderson bill is a very, very inadequate bill. It only provides for 18 to 30 percent of the person's medical care.

I think we should give to the aged the best we can give them and give them all of their needs rather than 18 to 30 percent. That is why I feel that the appropriation by the Federal Government would be the method by which we could take care of those that need it. We do not have to give it to those who do not need it.

The payroll deduction envisioned under the King-Anderson bill requires an individual earning $5,200 to pay $27.50 more per year in social security taxes.

You take a man who is gainfully employed from the age of 20 years old to the age of 65, he has worked 45 years; if he puts that $27.50 in a building and loan at 4¾ percent compounded quarterly, he will get a sum in excess of $4,000.

Testimony given this year by the Health, Education, and Welfare Department indicated that this one-fourth of 1 percent on a worker is not sufficient. They would have to increase it to one-half of 1 percent. If a man could save that $27.50 for 45 years in a savings and loan, he would have a nest egg exceeding $4,000, or $8,000 if the rate were one-half of 1 percent and his tax were $55 a year. Leaving it there $4,000 or $8,000 at 4¾ percent, he would have a dividend of approximately $200 or $400 a year which should take care of all of his medical expenses if he bought an insurance policy, and if he died he will still have his $4,000 or $8,000 in his estate.

Now, under King-Anderson the Government is going to take $27.50 or $55 away from him every year; when he arrives at the age of 65 and dies, he gets nothing.

It is very difficult for me to find the social security approach is the right approach with all of these arguments that have been presented to me.

Have you anything to say about that?

Dr. DAILY. Senator Fong, I am a doctor, you have raised questions which would be appropriately raised with a banker, I hope one who lived through 1929.

Senator MCNAMARA. Isn't this a little philosophical? Is this not getting a little out of hand at this point?

Senator FONG. I am through, Mr. Chairman.

Senator MCNAMARA. Thank you. I do not want to cut anybody off. It is getting late and we do have many other witnesses here. I appreciate the cooperation of the Senator.

You mentioned 45,000 were covered under your plan, you are just talking about 45,000 over 65. What is your total coverage under your plan?

Dr. DAILY. Approaching 700,000.

Senator MCNAMARA. Thank you very much.

Now, any further questions?

Senator NEUBERGER. No, thank you.

Senator WILLIAMS. No, thank you.

Senator MCNAMARA. Thank you very much.

PREPARED STATEMENT BY EDWIN F. DAILY, M.D., FOR GROUP HEALTH ASSOCIATION OF AMERICA, INC., AND HEALTH INSURANCE PLAN OF GREATER NEW YORK

Mr. Chairman and members of the committee, I am Dr. Edwin F. Daily, board and executive committee member of Group Health Association of America, Inc., and vice president of the Health Insurance Plan of Greater New York. I am a physician and a diplomate of both the American Board of Obstetrics and Gynecology and the American Board of Preventive Medicine and Public Health. GHAA and HIP are dedicated to prepaid comprehensive medical care through group practice. Group Health Association of America is a nonprofit organization representing over 4 million people, many of them over age 65, receiving group practice medical and hospital care from its 25 member plans. These medical care plans are sponsored by labor, by cooperatives, and, in the case of HIP and several others, by the community. In addition, GHAA is supported by other organizations representing the consumer interest, such as the National Farmers Union, the Cooperative League of the U.S.A., the International Association of Machinists, and the United Auto Workers.

Both President Johnson and the late President Kennedy have, in health messages, recommended encouragement of group practice.

Mr. Johnson, in his health message on February 10, 1964, said:

"To meet the needs of their communities, group physicians—general practitioners and specialists—more and more are pooling their skills and using the same building, equipment, and personnel to care for their patients.

"This is a sound and practical approach to medical service.

"It provides better medical care, yet it yields economies which can be passed on to the consumer.

"It makes better use of scarce professional personnel.

"It offers benefits to physicians, patients, and the community.

"The specialized facilities and equipment needed for group practice are often not available, especially in smaller communities.

"Therefore: I recommend legislation to authorize a 5-year program of Federal mortgage insurance and loans to help build and equip group practice medical and dental facilities.

"Priority should be given to facilities in smaller communities, and to those sponsored by nonprofit or cooperative organizations."

At its November 3, 1963, convention in New York City, the AFL–CIO adopted a resolution listing the following advantages of group practice health programs over the traditional patterns of health insurance available through Blue Shield and commercial insurance:

"(1) They (group practice plans) assure that the medical care provided is of high quality.

"(2) They provide diagnostic and preventive as well as curative health services.

"(3) They guarantee a service benefit.

"(4) Total family expenditures for health services are less than under conventional insurance programs."

Hospital utilization under the Federal employees' health benefits program shows one great difference between the prepaid group practice plans and other types of health insurance. The prepaid group practice plans in 1962 had 45.4 hospital days per 100 enrollees, as compared with 82.6 under Blue Cross-Blue Shield fee-for-service medical care.

This difference of more than 40 percent in hospital days, resulting from fewer admissions, certainly requires careful study to determine whether or not hospital admission rates, and expenditures for hospital care, can be generally reduced below their current levels. A remarkable difference in the hospital admission rates of group practice plans has been demonstrated in other studies as well. It would appear that group physicians who have modern diagnostic equipment in their medical centers, who have ready access to consultation with group specialists, and who are paid on a salary basis (without the incentives of the fee-for-service system) hospitalize their patients less frequently.

This 40 percent difference, if it could have applied to all of the Federal employees in 1962, would have achieved a saving of over 1,800,000 hospital days which, at a conservative figure of $30 per hospital day, would mean an overall saving of $54 million in 1962 for the employees and the Government.

It was the Congress that made certain Government employees and their families could have the benefit of prepaid group practice plans wherever available. The Civil Service Commission has encouraged the participation of prepaid

group practice plans, even though they are currently available to the public in only a few geographic areas of the country.

You are all familiar with the Group Health Association serving the District of Columbia; and many of you know of the Ross Loos Plan in Los Angeles; the San Diego Health Association; the Kaiser Health Plans in California, Oregon, and Hawaii; and the Group Health Cooperative of Puget Sound in Seattle, Wash. There are others, such as the new Community Health Association in Detroit, the Cleveland Health Foundation which is just starting, and the East Point Medical Center now being built in Baltimore.

The planning and financing of a new prepaid group practice plan is a formidable undertaking. The Congress is actively engaged in developing programs to provide financial aid and other assistance to expand the availability of hospital and medical care skills and facilities. The economic advantages of group practice merit the adoption of measures to finance and encourage the development and expansion of group practice prepayment programs.

Senator Hubert H. Humphrey introduced in the Senate, S. 1426, a bill to assist voluntary nonprofit associations offering prepaid health service programs to obtain necessary facilities and equipment through long-term interest-bearing loans.

One of the prepaid group practice plans mentioned above is the Health Insurance Plan of Greater New York.

HIP provides medical care, through 32 affiliated groups of physicians, to some 685,000 men, women, and children residing in and around New York City. Medical services include diagnostic, preventive, and therapeutic care at home, office, or in the hospital. Also provided are most injectable drugs, all immunizations including biologicals, home visiting nursing, and ambulance services, and a few appliances, without any charge above the premium.

Forty-five thousand HIP enrollees are over age 65. About 16,200 of these enrollees pay premiums directly to HIP for their medical service benefits and, for the most part, also pay Blue Cross premiums for hospital coverage. Another 13,500 have their premiums paid by the welfare department and the remainder are under group enrollment through employers or union-management trust funds.

Elderly people, we find, need more medical attention than other age groups; i.e., they have to see or be seen by a physician more frequently for preventive care and observation of chronic conditions. Their medical attention usually requires more physician time, more laboratory and X-ray procedures, more services from nonphysician personnel, including visiting nurses.

For example: Our over-65 enrollees see physicians at the medical group centers about twice as often and in hospitals approximately three and a half times as often as do those between the ages of 25 and 45. When an enrollee is in a nursing home, about 20 medical visits per year are needed.

HIP, its participating medical groups, and the Department of Welfare of the City of New York are coping with the special problems involved in providing office and home medical care to approximately 13,500 elderly people. This is a pilot program to determine whether better medical care can be provided for these people under prepaid group practice and to compare its costs and results with fee-for-service systems.

In addition to the greater number of physician services required, the special problems of many of these elderly people increase the costs of providing medical care in other ways. Physical limitations and difficulty in traveling often require special arrangements for transportation to medical facilities for X-ray and other procedures that are best performed at a group center. Elderly people who move more slowly than others and frequently have faulty memory require 20–30 percent more physician time for history taking and physicals as well as more technicians' time for X-ray, laboratory and other diagnostic procedures. Difficulties in hearing and reading, and approaching senility frequently further complicate the provision of health services.

The present premium for office and at-home care for these welfare patients living at home is $72 per year, and the premium cost for caring for patients in nursing homes is $96 per year. If we were to cover medical care in hospitals as well as in the homes and doctors' offices for those welfare recipients who live at home, we estimate the annual premium would be at least $130.

Under this welfare program, utilization and costs are reviewed every 6 months to permit adjustments which may be indicated. It is believed that studies now underway will show much lower welfare department administrative cost for medical care financed by annual capitation payments to medical groups than under fee-for-service solo practice.

A recent study by the welfare department revealed that its cost of prescription drugs was 50 percent less in nursing homes under HIP than in all other nursing homes in welfare programs.

Let us look at hospital costs—how the continuing acceleration of hospital costs makes it impossible for a person of moderate means to cope with the expense of an illness requiring long-term hospitalization.

The recent hearings on the rate increase request of the New York Blue Cross plan revealed that Blue Cross payments to hospitals in the New York area increased from $31.94 a day in 1959 to about $44 a day in 1963, an overall increase of about 38 percent. The New Jersey State Banking and Insurance Commissioner, Charles E. Howell, as reported in the April 15, 1964, issue of the New York Herald Tribune, faced with a request for a 32.5 percent boost, approved an 18.5 percent increase in New Jersey Blue Cross rates, effective August 1, 1964. He stated that "even under the present Blue Cross rates, the costs were already beyond the reach of a very large number of persons with low or limited income."

Under the current New York Blue Cross rates, an individual who had been enrolled prior to age 65, pays $55.80 per year for the 21 full and 180 half-day plan.

The present HIP premium rate for its medical care program for an individual enrolled prior to age 65 is $57.80. Thus, a single person insured before age 65, in order to continue coverage on a direct-payment basis for both HIP and Blue Cross, has to pay an annual premium of $113.60 ($57.80 for HIP and $55.80 for Blue Cross). These are community rates and reflect the average costs of young, middle-aged, and older people. The present Blue Cross rate for people entering the plan after age 65 is $129.60 per year for an individual found medically acceptable. I am certain that if HIP should decide to open enrollment to such persons over age 65, the cost of medical care would be as high or higher than the cost of hospital care.

The cost of assuring adequate physician and hospital coverage is now beyond the means of elderly people with limited incomes and will soon be beyond the means of even those with moderate incomes. In HIP we have many enrollees who, upon attaining age 65, lose their group enrollment. They are all urged to retain their insurance at practically the same rate for the same medical benefits as before. Yet at this time when they need it most and when their incomes are sharply reduced, two out of three drop their insurance because they cannot afford to take on the full cost formerly shared with or totally paid for by an employer or union. The sensible way would be to pay the hospital costs for the aged by regular contributions during their earlier working years. Hospital coverage, if financed through social security as proposed by the administration, would enable many elderly people who now drop their medical care insurance to continue it during retirement.

I have been reading a new book, "Episode," by Mr. Eric Hodgen, who describes his own serious illness. If the committee permits, I will read a short excerpt, very pertinent to the subject of this hearing. Mr. Hodgen itemizes the expenses of a single illness which totaled $21,911, of which about one-third, $7,891, was covered by insurance. He states:

"If while still semispeechless half an hour after the CVA (cardiovascular accident) struck me, I had had to shake my head no to the only open room in the hospital across the street because it cost $48 a day, I don't know where I would have been that night and I don't know where I would be today. I do know that something in addition to medical skill and dedication saved me—and I know what that something was. It was cash, '——.' A CVA somewhat predisposes to a recurring CVA. And I might well survive a second or a third CVA, medically. What is now inevitable and foreordained is that I could not survive another, financially. The $14,000 that was the cost of the first one and its sequels was too big a chunk of my assets: these, like nerve fibers, do not regenerate if the damage is heavy enough."

Senator McNamara. The next witness is Walter J. McBee, executive director of the the Blue Cross-Blue Shield, Dallas, Tex.

STATEMENT OF WALTER R. McBEE, EXECUTIVE DIRECTOR OF BLUE CROSS-BLUE SHIELD, DALLAS, TEX.; ACCOMPANIED BY WALTER F. HACHMEISTER, ASSISTANT CONTROLLER, AND E. W. AUNE, ASSISTANT DIRECTOR OF ADMINISTRATION

Mr. McBEE. I am Walter R. McBee, Senator. May I introduce my associates?

Senator McNAMARA. Please.

Mr. McBEE. This is Walter Hachmeister, our assistant controller, I am Walter R. McBee, this is Eugene Aune, assistant director of administration and head of our claims department.

Senator McNAMARA. Thank you, and be seated.

Mr. McBEE. I have a prepared statement here, Senator, which is pretty condensed and I will present it if it is agreeable.

Senator McNARAMA. You go right ahead.

Mr. McBEE. I am Walter McBee, executive director of Blue Cross and Blue Shield of Texas.

The Blue Cross plan serving the State of Texas provides hospitalization protection for 1,771,494 persons, about 17 percent of the State's population; 97.5 percent of these also hold Blue Shield medical-surgical coverage. The figure includes 228,780 who are enrolled through the Kerr-Mills old-age assistance program of the State of Texas.

Our enrollment of the aged has been a steady, accumulative process through the years, as the result of deliberate planning and concerted effort. The sources of enrollment and present extent of coverage of the elderly, 65 and over, in the various categories are given below:

No person in any category is ever terminated, deprived of membership, or required to change form of coverage because of attaining the age of 65, or any other age.

There were 745,391 persons in our State who had attained the age of 65 years, according to the 1960 census. The figure has increased now to an estimated 845,000, according to our sources of information; 324,787 or 38 percent of the 845,000 are enrolled today in Blue Cross; and if the OAA enrollment and population are removed from consideration, the number enrolled would be 96,007, which is 16 percent of the estimate of the remaining aged population. This is about equal to our present share of the total population.

THE EMPLOYED GROUP ENROLLMENT

There is no age limit on employed group enrollment; and currently there are 17,561 actively employed persons 65 and over enrolled in Blue Cross and Blue Shield groups.

GROUP RETIREES

Industry often arranges for a continuation of coverage for retiring employees, and 12,438 who are 65 and over are enrolled through that source. (This figure includes only those that we are able to identify as retirees. Others are included in the group enrollment category above.) Usually, the employer pays the entire cost, and in almost all cases some of the cost.

ASSOCIATED GROUPS

Associated farm and other groups without a common employer have been encouraged to enroll, and through such sources we have accumulated and now have participating 13,699 members 65 and over.

GROUP CONVERSION

Members leaving a group as individuals for retirement or any other reason, and regardless of their age or health condition, are permitted and urged to retain their Blue Cross and Blue Shield coverage. There are 29,637 who are 65 and over that are participating through this source.

INDIVIDUAL ENROLLMENT

Individual enrollment is open to the public at all times and 11,935, who have attained the age of 65 since enrollment, are participating through this source.

SPECIAL 65 AND OVER ENROLLMENT

Nongroup enrollments for those 65 and over were initiated through special campaigns as early as October 1959. Now particpating are 5,339 through this source.

SENIOR TEXAS SERVICE

The "Senior Texan" was a program developed and initiated specifically for those 65 and over, effective April 1, 1962. There are now 5,398 persons participating through this source.

KERR-MILLS-OAA

The State of Texas adopted the OAA phase of the Kerr-Mills Act effective January 1, 1962. This vendor payment program in Texas is handled by the State department of public welfare, and through a contract with that department Blue Cross is providing, on an insured basis, coverage for 228,780 Texas people who are recipients of old-age assistance.

Because of the evolution in offerings which has taken place over the period of years during which these enrollments have occurred, and because of the different sources of enrollment—employed group, nongroup, Senior Texan, and so forth—and available options, the benefit levels of our coverages held by aged Texans vary widely; and this is reflected both in the adequacy and cost figures appearing below.

Summarizing, our enrollments of those 65 and over are tabulated as follows:

Group enrollment	17,561
Group retirees	12,438
Associated groups	13,699
Group conversion	29,637
Individual enrollment	11,935
Special 65 and over enrollment	5,339
Senior Texan service	5,398
Kerr-Mills-OAA	228,780
Total	324,787

As to adequacy, the average portion of the total hospital bill covered by our Blue Cross benefits is: For Senior Texan coverage, 85 percent; for Kerr-Mills-OAA 77 percent; and for other coverages, 75 percent.

Monthly rates for Blue Cross coverage range from $2.94 to $8.75 for an individual, and from $5.80 to $17.50 for husband and wife. The Senior Texan rate is $8.75 per person. OAA recipients pay no part of the monthly charges, of course, but we receive from the State $8.68 per month per recipient, which includes medical surgical coverage; $6.57 of this is allocated to the hospitalization portion of the coverage we provide.

Senator McNAMARA. Thank you, Mr. McBee.

Are you familiar with the New York 65 plan?

Mr. McBEE. Am I familiar with it? No, sir; not to a great extent.

Senator McNAMARA. I was about to ask you how it compared to the Senior Texan plan. I assume they are similar?

Mr. McBEE. My impression is that it is similar, but I could not compare it exactly.

Senator McNAMARA. Apparently the rates are the same. They gave us a rate of $8.50; you give us a rate of about $8.75.

Mr. McBEE. Yes, sir.

Senator McNAMARA. This old-age assistance group that you refer to, you say consists of more than 200,000, covered under your plan now. Is this a separate plan for these people in your Blue Cross?

Mr. McBEE. Yes; it is a separate specific individual plan; yes, sir.

Senator McNAMARA. That includes both hospitalization and medical care?

Mr. McBEE. That is right, with certain limitations on the medical care, $200 surgical plan in-hospital medical benefits.

Senator McNAMARA. Is this premium paid directly by the old-age assistance program to Blue Cross, or is it paid to the State and immediately turned over to you?

Mr. McBEE. It is paid to the State and comes to us from the welfare department.

Senator McNAMARA. Very good.

Senator Neuberger, do you have any questions or comment?

Senator NEUBERGER. Yes; I thought that was a unique plan. I never realized that that is the way a State was using its Kerr-Mills.

How many people are covered in the State of Texas by Kerr-Mills?

Mr. McBEE. 228,780.

Senator NEUBERGER. Do they have to submit to a means test?

Mr. McBEE. Well, they have to be recipients of old-age assistance and to obtain old-age assistance they do have to undergo this means test and, of course, you would not be providing old-age assistance unless they were indigent. But it might interest you more, Senator, to know that this is an insurance plan, the welfare department put this out on bids.

Senator NEUBERGER. What is the difference, then, between that special 65-and-over plan and the Senior Texan service?

Mr. McBEE. The special 65 was a plan that we developed earlier specifically for those 65 and over; in fact, other people do have that, but it is a plan with which we made concentrated efforts to enroll those over 65, and while it was available to others, we did separate and

segregate those over 65 so that we could have more information on their experience.

Then the Senior Texan is available only to those 65 and over, which was developed later.

Senator NEUBERGER. Can they come in at any age?

Mr. MCBEE. The Senior Texan? Yes, ma'am, there is no age limit.

Senator NEUBERGER. You have said, I think, that the administrative costs are how much for Blue Shield?

Mr. MCBEE. For Blue Shield, our overall plan, or only the old-age group?

Senator NEUBERGER. I am more interested in the old age because I am wondering how much of it is borne by State welfare?

Mr. MCBEE. In our contract with the welfare department we took the contract and agreed upon a guaranteed retention of only 3 percent. Three percent is all we can retain. Any remainder has to be used for benefits or returned to the welfare department. The contract has been revised. The agreement was that after the first 12 months we would revise it. We did expand the benefits some, and our actual cost on that is running about 2.51 percent for handling the welfare department program, but the State is assured of 97 cents out of every dollar.

Senator NEUBERGER. But who does the investigation to find out if the person is deserving of the welfare assistance? Do you share the cost of the means test with the State?

Mr. MCBEE. No, ma'am; not as such. Not directly. No, ma'am.

Senator NEUBERGER. So the cost is really borne by the taxpayer then?

Mr. MCBEE. That is right. At the first of the month the State department says, "We have 228,000 recipients; here is your check." The doctor certifies their need for hospital care, and, of course, the local welfare department person certifies that they are recipients of old age and if they are, they are entitled to the benefits.

Senator NEUBERGER. But if you had to do the investigating it would be quite a bit different; would it not?

Mr. MCBEE. There would be some difference.

Senator MCNAMARA. Would you yield at that point?

Senator NEUBERGER. Yes.

Senator MCNAMARA. You are discussing the old-age assistance people now.

Is there a limit to how much you pay under this old-age assistance plan?

Mr. MCBEE. Yes, sir.

Senator MCNAMARA. How much a day do you allow?

Mr. MCBEE. On the room accommodations all Blue Cross members in Texas are on a cash allowance indemnity basis on the room only. On the room we allow $10 for accommodations for 15 days. All other benefits are covered for 15 days, and then after 15 days half of all ancillary benefits and $6 on the room, with no limit as to the number of days.

For instance, we have some people in the hospital that were in there when we took the program in 1961.

Senator MCNAMARA. Well then, somebody has to pick up the difference between the $10 which obviously would not be the total cost

of the hospital room in most of the urban areas. These people cannot pay it themselves because they are old-age assistance people to start with and they have passed a means test. So who pays the difference to the hospital?

Mr. McBee. Somebody is privileged to pick up the difference.

Now, we have many hospitals who report to us they are being paid 100 percent; neither we nor our welfare department have ever had a report of any recipient being badgered for money. Usually some relative or friends will say, take care of dad or mother, we will pay you the difference. They have pretty good coverage. Then, too, it is surprising how many of these people have other insurance policies and a number of them already had Blue Cross coverage and many of them retained it, and a surprising number of them have their old-age benefits and other insurance which supplants the difference.

Senator McNamara. Even though they have other insurance policies they are still eligible under the old-age assistance program?

Mr. McBee. Yes, sir.

Senator McNamara. That is interesting.

And then about $10 a day is paid under your plan and the rest would be paid in some other manner either through charity or through relatives or other people who are responsible for the old-age person?

Mr. McBee. I did not quite get your question.

Senator McNamara. As I understand your answer, since the $10 a day does not pay the hospital bill that is allowed under your plan, somebody has to pick up the difference and you think it is done through relatives or charitable organizations; is that correct?

Mr. McBee. That is only on the room accommodations.

Senator McNamara. I am talking about the room accommodations, too.

Mr. McBee. All right. Yes, sir. It is picked up. Sometimes it is picked up, sometimes it is not. Hospitals——

Senator McNamara. Then the hospital loses the difference?

Mr. McBee. They lose it or it becomes a community responsibility, but by and large someone pays it, or otherwise it does become a community responsibility.

Senator McNamara. Thank you. I did not mean to interrupt you.

Senator Neuberger. That's all right. I am through. The State pays about $108 a year for each of those.

Do you provide $10 a day hospital care on a return of—do you give more than that on the premium? It says here, $8.68 you receive for each recipient. That is about $108 a year.

Mr. McBee. Ma'am?

Senator Neuberger. $104.16.

Mr. McBee. $104.16.

Now, your question, Senator, then was?

Senator Neuberger. You give medical-surgical coverage included in that?

Mr. McBee. Yes, ma'am; $6.57 of that is allocated to the hospital care, and the remainder for medical-surgical coverage.

Senator Neuberger. So, six from eight is two—$24 a year from the State cover $10 a day hospital? Is that right?

Mr. McBee. I am not sure I understood your question.

Senator NEUBERGER. Out of the $8.67—it is the other way, I am reading it without the semicolon, the other way, $24 a year is for the medical-surgical coverage then?

Mr. MCBEE. That is right. That is $2.11 per month for medical and surgical. Yes, ma'am.

Senator NEUBERGER. Thank you.

Senator MCNAMARA. Senator Williams?

Senator WILLIAMS. Yes, Mr. Chairman.

For your old-age assistance program, you have a per diem indemnity, $10 a day for 15, reducing to $6 a day; is that right?

Mr. MCBEE. Yes, sir.

Senator WILLIAMS. Is it a per diem indemnity for your other programs outside of old-age assistance, regular Blue Cross coverage, or is that a comprehensive payment?

Mr. MCBEE. It is per diem indemnity on the plan for all of our plans except for some specially written national contracts.

Senator WILLIAMS. Is this characteristic for all Blue Cross plans, do not some for the period of coverage pay the entire bill for a period where there is no contribution from the patients to make up the difference between the indemnity and the total bill?

Mr. MCBEE. You say is that characteristic?

Senator WILLIAMS. Yes.

Mr. MCBEE. Yes, sir; on the regular enrollment, not talking about the aged?

Senator WILLIAMS. That is right.

Mr. MCBEE. Characteristically all of the benefits are paid, and the room in the majority of the plans we happen to have an indemnity on the room, and in our regular services you can buy any indemnity you want.

Senator WILLIAMS. I see.

Just one further question. Do the hospital bills to you, that come to you, reflect any discount to Blue Cross-covered patients?

Mr. MCBEE. No, sir; they do not.

Senator WILLIAMS. Thank you.

Senator MCNAMARA. Senator Fong?

Senator FONG. Yes, Mr. Chairman.

You have in this program of Blue Cross about 1.75 million persons?

Mr. MCBEE. Yes.

Senator FONG. And of the 1.75 million persons, those who are 65 and over were 324,787?

Mr. MCBEE. That is right.

Senator FONG. For the Senior Texan you say the coverage of the average total hospital bill is 85 percent?

Mr. MCBEE. Yes.

Senator FONG. For Kerr-Mills, coverage is 77 percent?

Mr. MCBEE. Yes, sir.

Senator FONG. And for other coverages, 75 percent?

Mr. MCBEE. Yes, sir.

Senator FONG. A person under Kerr-Mills or OAA as you have it here is immediately indigent; is that correct?

Mr. MCBEE. Yes, sir.

Senator FONG. He is unable to pay for any of his hospital bills?

Mr. MCBEE. That is right.

Senator FONG. So, when you say 77 percent, what do you actually mean?

If I were a medically indigent and I came within the provisions of Kerr-Mills-OAA and I went to the hospital and I had a bill, say, of $100, would the $100 be paid by Blue Cross?

Mr. MCBEE. No, Senator Fong, on the basis of what this says it would be $77. That is the average payment.

Senator FONG. You would pay the hospital $77?

Mr. MCBEE. On the average.

Senator FONG. You will pay $100 but you find that you lose $23?

Mr. MCBEE. No; we don't just pay that amount. We don't just pay the $77.

Senator FONG. In other words, if there was a bill of $100 for me in the hospital, you would pay $77 of that?

Mr. MCBEE. If it happened to work out that way, yes. This $77, you understand, is an average.

Let me give you another picture here, Senator.

You see we have 15 days we term full coverage, it is not exactly, but it is where they get the $10 room and the full benefits. Now, this figure varies greatly, which is not included here. 87.1 percent of our OAA-Kerr-Mills people get out of the hospital within this 15-day period when they have full coverage on all ancillaries and $10 on the room, and for those we pay 88.4 percent of the bill.

In other words, for 87 percent of all Kerr-Mills patients we pay 88 percent of the hospital bill.

But when you get into this long-stay cases it pulls it way down, of course.

Senator FONG. I understand that. What I am saying is for an individual who goes to the hospital under OAA-Kerr-Mills plan in which you have a contract with the State, you said that 88 percent of his hospital bills is paid for in the majority of them.

Mr. MCBEE. For the majority, yes, sir.

Senator FONG. And who picks up the other 12 percent?

Mr. MCBEE. That is what Senator McNamara, I believe, was asking.

Usually it is picked up by relatives, I would say. Periodically there may be a chargeoff, but we have actually not had reports of chargeoff. I know there must be some charged to the community which usually supports the majority of the hospitals. There is some chargeoff, many of them, to our surprise after we got into this, have other insurance policies, bought maybe by themselves but maybe by their relatives; and some of them have as many as five.

Senator FONG. If they are not able to pay for it, it is forgotten?

Mr. MCBEE. Yes, sir.

Senator FONG. If they are able to pay for it——

Mr. MCBEE. Yes.

Senator FONG. You are now contracting with the State to take care of their old-age assistance recipients at the rate of $8.68 per month per recipient?

Mr. MCBEE. Yes.

Senator FONG. And of that, $6.57 is allocated to hospitalization?

Mr. MCBEE. Yes, sir.

Senator FONG. In other words, you have stated to the State government of Texas that for $78.84 a year, you will provide hospitalization for the aged?

Mr. McBee. Yes, sir.

Senator Fong. You find that $78.84 is sufficient to take care of your cost?

Mr. McBee. Is sufficient——

Senator Fong. That is, operating as a nonprofit and eleemosynary institution?

Mr. McBee. It is sufficient to take care of the care specified or provided by this contract, this specific set of figures.

Senator Fong. But it gives to the majority of the recipients 88 percent of the hospitalization?

Mr. McBee. That is correct, Senator Fong; and it also gives to the recipient another $2 and some-odd cents for medical and doctor bills?

Senator Fong. Thank you.

Senator McNamara. If there are no further questions.

Senator Williams. I have one brief one.

Senator McNamara. Senator Williams.

Senator Williams. Does the benefits reduction after 15 days apply to your regular policies?

Mr. McBee. No, sir; it does not.

Senator Neuberger. I am just thinking out loud. Of that $3, or whatever figure we used, that the State of Texas pays, how much of that is supplied by the Federal Government?

Mr. McBee. About 75 percent. It is about 75–25; yes, ma'am.

Senator Neuberger. Of that cost, 75 percent is paid by the Federal Government under the Kerr-Mills, but if we had the other plan the recipient would have prepaid it himself, would he not, by payroll deductions over a period of years?

Senator McNamara. Yes.

Thank you very much. We appreciate your testimony. It is very helpful to the committee.

The next witness is Mr. Robert T. Evans, executive director, Hospital Service Corp. of Illinois.

Will you please identify your association for the record?

Mr. Evans. I am Mr. Evans, this is Mr. Robert M. Redinger, vice president for finance in our organization.

Senator McNamara. All right. Will you please proceed in your own manner?

I am going to ask Mrs. Neuberger to take over, because I have to be on the floor of the Senate for a little while.

Senator Fong. Madam Chairman, will the record show that Senator Dirksen, the minority leader, had intended to be present here to listen to the testimony of these fine gentlemen, but he was unfortunately called to the White House.

Senator Neuberger (presiding). Is that unfortunate? [Laughter.]

Senator Fong. He is not present to introduce his people. Fortunately for the country he has been called.

Senator Neuberger. You may proceed, Mr. Evans.

STATEMENT OF ROBERT T. EVANS, PRESIDENT, BLUE CROSS PLAN FOR HOSPITAL CARE OF HOSPITAL SERVICE CORP.; ACCOMPANIED BY ROBERT M. REDINGER, VICE PRESIDENT

Mr. EVANS. Senator, I have prepared a digest of my testimony which I have before me.

For the record, I am president of Blue Cross Plan for Hospital Care, of Hospital Service Corp., a not-for-profit organization with headquarters in Chicago, and 21 branch offices throughout Illinois.

Our plan operates under the laws of the State of Illinois and certificates and rates must be filed with and are subject to approval of the Illinois State Department of Insurance.

In reply to Senator McNamara's letter of April 7, 1964, I would like to discuss the five points outlined, as they relate to our Illinois Blue Cross plan.

The first point: Availability of coverage and number of older people covered.

There has never been any age limit for joining through 16,000 firms in Illinois, which sponsor our Blue Cross plan. Many of these allow retirees to remain as members through the group after they retire or reach age 65. We also have a special group program for farmers and people in small communities. A substantial number of these persons are over 65 years of age. In addition, we offer special enrollments in our over-65 Blue Cross plan. One of these enrollments will be held later this spring.

As a result of all Blue Cross activities, a total of 274,308 people, or 1 out of every 4 persons over 65, in Illinois, is now a member of our Blue Cross plan.

The second point: Ability of older persons to retain membership.

"Once a member, always a member" has been the principle upon which our Blue Cross plan has operated. It has never been our policy to terminate membership because of use or condition of health.

When a Blue Cross member leaves a group for any reason, including retirement, he is given the opportunity to convert to individual membership. Present individual members who reach age 65 may become members of our special over-65 plan.

The third point: Adequacy of coverage.

The service benefit ideal of Blue Cross is especially important because it follows the advances of scientific research as reflected in modern hospital care. We feel that when you start with this service benefit principle, the question of adequacy of benefits is answered positively. The principle is also embodied in our special over-65 plan, which provides 30 days of hospital service benefits in a semiprivate room for each hospital confinement.

In the other complete testimony there were examples of some of these cases.

A study of all of the 7,223 cases paid during 1963 for our over-65 plan members shows that 6,375 or 88.3 percent of these persons were discharged from the hospital, before they had used the full 30 days of benefits.

The fourth point: Coverage.

The cost of our over-65 Blue Cross plan has remained constant. The rate of $9.65 per month for each individual membership, estab-

lished when the over-65 plan was first introduced in 1960, is still in effect today.

No rate increases are contemplated in the foreseeable future for this over-65 plan.

The fifth point the Senator asked about was: Changes in nongroup and conversion plans.

Last year members of these groups were receiving benefits to a point where it became necessary either to make a very substantial increase in rates or to alter the scope of benefits. After consideration of various alternatives and in line with expressions from many members, we offered new plans which would hold the line on rates and not alter materially the scope of benefits.

Under these plans, members who actually utilized hospital services would share in more of the cost in order that all individual members could continue to enjoy the Blue Cross protection at the lowest possible rates. These plans were submitted to the Illinois State Department of Insurance.

These new plans increased private room benefits. They also incorporated a deductible feature whereby the member would pay the first $25 and 25 percent of the benefits and Blue Cross would pay 75 percent. This was in lieu of the former daily deductible payments. Existing rates were continued for conversion members, and there was a minimal adjusting increase for the nongroup plan.

At the time these new programs were put into effect, all nongroup and conversion members age 65 and over were given the choice of converting to our over-65 plan and many of them took advantage of this right of choice and chose our over-65 plan.

In conclusion I would like to summarize briefly. Blue Cross shares a common concern about availability, adequacy, cost, and retention privileges in health care protection for the aged. We believe we have developed very practical ways to help the aged pay hospital bills, as evidenced by the 274,308 people, or 1 out of 4 persons in Illinois over 65, who belong to our Blue Cross plan.

The adequacy of Blue Cross is matched by its availability. The fundamental concepts of Blue Cross, the wide recognition of the Blue Cross identification card by hospitals, the provision of hospital service benefits, the practice of never terminating membership because of use or condition of health, are well known and also apply in our over-65 plan.

It is our intention to carry forward this program to the increasing number of people who are living beyond the age of 65, with the same sense of public responsibility which has characterized our Blue Cross service in Illinois for 27 years.

Thank you for the opportunity of appearing before your committee in the interest of the aged and in being able to tell you how we in our Blue Cross plan in Illinois help to solve their hospital care needs.

Senator NEUBERGER. Thank you, Mr. Evans.

Any question, Senator Fong?

Senator FONG. Yes.

Mr. Evans, you stated that this Blue Cross package carries a cost of $9.65 per month?

Mr. EVANS. That is correct, per person, Senator.

Senator FONG. Under that amount, how much of the hospitalization is taken care of?

Mr. EVANS. I do not have that figure with me. We gave you some examples of some large amounts in our prepared testimony, some specific bills. In one case $2,406, another case $2,888.45; $1,178.90; another case $1,863.10.

Senator FONG. Approximately how much of that was doctor bills?

Mr. EVANS. There are no doctor bills in this, this is just hospital bills. We have a Blue Shield program available for these people that provides for medical coverage.

Senator FONG. Blue Cross is hospitalization, Blue Shield is——

Mr. EVANS. Medical, surgical, doctors.

Senator FONG. So, for hospitalization the premium is about $115.80 a year; that is correct, is it not?

Mr. EVANS. That sounds about correct.

Senator FONG. For $115.80 a year you provide hospitalization as you have shown by your figures of approximately $2,000.

Mr. EVANS. These were examples of cases. These are 30-day, full-service contracts. The subscriber is required to provide a $5 cooperative payment in the Chicago metropolitan area, $3 in the rest of the State.

Senator FONG. In the examples that you have shown, approximately what percentage of the hospitalization is taken care of?

Mr. EVANS. We do not have that figure. We would estimate it as 90 percent or perhaps a little larger.

Senator FONG. A little over 90 percent?

Mr. EVANS. Yes.

Senator FONG. And how many of your patients or your enrollees get this benefit of 90 percent or over in their hospitalization?

Mr. EVANS. The 274,000 I am talking about in the over-65 category. It could be higher if they have retained membership through their group.

Senator FONG. So, for any person who is an enrollee in your program, he could expect a 90-percent or over refund?

Mr. EVANS. On an average I would think this would be a reasonable figure.

Senator FONG. Payment to the hospital?

Mr. EVANS. Yes.

Senator FONG. Did you have a figure here that would show for the greater number of aged how many days they remain in the hospital—65 and over—do you have that figure?

Mr. EVANS. We do not have that detail, although there is one figure, I think, that bears on this point, Senator.

We found in analyzing over 7,000 cases for 1963, for persons over 65 under this program, that in over 88 percent of the cases they did not use the full 30 days of care that was available.

Senator FONG. So, actually the 30-day period for which you provide compensation is adequate for 88 percent of the people over 65?

Mr. EVANS. Our studies show this.

Senator FONG. And you are a nonprofit organization?

Mr. EVANS. Yes, sir.

Senator FONG. And there is no termination of policy as you stated?

Mr. EVANS. That is correct, sir.

Senator FONG. In other words, a person may be sick throughout the year and then the next year if he pays his premium he will still be continued?

Mr. EVANS. Yes, sir.

Senator FONG. You do not cancel his policy?

Mr. EVANS. No, sir.

Senator FONG. Thank you.

Senator NEUBERGER. Senator Williams?

Senator WILLIAMS. Yes.

You have a $25 deductible for the old-age program?

Mr. EVANS. No; not for the old age. That is for the conversion persons under 65 years of age.

Senator WILLIAMS. I see.

Mr. EVANS. Some few of our persons over 65 have chosen to remain with that program, something slightly over 25 percent.

Senator WILLIAMS. But you have a 75–25 split?

Mr. EVANS. This is for people who leave groups.

Senator WILLIAMS. I see.

Mr. EVANS. But this is not applicable to our over-65 program.

Senator WILLIAMS. It is?

Mr. EVANS. It is not.

Senator WILLIAMS. Oh. In other words, there is no division?

Mr. EVANS. The over-65 program carries a fixed $5 cooperative payment per day for hospital care rather than a percentage figure.

Senator WILLIAMS. How about your regular program of coverage? Is that on a per diem basis as it is in Dallas, or do you have a comprehensive payment for that?

Mr. EVANS. We write no per diem room allowance contracts.

Senator WILLIAMS. Does the individual hospital bill for a patient come to you as it would be stated to any other noncovered patient? Or do you have a discount arrangement with the hospital?

Mr. EVANS. It comes to us as it would to any other patient.

Senator WILLIAMS. In other words, you pay the same rates that any other person pays? Any noncovered person?

Mr. EVANS. Yes, sir; except that we have a contractual arrangement with the hospitals and annually we revert to cost of care rather than billed charges.

Senator WILLIAMS. The answer to the first question was yes, then?

Mr. EVANS. We do pay that, but if there is an adjustment it is made at the end of the year.

Senator WILLIAMS. What would you say this adjustment averages on an annual basis? In a percentage figure I guess?

Mr. EVANS. We will pay hospitals in Illinois through our Blue Cross plan approximately $150 million this year.

Senator WILLIAMS. Now, it would be an average after the reverter or whatever you call it, would you say, accounting back to the original bill you are paying 50, 60, 70 percent of the bill?

Mr. EVANS. It would be less than 1 percent.

Senator WILLIAMS. The reduction?

Mr. EVANS. Yes, sir.

Senator WILLIAMS.Thank you.

Senator NEUBERGER. I do not understand that $5 cooperative. Is that another way of saying deductible or——

Mr. EVANS. That is probably a bad term for me to use, Senator.

Senator NEUBERGER. I never heard it before, I do not know quite what it means.

Mr. EVANS. It means simply this, that for each day the patient is in the hospital he receives the full benefits of the certificate and we agree to pay that with the exception that he must contribute $5 to this. This tends to hold the rate down.

Senator NEUBERGER. It holds down his benefits, too, does it not?

Mr. EVANS. Well, his benefits are the same.

Senator NEUBERGER. Minus $5. Depends on which way it is viewed. It is a matter of semantics there.

You said that these were noncancelable policies in answer to Senator Fong, and I think the Senator stated a hypothetical situation, if they were sick a lot during the year, used the policy when it came time to pay the premium it would still be renewed; at the same rate?

Mr. EVANS. For the rate of that classification of business; I do not think we guarantee rates indefinitely, but this particular certificate because of use would not be uprated.

Senator NEUBERGER. But then you might find it quite unprofitable, even though you are a nonprofit organization, to carry somebody who had so much use and you might say to him, might you not, that we will continue but we will have to charge you a little bit more? I would think that would be good business, really.

Mr. EVANS. Unfortunately, whether that is the issue or not, our regulations by the department of insurance do not allow us to impose individual rates on individual memberships, we must rate by all persons in that classification. If everyone uses it this would tend to increase the cost.

Senator NEUBERGER. How much—you said that not very many of your beneficiaries use their full 30 days. I presume that on an actuarial basis this is the way you account for—you have to continue on that in order to make ends meet; is that right?

In other words, did you pay out in benefits quite a bit less than you collected in premiums from these over-65 people as a result of their not staying as long as they were budgeted to stay?

Mr. EVANS. Well, a rate was not calculated to provide that they would all stay 30 days. We hoped that this would be the exception rather than the rule. We find they do stay a little longer, but no longer than we anticipated they would stay.

Senator NEUBERGER. Then, how much do you pay out in benefits and how much do you collect in premiums from your 65 and over subscribers during 1963?

Mr. EVANS. I will have to take a look at those figures.

In this over-65 category our income, $2,512,000——

Senator NEUBERGER. I did not quite hear you.

Mr. EVANS. I am sorry.

Our premium income in this category in 1963, $2,512,000; our claims incurred, $2,429,000.

Senator NEUBERGER. It just about breaks even.

Mr. EVANS. Well, it has been our practice, and of most all Blue Cross plans, to continue rates until they become inadequate, so if you get a break in experience in one year, you would move into the next year with it.

Senator NEUBERGER. You insure people under 65; I presume that they carry a little bit of this, really, do they not?

Mr. EVANS. Well, I think that all members of a plan tend to carry part of the risk of other members of the plan, through the various devices of pooling their experience.

Senator NEUBERGER. Of course, that is what all insurance is.

Mr. EVANS. That is really what insurance is.

Senator NEUBERGER. If a social security plan were passed to finance hospital care, would you think that Blue Cross could contract with the Government to take care of hospitalization? Based on the idea that the previous witness said was happening in Texas; would Blue Cross be a good organization to make an agreement with the Government to handle that?

Mr. EVANS. That is a quite difficult question to answer, Senator. I would answer if I might, this way: When the Government provided coverage for the Federal employees, Blue Cross cooperated with the Federal employees; when the U.S. Government provided care for dependents of servicemen, we cooperated with the Government; whether I can answer your question correctly or not, I am not sure. It has been our intent to do this over the years. I think the circumstances would require our taking a look at them. But I think we have shown in this effort——

Senator NEUBERGER. As a Government employee who has used her benefits, I have found working with Blue Cross very satisfactory and very prompt in payment. Of course, I have deducted from my payroll every month the money to take care of it, and I think the same thing would continue under a social security plan, and it would seem wise that an organization so well equipped as Blue Cross could contract to handle it. It would be the same idea.

Mr. EVANS. We appreciate those comments, Senator.

Senator NEUBERGER. Thank you.

Any other questions?

Thank you very much, Mr. Evans.

PREPARED STATEMENT OF ROBERT T. EVANS, PRESIDENT OF BLUE CROSS PLAN FOR HOSPITAL CARE OF HOSPITAL SERVICE CORP.

My name is Robert T. Evans, and I am president of the Blue Cross Plan for Hospital Care of Hospital Service Corp. This is a not-for-profit organization, with headquarters in Chicago, Ill., and 21 branch offices throughout the State.

Our plan was founded in Chicago in 1937 by a group of civic-minded citizens to help people of all ages pay both large and small hospital bills. Our Blue Cross plan remains dedicated to the ideal of service benefits, which means members receive hospital benefits in terms of the hospital services they need without dollar limits.

By efficient operation, we hold operating costs to a very low figure, and an extremely high percentage of every income dollar is used to pay hospital bills for members.

The board of directors, which sets our objectives, is made up of prominent, public-spirited citizens, who serve without pay, in the public interest. They represent the various aspects of our State's life: business and industrial firms, labor union, social welfare agencies hospitals, medicine, banking, and agriculture.

Our Blue Cross plan operates under the laws of the State of Illinois. All certificates and rates must be filed with and are subject to approval of the Illinois State Department of Insurance.

It is therefore, with a deep sense of responsibility and a sincere appreciation for your interest in what we have done and are doing in Illinois, that I appear before you today.

My purpose is to respond as helpfully as possible to the letter from Senator McNamara, dated April 7, 1964, and to give you information in the specific areas of inquiry cited by Senator McNamara. My testimony today will focus, for the most part, on our programs which relate specifically to the elderly—men and women in Illinois who are 65 or over.

However, please permit me to state a few principles which, I believe, will be of particular interest to you:

(*a*) We have always devoted our efforts to providing the benefits of hospital service for people of all ages.

(*b*) Many thousands of our present members have passed the 65-year mark as Blue Cross members since our plan was started 27 years ago.

(*c*) There has never been any age limit for joining through the thousands of firms which sponsor Blue Cross groups.

(*d*) When a member leaves a group for any reason, including retirement, he is given the opportunity to convert his membership to an individual basis, without regard to age, prior usage, or health condition.

(*e*) Enrollment opportunities are regularly offered to all people under individual memberships.

I would like now to discuss the points outlined by you as they relate to our Blue Cross plan in Illinois, including:

I. Availability of coverage and number of older people covered.
II. Ability of older person to retain membership.
III. Adequacy of coverage.
IV. Cost of coverage.
V. Changes in nongroup and conversion plans.

SECTION I. AVAILABILITY OF COVERAGE AND NUMBER OF OLDER PEOPLE COVERED

Membership in our Blue Cross plan is available to people over 65 in these six different ways:

1. Blue Cross protects older people through continuing group membership

Group memberships constitute 83.8 percent of our total membership. Therefore, I would like to address myself, first, to the subject of group membership in relation to older people.

We have more than 16,000 firms in Illinois representing every phase of our State's industrial, commercial, professional, educational, civic, cultural, and philanthropic life * * * which sponsor Blue Cross groups.

Thus, Blue Cross membership is available, on a group basis, to men and women of all ages, including those over 65. These people may retain Blue Cross group protection as long as they are employed by the organization sponsoring the group. In fact, 141,962 Blue Cross group members are over 65 today.

2. Blue Cross encourages firms to allow retirees to continue as group members

We have encouraged many firms to allow employees to continue their Blue Cross membership through the group's regular benefit plan when they retire. For years, many of our Blue Cross groups, both large and small, have assumed the responsibility of providing for the health care needs of their retired employees. Examples are: Illinois Bell Telephone Co.; Marshall Field & Co.; the Chicago Tribune; Board of Education of the City of Chicago; Corn Products Co.; the Olin Mathieson Co.; General Motors; and Western Electric Co.

3. Blue Cross offers members who leave groups and are over 65 years of age our Blue Cross over-65 plan

We give all members over 65 the opportunity to convert their membership to our over-65 plan—when they retire—and may no longer be covered under the group to which they had belonged during their working years.

4. Blue Cross provides continued membership to rural people over 65 years of age on a group basis

Many rural people over 65 are members through the statewide Health Improvement Association. One of the major activities of this voluntary organization is to enroll people in Blue Cross who are under 65 and live on farms or in Illinois communities of 2,500 or less.

Those who join Blue Cross through 1 of the 91 county Health Improvement Association groups in the State of Illinois may continue as members through that group as long as they live.

A total of 170,137 people in rural Illinois now belong to Blue Cross through these health improvement associations, first started in 1948. Of this number, 31,943 are over 65 years of age.

5. Blue Cross regularly promotes special enrollments in the over-65 plan

Being cognizant of our responsibility to older people, we introduced a special over-65 plan in May 1960. This was done because many individuals—who were not our members—no longer had the opportunity of having coverage upon attaining age 65.

Since then, Blue Cross has held four special enrollments giving people, over 65, additional opportunities to join as individuals.

Another special over-65 enrollment will be held throughout the area we serve in Illinois this spring. This will be supported by widespread publicity throughout the State of Illinois to let every man and woman know that this over-65 plan is available to them, regardless of age or condition of health.

6. Blue Cross makes it possible for present individual members, who reach age 65, to become members of our over-65 plan

All of our present individual members upon attaining age 65 are notified by us that they are eligible for membership in the special over-65 plan. We then take steps to convert their membership to this over-65 plan.

As a result of making Blue Cross available to older people in these 6 different ways, our Blue Cross plan now has a grand total of 274,308 members who are 65 years of age and older, and 141,962, or 51.8 percent of these people, belong to Blue Cross through groups. This means that 1 out of every 4 persons over 65 in Illinois is provided with an adequate program through our Blue Cross plan.

No discussion of availability of Blue Cross protection can be complete without a pertinent reference to the manner in which these 274,308 members over 65, as well as all members under 65, may receive benefits easily and without redtape.

A Blue Cross membership card is unique in expediting admittance to a hospital, when hospital care is required. The readiness with which hospitals accept a Blue Cross card is especially important to an older person whose needs are often more urgent in case of a sudden accident or illness. The simple act of presenting a Blue Cross card at a hospital-admitting desk cuts redtape and eases the patient's mind at a time when reassurance is particularly important. And Blue Cross pays the hospital direct for the benefits a member receives. This is most important.

The Blue Cross card is recognized by 266 Blue Cross member hospitals in Illinois and by over 7,000 hospitals throughout the United States.

SECTION II. ABILITY OF OLDER PERSONS TO RETAIN MEMBERSHIP

I am proud to tell you that through the years, since our Blue Cross plan was founded in 1937, the ability of older people, as well as people of all ages, to retain membership—has been one of its outstanding advantages.

It has never been and is not the policy of Blue Cross to terminate membership because of age or condition of health. Neither is it the policy of Blue Cross to terminate membership because members may need to receive lots of hospital services.

Continuation of membership—regardless of use or condition of health—is a cardinal point in Blue Cross protection. Although we have stated this several times before during this report, it still bears repeating: People have repeated opportunities to obtain Blue Cross protection after age 65—and to continue membership—regardless of the state of their health. "Once a member, always a member" has been a principle upon which our Blue Cross plan has operated.

SECTION III. ADEQUACY OF COVERAGE

The service-benefit ideal—which Blue Cross carries into its contracts—is especially important because it follows the advances of scientific research as reflected in modern hospital care. We believe sincerely in the service-benefit concept of protection. We feel that when you start with this premise, the question of adequacy of benefits is answered positively. In addition to the service benefits provided to older members through group programs I have previously mentioned, the service-benefit principle also has been embodied in the special over-65 plan. This plan provides:

1. Thirty days of hospital service benefits in a semiprivate room per hospital confinement.
2. The 30 days of benefits may be provided over and over again each time a member has been out of the hospital for 90 days.

Illustrative of what service benefits really mean are these examples from the 7,223 cases for which benefits were provided in 1963 for over-65 members under this plan:

Hospital case No. 668208—Blue Cross paid $2,406

L.C., a woman, 67 years of age, received 30 days of hospital benefits. She had a gallbladder operation with jaundice and other complications. Among the large items on her hospital bill were: $388 for oxygen; $393 for laboratory services, $701.25 for drugs, and $660 for semiprivate room charges.

Hospital case No. 747841—Blue Cross paid $2,888.45

I.T., a woman, 68 years old, had an intestinal obstruction for which she had to have an operation and remained in the hospital 23 days, receiving large amounts of drugs and laboratory services.

Hospital case No. 733527—Blue Cross paid $1,178.90

H.H., a man, 86 years of age, had an operation for cancer of the colon and had to remain in the hospital 22 days following the operation. During the first part of his stay he required a large amount of oxygen, drugs, and laboratory services.

Hospital case No. 114899—Blue Cross paid $1,863.10

D.T., another man, 83 years of age, was seriously ill with an abdominal condition, and had to be rushed to the hospital. He required 22 days of in-hospital care including many laboratory tests and drugs to treat his condition.

We use these figures to underscore the advantages which over-65 Blue Cross members receive under the service-benefit concept of health care protection. Admittedly, most of these are above-average cost cases, but they do illustrate the degree of protection available to older citizens under our basic over-65 plan.

It is interesting to note that a study of the 7,223 cases paid during 1963 for members of our Blue Cross over-65 plan shows that 6,375, or 88.3 percent of these persons, were discharged from the hospital before they had used the full 30 days of benefits.

Individuals who wish greater coverage also may add a special rider to the basic over-65 plan increasing the number of days and other benefits.

SECTION IV. COST OF COVERAGE

The cost of our over-65 Blue Cross plan coverage has remained constant. The rate of $9.65 per month for each individual membership, instituted when the over-65 plan was first introduced in 1960, is still in effect today.

No rate increases are contemplated in the foreseeable future.

This over-65 program is a practical plan which is based on the principle of service benefits, as are all of our plans for people of all ages. We also believe it is fair to say that the number of people 65 or over who belong to Blue Cross reflects the reasonableness of our dues structure.

SECTION V. CHANGES IN NONGROUP AND CONVERSION PLANS

Last year, it became apparent that individual members, both nongroup and conversion, were receiving benefits to a point where it became necessary either to make a very substantial increase in rates for these members in order to meet increasing hospital costs and their greater use of hospitals, or to alter the scope of benefits available to them.

After consideration of the various alternatives, and in line with expressions from many members, we proposed to offer new plans which would hold the line on rates and not alter materially the existing scope of benefits.

These new plans allow our members, who use hospital service, to share in more of the cost of care in order that all individual members will continue to enjoy the security of Blue Cross protection at the lowest possible rates.

These plans were submitted to the Illinois State Department of Insurance.

These new nongroup-75 and conversion-75 plans:

(*a*) Continued to provide the broad range of benefits of the plan these members had, including those related to new miracle drugs and other new expensive techniques of hospital care.

(*b*) Increased private room benefits, because of the increasing use and availability of private rooms.

(*c*) Incorporated a deductible feature whereby the member would pay the first $25 for in-hospital bed care. After this payment, Blue Cross would pay 75 percent and the member 25 percent of the hospital's charges for in-patient benefits. This was in lieu of the daily cooperative payments which had been in effect for these contracts.

(*d*) Provided for the continuation of existing rates for conversion members and a minimal adjusting increase for nongroup members of 16 cents a month for family coverage and 66 cents for individuals.

Adoption of these plans, in lieu of a substantial increase in dues, once again represented recognition that the service-benefit principle should be maintained and, at the same time, membership dues held down as low as possible.

All nongroup and conversion members age 65 and over were given the opportunity of converting to our over-65 plan.

Recognizing that nongroup and conversion members who had reached 65 years of age would find it advantageous to have our regular over-65 plan, we made a special offer giving them the opportunity of changing to the over-65 plan.

Thus, last fall, when a substantial rate increase or revision in benefit structure for nongroup members and conversion members became necessary, we offered all members in these categories over 65 years of age the right of a choice between a new conversion or nongroup-75 plan and the over-65 plan. Many took advantage of this opportunity to join our special Blue Cross over-65 plan.

CONCLUSION

Blue Cross shares a common concern about availability, adequacy, cost, and retention privileges in health care protection for the aged. We believe we have developed a very practical plan to help the aged pay hospital bills. We cover a large number of people over 65 as evidenced by the 274,308 people—or 1 out of every 4 persons in Illinois over 65—who belong to our Blue Cross plan. Thousands of others have coverage from other sources.

The adequacy of Blue Cross is matched by its availability—in the different ways I have described. Once a year, it is our plan to offer a special enrollment giving people in Illinois an opportunity to join our over-65 plan—regardless of health. We announce and promote the availability of this program through all major communications directed to older citizens and the sons and daughters who care for them.

The fundamental concepts of Blue Cross—the wide recognition of the Blue Cross identification card by hospitals, the provision of hospital service benefits, the practice of never terminating membership because of use or condition of health—are well known and also apply to our over-65 plan.

It is our intention to carry forward this program to the increasing number of people who are living beyond the age of 65 with the same sense of public responsibility which has characterized our Blue Cross service in Illinois for 27 years.

Thank you for the opportunity of appearing before your committee in the interest of the aged and in being able to tell you how we, in our Blue Cross plan in Illinois, help to solve their hospital care needs.

Senator McNAMARA. Mr. McNerney, would you introduce your associates?

Mr. McNERNEY. This is Mr. Singsen on my left and Mr. Heitler on my right, both vice presidents of Blue Cross Association.

Senator McNAMARA. Glad to have you gentlemen here. You may proceeed.

STATEMENT OF WALTER J. McNERNEY, PRESIDENT; ACCOMPANIED BY A. G. SINGSEN, VICE PRESIDENT, AND G. HEITLER, VICE PRESIDENT, BLUE CROSS ASSOCIATION

Mr. McNERNEY. Thank you very much, it is a pleasure to be here. I have a relatively short statement, as you know, which I should like to submit for the record. Perhaps the easiest thing would be for me to

skip through it quickly and apologize in advance for the fact that it duplicates some of the things that have already been said by Messrs. Evans and McBee.

To repeat the beginning of it, I am president of the Blue Cross Association, national organization of Blue Cross hospital service plans. I appear here today as a representative of these plans, which collectively provide hospital benefits to 59 million people in the United States, including approximately 5.3 millions 65 years of age or older as of January 1, 1963.

We have mailed to the staff of your committee under separate cover details on each Blue Cross plan, with the exception of one which will arrive shortly, regarding coverage, benefits and rates, so that I should like to confine my remarks here in the beginning largely to the policy context within which Blue Cross conceived and implemented coverage for the aged.

As of January 1, 1963, approximately 9.1 percent of the 58 million Blue Cross subscribers, constituting a total of 5.3 million citizens, were senior citizens. This percentage is practically the same as the percentage of senior citizens in the total national population.

This number of 5.3 million if I could move from my written statement for a moment, is now larger having extended to approximately 5.6 million, which we indicated in a separate memorandum to you, and perhaps some beyond that because our count is not yet complete. In a market that in recent years has been actively competitive, both in regard to the younger and older age groups, we are proud of this record.

We attribute it to a few important practices and objectives which have characterized Blue Cross from its beginning. As a matter of general objective Blue Cross reflects the broad community and voluntary hospital concept that all people needing and seeking hospital care should receive it regardless of such factors as age or physical condition.

As a matter of practice, we have stressed such factors as hospital service at the time of need rather than cash payments to individuals, returning a high degree of subscribers' dollars in benefits, widespread availability of benefits, leadership in utilization controls and encouragement of area-wide planning of health services and exploration of new benefit areas.

In essence, we feel that health protection and care should be patient and community centered rather than impersonally arrived at through dollar competition.

Over 30 percent of the country's population have supported this point of view and the practices stemming from it. With particular reference to the aged, which we think are in a vulnerable position, we have taken several steps since our inception.

Every Blue Cross plan in the United States has enrolled senior citizens through some combination of the following methods. You have already heard of most if not all, of the methods.

Blue Cross has stimulated management and labor interest in retaining retired workers within groups of those actively employed.

Members leaving a group are encouraged to convert to an individual, direct-pay basis. Open enrollment periods are held during which all persons in the community including the aged are able to enroll. Special programs for the aged have been designed and offered.

We do not as a matter of practice, cancel anybody who has become a member of Blue Cross. Our benefits are designed to be as helpful and as economical as possible and we believe that the rates covering these benefits are probably lower for comparable coverages than almost any you can find by any responsible carrier.

Those on group rates, those aged that are part of a group receive the same rates and benefits as other members of the group. In many instances this care is financed completely or in part by the employer.

Those eligible for group conversion, who pay directly for their protection must pay a higher rate for the same coverage that is offset in part by the subsidy resulting from community rating, or from the community factor generally included in contracts based on some form of merit rating. Nongroup subscribers, although helped in part by subsidy, pay on the average a rate related more closely to their experience.

These practices and others were evaluated by the Blue Cross Association and the American Hospital Association in 1961 and 1962. Their findings were published in a study entitled, "Financing Health Care of the Aged." It provided a factual basis for policy formulation on the respective roles of voluntary health institutions and government in bringing about greater health security to all our older citizens, and this has been made widely available.

The study documents the widely recognized fact that some of the aged are unable to pay for all the medical care they need. The reasons are complex, but the simple fact is that a portion of the aged population lack the purchasing power to protect themselves against heavy medical costs.

Yet good programs are available for purchase today at rates which reflect reasonably the costs of health care. The essential problem is uneven distribution of ability to pay. This problem is not confined to the aged. It centers on those whose needs cover most of the necessities of life, such as food, clothing, and shelter. These citizens require government assistance.

Blue Cross in general, across the country, welcomes the responsibilities inherent in its community structure. It has made wide and full use of its resources to help the aged and other disadvantaged groups or individuals in the Nation. In regard to benefits and controls it is making eminently satisfactory progress. It cannot and does not purport to solve all the financing problems of the disadvantaged, but has and will cooperate with any responsible group, government or nongovernment, that is working toward this objective.

I hope that these brief comments will provide your staff with assistance.

Senator NEUBERGER. I was particularly impressed by the comments you just made about the fact that some people are just unable to provide for their own insurance.

Oregon Blue Cross requires an older couple to pay $23 a month under its particular senior citizens program, and, as I recall, that only pays about 80 percent of the covered charges.

A couple under a group plan, I think, it was brought out here from the other witness, paid $9.45 a month and they get better protection. Now, I want to ask two questions. How can Oregon Blue Cross call

this community rating, which it does? And how could I oppose a King-Anderson program when I am faced with facts like this?

Mr. McNERNEY. You are saying that the group program in which the aged are included does a more effective job in meeting hospital costs than the nongroup programs.

Senator NEUBERGER. At $9.45 a month they really do?

Mr. McNERNEY. Well, it is true that around the country, that people who are part of a group, either by virtue of working or by virtue of retirement, are able to get more benefits for a given amount of money.

There are available in that group a goodly number of people under 65 whose experience is more favorable to help those who are aged.

When you move outside of this situation to those who enroll on a direct-pay basis, who might or might not be employed or who might be older or younger, you find usually a disproportionate number of disadvantaged citizens, or aged citizens, so that whereas there is some helping of the disadvantaged by those who are better risks, the degree of it is less.

So, as a result, for the same amount of money you get slightly lesser benefits.

Blue Cross has tried to equilibrate these risks by taking money from one category and giving it to another. This still goes on in a majority of our plans. The degree to which it goes on is being compromised somewhat by competition which is a fact of life, but there is still a significant amount of it.

Senator NEUBERGER. We have a quorum call and it is just the lunch hour. Would you like to suspend then?

Senator FONG. I have just two questions.

You stated you have 59 million people enrolled in your program. Is that correct?

Mr. McNERNEY. Yes, as of the end of 1963.

Senator FONG. And of that—in other words, that represents 30 percent of the population of our country?

Mr. McNERNEY. Slightly over—the actual figures would come out to about 32 percent of the population of the United States.

Senator FONG. And you represent 5.3 million of those who are 65 years and above?

Mr. McNERNEY. That was in the beginning of 1963. It is a higher amount now.

Senator FONG. It is 5.6 million now.

Mr. McNERNEY. Perhaps that or a little more.

Senator FONG. We have had figures showing that approximately 9 million of the aged have health policies. So, therefore, you represent almost two-thirds of those who have health policies, who are 65 years and above?

Mr. McNERNEY. The exact number of the aged who are covered by some form of private health protection is not definitely established. I, myself, cannot say exactly what it is—if it is 10 or 11 million then our relationship to it would be slightly over half or about half.

Senator FONG. You have been in the field longer than the other insurance companies?

Mr. McNERNEY. The insurance companies, commercial companies, have written some form of health insurance since the late 1800's depending upon how you want to define health insurance.

The focus was on the wage earner and on replacement of income. In terms of widespread health benefits of a service nature we were the first, and this stems back to the early 1930's.

Senator FONG. Even assuming that all insurance companies are profitmaking companies, though many of them are mutual companies, we could safely say that more than 50 percent of the aged who have health policies are in a plan or in certain group plans which do not make a profit from their policies?

Mr. MCNERNEY. That is true, depending upon what you say is the top figure. Whether 10 or 11 million covered, or 9 but our figure, I think, is firm. Of this we are quite sure.

Senator FONG. Thank you.

Senator NEUBERGER. Can you come back after lunch, Mr. McNerney?

Mr. MCNERNEY. I would be glad to.

Senator NEUBERGER. Suppose we recess until 1:30?

Senator FONG. I will not be here.

Mr. MCNERNEY. What time would that be?

Senator NEUBERGER. 1:30.

(Whereupon, at 12 noon, the committee recessed, to reconvene at 1:30 p.m., the same day.)

AFTER RECESS

(The subcommittee reconvened at 1:40 p.m., Senator Maurine B. Neuberger, presiding.) I want the hearing record to show that Senator Fong was unable to attend this afternoon's session of the hearing because he is one of the floor captains today for the civil rights bill.

Senator NEUBERGER. Will Mr. McNerney come back to the stand, please, and his aides if he wishes them?

Senators McNamara, Williams and Fong really wanted to continue with the questioning but various activities are keeping us from all being here at the same time. So, I will authorize the staff members to ask any questions that they would like to ask.

Mr. CONSTANTINE. Mr. McNerney, we recently received quite a bit of information from your plans and while we have not had an opportunity to analyze it in great depth, two conclusions were drawn from the data you gave us on the aged.

One is that most of the Blue Cross plans have abandoned or are in the process of abandoning community rating in favor of some form of experience rating, and that most of the Blue Cross plans have just had or plan to have substantial rate increases.

Now, all Blue Cross members are hit by this but the aged are hit probably as hard as any.

Would you first of all define community rating and then comment on these facts of life?

Mr. MCNERNEY. Well, first of all, a pure community rate would imply that you put together all subscribers without any exception and charge them the same rate. For years this absolutely pure concept has been compromised by the fact that we have offered semiprivate and ward contracts, group, and nongroup. We have offered single versus family contracts. So that a pure concept of community rating has never existed in practice. It is a matter, therefore, of degree to what extent you put people into classes.

There has been a move on the part of Blue Cross to go toward a little more of class or experience rating and the reason in many cases is competition as you know, particularly in reference to some large accounts, some national accounts. It is demanded by the account.

What Blue Cross is trying to do in places like Michigan and New York, where this sort of move has received the most attention lately, is to leave a community factor in each rate even though that rate might apply to less than the total community.

This would create a repository of money which could be used to help the disadvantaged groups. So that you are right when you say that Blue Cross has moved in the direction of class or community rating. However, where it has been the tradition to develop a community factor for use by the disadvantaged it is intended that this be continued using a different technique.

Mr. CONSTANTINE. But that is a relatively small factor, is it not?

Mr. MCNERNEY. It depends ——

Mr. CONSTANTINE. New York is 5 percent or so.

Mr. MCNERNEY. It could be 4 or 5 percent, such as that. Of course, when that percentage is derived from a majority of our group business—75 percent of our business is a group business incidentally—there can be created a fairly appreciable amount of money.

We have never pretended that the amount of money created would entirely do the job for any disadvantaged group. However, our intent is to do what we can for those who are poor risks.

So far as rate increases are concerned, as you mentioned second, we have these periodically because we pay in many sections of the country for a service contract.

This implies that our rates will follow fairly faithfully rises in hospital costs. These costs are continuing to go up, so periodically, of necessity, we have to raise our rates to meet them.

I would like to note here importantly that Blue Cross has made several efforts even though paying a large amount of the bill, to see that the money is well spent. In many of our plans we have encouraged the establishment of utilization committees within the hospital.

In many of our plans we have participated in planning of facilities; that is promotion of the orderly growth of hospitals and allied facilities. We are looking at our claims information with an eye toward asking questions when extreme variation is involved.

Through these and other methods, we have given the buyer or the citizen some feeling that his money is not being spent uncritically.

Mr. CONSTANTINE. You have referred, and I think the committee has quoted you in its earlier reports, to the use of deductibles and coinsurance as "fiscal gadgetry." You refer to that repeatedly as "fiscal gadgetry," and say this not only limits coverage of hospital expenses, but that it deters necessary care.

I believe it was derived from your Michigan study. If that is so, why have so many Blue Cross plans started to use these practices, including them in their new, so-called expanded plans for the aged?

Mr. MCNERNEY. I feel that the deductible copay devices are only poor substitutes for what I have just described in terms of more substantative controls.

In our senior citizen offerings 18 plans provide full room, board, and ancillary services; 20 plans offer an indemnity allowance toward

room and board charges while covering ancillary charges in full; and another 36 plans offer contracts which include deductibles, co-pay, or coinsurance provisions.

Many of these plans also offer other contracts to the aged which do not contain the limitations I have just outlined.

In each of these cases the amount was not large. It was not of a high order that I know of. I must confess that I have not looked over the worksheets as you have, I doubt if it is in the order of $100 or $200 or $500 or anything of the sort. The smaller deductibles run less danger of creating underuse which I have held as a criticism against the larger deductibles.

However, I still think they are a poor substitute for direct controls. They have been employed simply because the plan director faces this very difficult decision of whether to give lesser benefits at a given price or to enlarge the benefits a little bit and put some dollar limitation in.

In some market areas whether through tradition or through local culture or whatever, those contracts with some small limitations sell better, which has at least the advantage of pervasiveness, getting at or reaching a larger number of people.

I would predict that in the long run in prepayment, however, that you would find that deductibles, co-pay, and so forth, would not be major practices we would lean on.

Mr. CONSTANTINE. Just one more question. As a community agency, Blue Cross does receive hospital discounts ranging up to 20 percent, I believe, and that is another part of this question because Senator Williams would like to know the range of hospital discounts received by Blue Cross plans throughout the country, that is the percentage below charges, and has received these discounts and received tax exemption and other special treatment.

Now, how can Blue Cross justify continuing to receive favored treatment, and so on, based upon its quasi-public utility status, when its operations more and more resemble those of a commercial insurance company? That is, why should Blue Cross continue to receive tax exemption and special treatment?

Mr. MCNERNEY. It is true that Blue Cross does receive special treatment, if you mean by that that we have been established by State legislation, enabling legislation, as nonprofit corporations and charged with a community job.

Blue Cross has accommodated to changes in the organization of medical practice and methods of financing over the years, but I think it is important to note that whereas these changes have taken place they have not really affected the basic structure of Blue Cross as much as implied by some remarks.

We still make an effort to reach all groups in the community. We do not shun or turn our backs on the high risks. Once people enroll in Blue Cross they are kept, they are not canceled. We return of all the dollars we collect on an average 95 percent and keep only 5 percent for all purposes—reserves and administration. Quite importantly, we still are pioneering in new areas such as nursing homes, nursing in the home, and intensive care. We are now working closely with dental groups. I think it is important to note that in several sections of the country we have implemented many of the controls I mentioned earlier. That is, rather than paying a case in the nature

of trading money and being unconcerned about how well the care is rendered, we will look behind the scene in the hospital to see if that care, in fact, is well rendered.

We have attempted to put our weight behind discouraging the building of hospitals that are not needed and encouraging those that are.

There is a composite of activities here that in all instances reflects, I think, the community's interest.

Now, I would like to talk about another side of this same issue. Along with the prerogatives which really amount to a tax-free status——

Senator NEUBERGER. Will you excuse me, and may I say that I, too, have to report on the Senate floor. We have a battalion working on the floor and Senator Fong is doing his duty and that is why he is not here. I am due to check in at 2 p.m. Senator Moss will take over.

Senator Moss (presiding). I understand Senator McNamara will be here shortly so I will be interim chairman.

Mr. MCNERNEY. Thank you very much.

Along with these prerogatives have come a fair number of obligations. We sit before public bodies and justify our rates constantly through the years. We have been the object of more studies and commissions and investigations than one could possibly enumerate in a short period of time. So that there is no lack of scrutiny about our performance.

Now, so far as our relations with the hospitals are concerned I think reference to this relationship as a discount is inaccurate. In a majority of plan areas we pay on a basis related to reimbursable costs. This includes in addition to actual operating expenditures of the hospitals, ordinary depreciation, interest on indebtedness, or some other growth factor. Hospital bills covered in this process include some for people who, if they were not in our ranks would otherwise be bad debts or poor risks so far as the hospital is concerned.

Some of these reimbursement formulas, as you know, might be 105, 106, or 108 percent of operating costs, but the percentage doesn't mean as much as the actual items that go into determining what cost is.

Mr. CONSTANTINE. What percent are they of charges?

Mr. MCNERNEY. This would vary with how the charge structure is set.

Mr. CONSTANTINE. What are the ranges in the Blue Cross plans?

Mr. MCNERNEY. I cannot tell you exactly, but it goes from 0 percent (as you know, some pay charges, our maximum), up to, I would say in the order of 10 percent, but I would have to do some checking to give you further information on this. The point is that if a hospital establishes its charge structure, for whatever purposes, entirely unrelated to cost, then this factor will increase, without reference to how well we are carrying our share. And that is the important thing to know.

Mr. CONSTANTINE. You say that Blue Cross is trying to reach all the groups in the community. It seems that on the basis of all these changes to experience rating all the groups in the community cannot reach Blue Cross, and I think that that is part of the other side of the coin.

Mr. McNERNEY. Well, there is no question, and we have testified before the House Ways and Means Committee and here, that there are people, aged included, but not totally aged, who have not the purchasing power to avail themselves of coverage, of Blue Cross or any other type, and there is no thought otherwise.

The point is, again though, that we have attempted to do our best to reach these. Now, unless you have enrollment of fairly large size it handicaps your ability to reach them. We must, therefore, be cognizant of appealing to the market to maintain or improve our ability to reach and help the disadvantaged.

Senator Moss. Could you tell me what your payout or cost experience is on elderly subscribers for Blue Cross? How do the benefits compare with the premiums that are paid in this over 65 group?

Mr. McNERNEY. Well, we have the over 65 enrolled in several categories, one category, about 37 percent of all the aged we have enrolled are in working groups in the sense of retired members of working groups.

Here ordinarily the rate will stand on itself, and the younger members of that group will assist older members of that group.

We have about 52 or so percent on direct pay, some of these are conversions from groups, some of them have joined Blue Cross for the first time. We have about 5 percent on senior citizens, 5 percent on OAA or MAA. In regard to those that are on group conversion, formerly members of a group that did not continue them, so they had to go on their own, I will have to speak on the average amount of plans, because I cannot qualify it 76 times—on the average I would say that these pay a higher rate for the same benefits than those in the group, but that that higher rate is reduced by virtue of some subsidy from the working population.

Those who come in on a senior citizens program similarly on the average receive some subsidy and those who are on direct pay, enrolled during some sort of an open enrollment, may or may not get a subsidy.

I cannot quote you exact figures right offhand, although I can get these data, an average amount of subsidy for all plans.

Senator Moss. But as you move more then to this experience rating and away from the community rating, the rate has to go up very considerably for the over 65, is that correct?

Mr. McNERNEY. No; this is a function of how much you would add, as a so-called community factor to whatever class rating you went to. The design of the class rate would affect the distribution of contributions. In other words, today a group might be giving more under a community rate and another less. If you reclassified these groups and put a clearly understood community rate on each class, it might mean a more equitable contribution, if you stop to think about it, toward this need differing from the first but probably more equitably distributed between the two.

It depends upon what you set as a plus factor.

Senator Moss. Well, I have before me some figures from the Salt Lake City Blue Cross plan. They show that the nongroup premium is $10.22; the group premium is $11.95, and $10.43, there are two groups within there; but when you get to the senior citizens, you go up to $19.80, and the second group is $14.30. The benefits are very

much curtailed for this contracts that costs $14.30; that, evidently, is why it is so much less; but this $19.80, for instance, is nearly double what the premium is for the nongroup subscriber and a great deal more, 60 or 70 percent more than the group monthly premium.

That is the reason for my asking the question: Is it not necessary to raise this premium very high when you take the senior citizen out of the group and the group cannot level him in?

Mr. McNERNEY. The senior citizen standing on his own, without any support from any other segment of the community, will usually involve a rate that would be two times as much because their experience totally—hospital, medical and otherwise—is roughly that.

When I talk to you about an average it implied that some of our plans on some of their contracts do not subsidize a group, including the aged. This may be an example of just such a contract.

Within the nongroup there, incidentally, which does include aged in a different category, there is some subsidy involved by virtue of the fact that they are in with other age groups and possibly some help, too, from the groups themselves.

Senator Moss. The monthly premium, and I understand there is another 10- to 14-percent increase for this year, would be pushing the premium up for an aged person to almost prohibitive level when it gets above $20 a month, would you not say?

Mr. McNERNEY. Well, I would say this, first, that the large bulk of the aged will be within that group and nongroup categories you have in front of you. On a nationwide basis only 5 percent of our aged are in that senior citizens type of program, so that you are talking about a small minority experiencing such unusual rates.

Yes; when you get up to premiums of $20 per person per month, or $19—I am not sure what the benefits are on that, you are talking about a lot of money and not everybody can afford it.

Senator McNAMARA (presiding). Are you familiar generally with the Michigan Blue Cross plan?

Mr. McNERNEY. Generally.

Senator McNAMARA. It is my understanding now that they come under what you refer to as the community rating system?

Mr. McNERNEY. Yes.

Senator McNAMARA. And they are advocating a change to experience rating?

Mr. McNERNEY. They are in the midst of discussing that now, Senator.

Senator McNAMARA. Well, I wonder what effect that change would have on the cost of the coverage for the quarter of a million people who are now covered by Blue Cross in Michigan and are over 65?

Mr. McNERNEY. I cannot give you an exact answer to that. I can say that the formula that is being proposed or at least discussed at the moment with the insurance commissioner, does contain a factor for all classes that would be created. A factor called a community factor which would be composited and used to help the disadvantaged people, including the aged.

Senator McNAMARA. I do not understand where this help would come from.

Mr. McNERNEY. For example, a group might pay its projected experience plus overhead, plus a community factor. They would agree

to contribute beyond their experience to help out other members of the community. Now, they do that presently in Michigan by virtue of the fact that they are on a community rate.

This is a different way of doing the same thing. It has the advantage of the group being more conscious of that contribution, of being able to discuss how much it is and not having some in a much more contributing position than others. So that it is not as much of a change in philosophy as one might first suppose, and, in fact, has some matters of equity in it that perhaps will create a greater social consciousness among the major buyers.

Senator McNAMARA. Well, I think the social consciousness is very important. But what I was trying to get at is, How much will it cost? Will it cost more or less to this quarter of a million people?

Mr. McNERNEY. Let me answer you this way. I am sorry I cannot give you a definitive answer, I am not trying to be evasive. If the insurance commissioner improves an adequate percentage they will still get the same amount of help they get now.

Senator McNAMARA. Get a subsidy from what, the State?

Mr. McNERNEY. No. If the plus factor that can be added to the groups who are paying is in effect comparable to the community rate subsidies that are now created, then the aged will not suffer in any way.

Senator McNAMARA. They will not suffer, but somebody else has to pick up the difference——

Mr. McNERNEY. This is always true.

Senator McNAMARA. Whether it is a charitable organization or relatives or somebody else?

Mr. McNERNEY. Or by virtue of a fact that you are in a group with younger people. The moment that takes place the aged are the beneficiaries of the good fortunes of the young people.

Senator McNAMARA. So, therefore, there is every indication that it will cost more whether it is done by——

Mr. McNERNEY. No. It will not cost more. If they go to class rating from community rating there will be only a redistribution of who puts up what "plus" amount.

Senator McNAMARA. Then if I were the individual who owns a Blue Cross policy, if he is to pay it all himself it will cost him more. Is that not correct?

Mr. McNERNEY. It is true that if people who are high risks paid according to their own experience then it would cost a lot of money for them. But the whole philosophy of prepayment is that you spread that risk as broadly as possible, which we would continue to do under this new type of class rating.

Senator McNAMARA. But obviously people over 65 are a higher risk than if you take it all the way across the board, so, therefore, we come out the same as stated in our case.

Mr. McNERNEY. They are a higher risk by approximately a factor of 2, and therefore must, in some manner, be folded within a group.

Senator McNAMARA. You say a factor of 2, and I say it costs about twice as much, so we are saying the same thing; are we not?

Mr. McNERNEY. Very good.

Senator McNAMARA. Thank you. Have you any further questions?

Senator Moss. Just one more. When older people who have regu-

lar group Blue Cross coverage pass the 65-year mark, does Blue Cross insist that they convert to nongroup or one of the senior citizen contracts?

Mr. McNERNEY. We have prevailed for years on labor and management to keep these people within the group, but the essential decision lies there, whether the employer, through whatever program he is going to establish, retirement or otherwise, will let them be a part of the group.

Now it is important to note that if the employer does not make provisions for them to continue as a member of the group in some manner then we give them the prerogative of what we call group conversion. They can convert to a direct pay, but they are never canceled under these circumstances.

Senator Moss. They are not canceled but they might have to take a different premium rate because they go to another——

Mr. McNERNEY. If they go from a group to a nongroup category and pay directly. They would lose the contribution of the employer under those circumstances. I will have to use the word "average," in an average instance we would subsidize that rate.

Senator Moss. Thank you. That is all, Mr. Chairman.

Senator McNAMARA. Thank you very much, Mr. McNerney. We appreciate your help and you can be sure your testimony will be given every consideration.

Mr. McNERNEY. Thank you very much, Senator.

Senator McNAMARA. The next witness is Prof. Frank Van Dyke, New York, School of Public Health and Administrative Medicine, Columbia University. Apparently Dr. Van Dyke is not here. The final witness is Paul E. Hanchett, educational director, Chicago Memorial Association.

Doctor, we are very glad to have you here and want you to proceed in your own manner.

STATEMENT OF DR. PAUL E. HANCHETT, EDUCATIONAL DIRECTOR, THE CHICAGO MEMORIAL ASSOCIATION

Dr. HANCHETT. Thank you Senator McNamara, and members of the committee. I want to say first of all that I am speaking as an individual. The organization I represent is a cooperative and we are not of uniform opinion, although I think many members would agree with me.

I am a professional economist——

Senator McNAMARA. Let me ask you at this point: Does your group write any insurance?

Dr. HANCHETT. No; we do not, sir. We are concerned about the cost of death for the aged and we try to help older people or anyone who dies to get a dignified, economical, and simple funeral.

Senator McNAMARA. I see; yours is a burial cooperative?

Dr. HANCHETT. Yes, sir.

Senator McNAMARA. Thank you; go right ahead.

Dr. HANCHETT. I am a professional economist who has been specializing in medical economics. I have taught in colleges and universities for about 15 years, and it is going to be a little bit hard for me to hold myself down to 5 minutes.

Senator McNAMARA. You go right ahead; you are not going to be too pressed for time. We recognize you came a long way and want you to get your testimony in the record. Go right ahead.

Dr. HANCHETT. Thank you very much, sir.

During the last 30 years there have been three very hopeful events related to the prepayment of the costs of medical care. First was the "Birth of the Blues" in the 1930's which brought the idea of service benefits. Then in the early fifties there came major medical which was an attempt to provide more comprehensive coverage.

Finally after 1957, the open-enrollment guaranteed-issue, senior citizens plans tried to break down the barriers for people who had preexisting conditions or who were obviously high risks.

Each of these three creative attempts was ardently pursued either by the nonprofit corporations or the insurance industry. Each, unfortunately, proved to be disappointing in results.

At the present time, our position is that we have a plethora of enrollment and a very moderate level of coverage.

Our good risks and our relatively high income people are enrolled. Our poorer risks and our lower income people either are not enrolled at all or are enrolled in inferior, high cost plans.

Furthermore, the strategy of today's insurance market, of which I have obtained some forebodings from the preceding testimony, indicates that attempts at enrollment from this point on will probably be obtained at an actual decrease in effective total coverage.

It is my suggestion that the predicament, the impasse that this situation implies, is not a matter of accident or lack of diligence on the part of the insurance industry. Rather, it is inherent in the medical care market itself.

Medical costs in this country simply are not budgetable for the typical individual, and they may not even be insurable.

The problems inherent in this situation have produced a "vicious circle" in which the sort of policies that the insurance companies try to write are actually automatically self-depreciating. Moreover, the structure of the insurance market is such that a kind of Gresham's law operates so that poor insurance policies tend to drive out good.

The irony of it all is that the very impossibility of writing an effective, comprehensive coverage today makes it that much easier to sell a multiplicity of inadequate policies. First let me explain why medical costs are unbudgetable.

Both budgeting and insurance involve the attempt to substitute average costs for actual costs. However, there are two reasons why the individual cannot budget for his own medical expense and why the insurance industry today cannot provide an effective, firm, adequate insurance policy in the health field.

In connection with medical costs, it is not so much the total amount of the expense as the dispersion, what the statistician would call skewness. For example, in 1961, the average old person paid approximately $226 for medical care. Now, that would be budgetable, if every individual had approximately that amount of expense or close to it. But this is not the case.

The great majority of senior citizens did not have that much expense, and in a particular year many of them will have as much as $3,000, or $4,000 bunched up at one time. It is not practical for a

senior citizen (or anyone for that matter) to set aside the average amount of cost that the whole group experiences in budgeting for his own expense. There is too great a risk, too big a chance of being hit by one of the high expenditures that would undermine his whole budget and his whole future position.

There is a second reason besides the skewness or dispersion that makes medical expenses unbudgetable: This is the fact that any average that we can obtain is always yesterday's average.

As you know, the medical expense field has become the most dynamic, and explosive in the whole economy. Since 1957 medical costs have risen three times as rapidly as the cost of living, and certain components such as hospital costs have risen about six times as fast. There is no reasons to think that this higher rate of escalation is going to stop next week. As a result medical costs are the one large expense of the individual that he cannot budget for because he is in danger of being hit by a very large amount in one particular but unforeseeable year and because any average that might be calculated would actually be obsolete.

Now the same considerations make for strains in the insurance industry such that the insurance companies and Blue Cross find it very difficult, if not impossible, to average. It is necessary, first of all, to obtain a reasonably firm average in advance, and second, it is necessary to obtain a nonselected group. I have already commented about the fact that averages of medical costs insofar as they are firm, are always out of date. So let me just mention the second point. It is next to impossible in the insurance industry to obtain a nonselected group to which any true average would validly apply.

In the early days of health insurance the companies went out looking for the better risks. In other words, company-selection prevailed. More recently as insurance became more popular and as the industry became more competitive, the buyers of insurance selected the companies so that self-selection prevailed. Either way there is a biased population.

Furthermore, even if you could in origin obtain a random, nonselected group, it tends to deteriorate over time because there is no guarantee that the members of the group will continue. In fact what happens, the purchase of a policy educates the buyer to a closer attention to the economics of speculation and risk. No one is closer in touch with the facts that control his own health prospects than he. Buyers will discontinue policies for assorted reasons, logical and illogical, but no one lets his policy lapse because he has contracted chronic illness or thinks that he has become illness prone. The insurance company is left holding on to an actuarially deteriorating group.

The net result is that a randomly selected group fails to be attained because either the company or the insured makes the selection originally, in the renewal of the policy, or both.

To summarize these points, the fundamental reason why health care costs are not an insurable risk today is because they are adversely subject to open end averages and open end groups.

In the attempt to meet this dilemma, the insurance companies have had to devise a very special contract—what I call the self-debasing insurance policy. They have to put fixed dollar amounts in it, like $20 a day for hospital room and board and $6 for medical visits. This is

not because the insurance companies are inhumane. It is because of the necessities of the situation. But these fixed dollar benefits—even in the absence of general inflation depreciate in real benefit value so long as medical costs continue to rise. I give a specific example in my paper—not a hypothetical—specific example of an actual policy.

This was a very progressive policy in 1939, a renewable hospital-surgical policy that was calculated to go on into retirement years. The insured who bought this policy in 1939 at the age of 61 is still living today. He still has the policy. At the time that policy was purchased it would cover 50 percent of his hospital costs on a short-term visit.

Five years later that 50 percent had depreciated to 33. Another 5 years later, to 19. Five years later, to 13 percent. Five years later, to 9 percent, and finally, just a little over a year ago when he went to the hospital, that policy actually covered only 7½ percent of his hospital cost.

That is what I mean by "the self-depreciating insurance policy."

However, there is even a more fundamental reason why any attained level of coverage under private insurance tends to deteriorate.

Selling health insurance has become something like a war or a football game—you cannot stand still; you have to go ahead; you have to sell more and more. A kind of parasitic competition has developed.

After any given level of selling the best risks and the people who most want insurance will be enrolled on the books of some insurance company. The poorer risks and those interested in insurance will not.

Any company or any salesman wanting to expand his volume, as is necessary in order even to stand still in today's market, realizes that his best sales opportunity is to go after a group that is already enrolled. In order to do so, he has to offer something that looks attractive.

In practice, he has to offer what looks like a lower price, because the market is very cost conscious and because price is objective. However, to make it seem even better, what he actually does is to offer a lower price and a better package of benefits at the same time.

Of course, this is ordinarily impossible, but the policyholder is neither a CPA, nor an insurance actuary. Hence he is not able to evaluate the quality of the package, although he can add up the dollar cost. The end result is that a kind of Gresham's law operates so that poor policies drive out good, and poorer companies sell larger volumes than better companies.

This is a series of interlocking vicious circles within vicious circles. The ultimate tragedy is that even the best companies finally contaminate themselves with the practices of their inferior competitors.

I want to call your attention to table II in my paper that lists the 10 largest insurance companies in this country. Every one of those companies—Prudential, Metropolitan, John Hancock (firstline, well-established legal reserve companies)—every one of them sells health insurance.

Not a single one of them has a comprehensive contract or a major medical policy for senior citizens. In February of this year I checked the insurance reporting forms for each of these 10 companies. Several of them have major medical policies, but they terminate at age 59. I found one company—I believe it was Aetna—that had a major

medical policy renewable to age 64. Of the 10 most substantial insurance companies in the country, not a single one is offering a major medical policy that goes beyond the age of 65.

Now, what I have to say can be brought to a very quick conclusion. If the insurance industry could offer an adequate policy, 56,000,001 policies would be more than enough, because we have only 56 million household units in this country. However, under the present circumstances the insurance industry knows that it cannot offer an adequate policy and the buyer knows that he cannot buy one.

The result is that both on the side of supply and on the side of demand, a proliferation of partial, inadequate enrollments is encouraged.

We have arrived at the situation where no conceivable number of policies could be sold that would give a comprehensive, adequate coverage, because the gaps, the holes, that exist in the policies of one company are equally matched by gaps and holes in the policies of others.

This problem is one that is too big for the insurance industry and it is too big for the nonprofit corporations.

The only possibility is that government might do something about it. I wish to list four advantages which the Federal Government would have over the insurance industry in dealing with this problem for the aged.

First, the Federal Government can obtain a group without adverse initial selection. Second, it can maintain the continuity of a group, once enrolled. Third, it can avoid the parasitic, competitive destruction in the quality of insurance that is inherent in the private insurance industry. Fourth, it has the financial power to supplement the contributions of needy groups to make this insurance policy possible.

I do not wish to indicate that the insurance industry has been deficient in energy, determination or goodwill. But these are not the problem. It is my hope that if the Federal Government provides a suitable program for the aged, that the insurance industry will then be able to put its good intentions to work to provide adequate policies for those who are not above 65. Thank you.

Senator McNAMARA. Thank you very much, sir. You have made some points that I am sure are very interesting to the committee. We will give them very careful attention.

PREPARED STATEMENT BY DR. PAUL E. HANCHETT, EDUCATIONAL DIRECTOR, THE CHICAGO MEMORIAL ASSOCIATION

SUMMARY

Medical care has become an unbudgetable commodity—especially for the aged. Being unbudgetable, it is not strictly insurable.

This predicament actually stimulates the sale of private insurance polices.

Fixed-dollar insurance contracts, under the explosive conditions of the market for medical care, are automatically self-debasing. Any attained level of benefits melts away. The process of erosion has now become independent of general inflation.

Erosion is more disastrous for the old than the young: Medical payments accumulate toward the end of life after insurance contracts have had a longer time to depreciate.

In the strategy of the insurance market, poor insurance drives out good. So any attained level of coverage becomes further diluted.

Poorer insurance companies outsell better insurance companies. To survive, the better companies must contaminate themselves with the practices of thir competitors.

Coverage is something quite different from enrollment. The enrollment statistics produced by the insurance industry to prove that private health insurance coverage is steadily rising are self-discrediting.

After 20 years of sales effort, the average benefit gap remains at one-sixth nonenrollment and five-sixths noncoverage of the insured. The coverage afforded the elderly, of course, is far less than these averages.

Adequate health insurance will never be provided "cafeteria style." Only the Federal Government can contain the open-end cost averages and the open-end insurance groupings which continue to bar effective benefit coverage for nearly all persons in the United States.

The insurance industry has not yet faced up to the fact that under prevailing conditions additional enrollment may actually mean diminished total protection.

Why the Private Sector Cannot Provide Adequate Health Insurance for the Aged

In the United States medical care has now become an unbudgetable commodity. Under conditions prevailing in the American economy for nearly two decades, each of the four basic cost determinants (population, price, utilization, and product mix) has escalated upward to produce an explosive and unbounded situation. Since at least 1957, firm planning to meet medical costs in advance—whether by individuals, families, nonprofit corporations, or insurance companies—has been generally impossible. And if medical care has become unbudgetable it has also become, in the usual understanding, uninsurable.

This predicament has not, however, hindered the sale of private insurance policies. Rather it has stimulated their sale. For while the market for an adequate policy would be distinctly limited by demand, there is no practical limit to the number of partial, inadequate, and unsatisfactory policies that might ultimately be sold.

This paper explores certain peculiar aspects of that field which is now called health insurance. It applies to medical indemnification plans for persons of all ages. But especially to the aged—who are at once our highest risk, highest cost, and least covered group.

THE SELF-DEBASING INSURANCE POLICY

About 1940, when private insurance companies decided to embark seriously upon the health-care field, a number of ingenious safeguards and innovations had to be created. Obviously health per se could not be guaranteed to anyone—certainly not to the general public, millions of whom were already chronically afflicted and ill. Furthermore, there was no practical way to control the prices of medical vendors or the amounts and kinds of services that doctors might prescribe. The compromise arrived at was to tailor partial packages of specified medical service, placing a maximum fixed-dollar "cap" on each. To deter excessive use, the "caps" were set substantially below prevailing prices.

Thus was born the "cafeteria approximation" to health insurance; and thus the service approach to health care (exemplified by the original Blue Cross), was replaced by indemnification.

The protection value of fixed-dollar benefits depends on the dynamics of medical care prices. If they rise relative to other prices, the insured will lose and the insurance company will gain; if they fall, the reverse is true; if both sets of prices keep in step, the initial positions of policyholders and insurance company under the contract will be maintained.

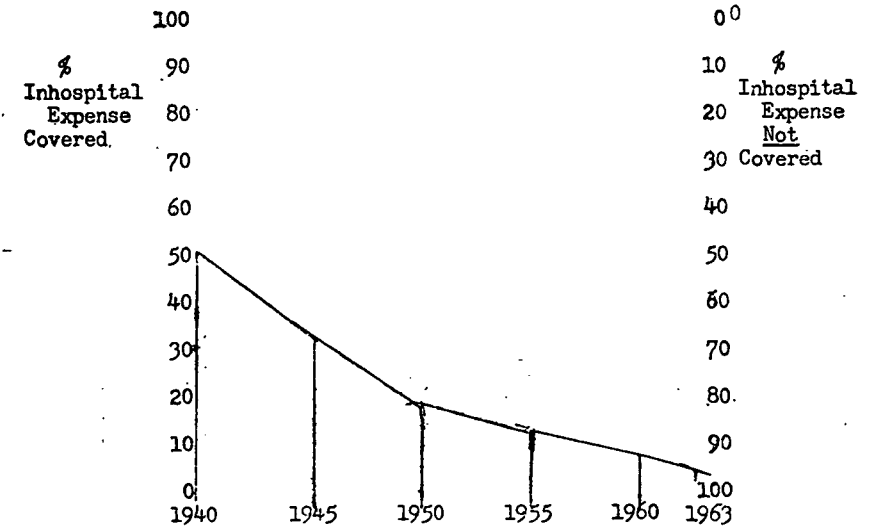
As it happened, medical prices soared. Apparently the rise was inherent in the structure of this particular market and not dependent upon general inflationary pressures. To consequence was that the fixed-dollar contract which has now become standard in health insurance is automatically self-debasing (fig. 7). The longer the policy is held, the further its real value shrinks.

This phenemenon of perpetual depreciation is of special consequence for the old. Since medical expenses are concentrated in the later years and since the old will have had a longer time to hold on to their policies than the young, a higher proportion of senior citizens benefits will derive from more fully discounted policies. This process, it should be noted, does not assume either the existence or continuance of general inflation.

TABLE I.—*Percentage of inhospital expenditures reimbursable for selected years under North American Life and Casualty contract (Policy No. 92125; issued Oct. 1, 1939, and still in force)*

	1940	1945	1950	1955	1960	1963
Percent of hospital expense covered	50	33	19	13	9	7.7
Percent of hospital expense not covered	50	67	81	87	91	92.3
Fixed-dollar daily benefit	$3	$3	$3	$3	$3	$3
Average daily hospital cost	$6	$9	$16	$23	$32	$39
Annual premium cost	$12	$12	$12	$12	$12	$12

Figure I: The Automatic Erosion of Fixed-Dollar Hospital Benefit Contracts, 1940-63 (Data taken from Table I).



Consider a specific case. As early as 1939 North American Life & Casualty Co. was progressive enough to offer a combined hospital-surgical policy with a $150 maximum surgical schedule, that could be purchased during working years and continued on indefinitely into retirement. At time of issue, the fixed-dollar benefits sufficed to cover about 50 percent of a short-term inhospital charges.

As time went on and hospital charges rose, however, this percentage of protection steadily declined (table I). Finally during retirement in January 1963, when an insured really needed protection under this contract, he went to the hospital and ran up a medical bill of $822.20 of which the policy then covered only $62.20 or about 7.5 percent.

What had been purchased as an advanced and effective policy steadily depreciated into trivial protection—at the very time when it was needed most.

This example could be repeated ad infinitum for surgical schedules, drug allowances, or any other partial benefit that such policies provide. The medical content and the initial level of coverage might be different, but the fact of steady shrinkage of effective benefit protection would not.

GRESHAM'S LAW APPLIED TO HEALTH INSURANCE

A second dynamic factor also tends to produce systematic erosion in the field of health insurance.

At all levels in a competitive, pluralistic economy there exists constant pressure for additional "business." After an initial round of policywriting has settled down, the safest risks and those most interested in owning insurance will

be already enrolled on the books of some nonprofit corporation or insurance company; the poorer risks and those least interested in insurance will be dispersed as scattered individuals. Any insurance salesman can plainly see that his best underwriting target will be among the large groups already "sold."

What will his sales strategy be?

He could stress lower price. He might stress higher quality. Or some combination of the two. In practice the best strategy is to claim both simultaneously.

Since this will virtually always be impossible to deliver, it takes considerable care to district the prospective purchaser from making any shrewd evaluation of his claims. The final equilibrium position of nearly all such maneuvers is an objectively demonstrable lower price financed out of concealed dilution in quality.

Thus poor insurance drives out good. What is worse, inferior companies gain business away from better companies. Even more tragic is the fact that the better companies are ultimately forced to imitate the tactics of their inferior competitiors in order to survive.

Nowhere is this rush by second-rate insurance companies to proliferate inferior policies more apparent than in the area of health insurance for the aged. Not a single one of the Nation's 10 largest insurance companies offers any guaranteed-renewable major medical or comprehensive policy to persons beyond the age of 65 (table II). Thus the aged are forced to seek out second-string companies like Continental Casualty Co. or even Mutual of Omaha.[1]

TABLE II.—*Senior citizen lifetime guaranteed-renewable major medical plans; 10 largest life insurance companies in the United States*

Company	Deductible	Coinsurance	Maximum benefit	Additional requirements	Annual premium
1. Metropolitan	No such plans for senior citizens available				
2. Prudential					
3. Equitable (New York)					
4. Travelers					
5. John Hancock					
6. Aetna Life					
7. New York Life					
8. Connecticut General					
9. Occidental					
10. Lincoln National					

THE LOSING STATISTICAL BATTLE BETWEEN QUALITY AND ENROLLMENT

Although the insurance industry has remained in doubt about the longrun feasibility of private health insurance, this has not prevented it from presenting the public with an optimistic picture of steady progress toward comprehensive coverage. Such semantic trick is accomplished by neglecting to define the goal of comprehensive coverage and by focusing attention upon enrollment rather than quality.

The enrollment figures presented by the insurance industry are certainly much overinflated. But evident inconsistencies and inadequacies within them make it clear that these figures are not worth deflating. When is it known as an upper limit that not more than 28 percent of private health expenditures are covered by prepayment, no self-respecting statistician could prepare data to prove that in 18 States "over 75 percent of the civilian population is covered by health insurance" and in the District of Columbia "166.4 percent of the civilian population is covered."[2] The incontestable giveaway of the statistical fraud is not the 166 percent (which any grammar school student would immediately recognize as spurious) but the 0.4 percent—a fraction which no responsible statistician would publish when dealing with empirical aggregates of such latitude.

After a thorough investigation of these matters, Prof. Seymour E. Harris has concluded recently that the benefit gap can be resolved into "one-sixth nonenrollment and five-sixth noncoverage of the insured." The latter part of this statement is especially revealing.

[1] I evaluate these companies as second rate on the basis of their percentage of premium income that is not paid out in benefits and by their reputation in the industry for the processing of claims.

[2] "Source Book of Health Insurance Data," 1963, p. 25.

If nearly 900 insurance companies "working both sides of the street" and selling mainly the better risks have been unable to provide anything more than "five-sixths noncoverage" after 20 years, what hope is there that they will ever be able to provide anything approaching satisfactory coverage for our more disadvantaged groups?

Harris' conclusions also confirm my earlier contention that the escalation of medical prices and the selling tactics of the insurance market both tend to dilute the quality of any attained level of coverage. It is evident, for example, that back in 1945 Blue Cross provided far more than "five-sixths noncoverage of the insured" for hospital care—although it probably no longer does so in all Blue Cross jurisdictions and for those insureds beyond the age of 65.

CONCLUSION

Sickness benefits in the United States began "as a frill on the accident form." They ripened and matured into a proliferation of fringes on employees' welfare contracts.

Thirty years of experience under Blue Cross-Blue Shield and 20 years of internecine warfare between and among the 879 private insurance companies and the "Blues" have made it demonstrably clear, however, that adequate prepayment planning for medical care, either for young or for old, can never be made available "cafeteria style."

What is required instead is some agency, larger than any nonprofit corporation or combination of insurance companies, which can act in the public interest and set guidelines so that the open-end cost averages and the open-end insurance groups which have produced the uncontrolled, escalating costs of medical care, can be contained. The only agency available to do this is the Federal Government.

It is therefore to be hoped that Congress will act with economy and with dispatch to author a hospital and health care bill that will truly conserve the 18 million senior citizens who already make up about 10 percent of our most precious natural resource. As a welcome side effect, we may also hope that this step will enable the private insurance industry to achieve a higher quality and more adequate health insurance protection for the remainder of our population.

Senator MCNAMARA. Thank you for your comments. Is Mr. Thomas J. O'Leary here?

Mr. O'LEARY. Yes; sir.

Senator MCNAMARA. We have run over the time we anticipated closing our hearings, but if you want to leave a copy of your testimony with the reporter we will see that it is included in the appropriate place in the record.

Mr. O'LEARY. There are also documents that I would like——

Senator MCNAMARA. Fine, we will include those in the record if the documents [1] the lengthy we will just refer to them in the record and they will be kept in the files of the subcommittee for further analysis.

PREPARED STATEMENT BY THOMAS J. O'LEARY, REPRESENTING THE BOARD OF FREEHOLDERS, HUDSON COUNTY, N.J.

Mr. Chairman and members of the subcommittee, my name is Thomas J. O'Leary. I represent the supervisor and Board of Freeholders of Hudson County, N.J. I am also the welfare officer and president of local No. 8-623 of the Oil Chemical & Atomic Workers International, and a former member of the Board of Managers of the Jersey City Medical Center.

Mr. Chairman, I've sat here now for 2 days and listened to health insurance tell you and this committee that they are offering real protection to older Americans. I find their arguments impossible for me to accept, and I base my rejection of their claims upon the experience I have had in this field within the last 12 years.

As a result of that experience, I have come here today to say that Americans—especially older Americans—are paying a heavy price for discriminatory policies that force many patients to pay a needless premium for hospital care. In a few moments, I'd like to explain to you how at least $4 billion can be cut out of the overall medical cost in this country.

[1] The documents referred to are on file with the Subcommittee on Health of the Special Committee on Aging.

But before I do that, I would like to explain, step-by-step what I mean when I say that many Americans suffer because of discriminatory Blue Cross cost policies.

Let's take two hypothetical patients, A and B:

A made $20,000 a year until his retirement last year. He bought a Blue Cross policy 5 years ago, and he is presently paying $57.24 a year for it.

A month ago he went to the hospital. Blue Cross paid $1,504 of his $6,591 bill. In other words, Blue Cross paid less than 23 percent of the stated bill.

To other than a Blue Cross subscriber, this payment would have been 77 percent higher. But because hospitals give a writeoff of 77 percent to Blue Cross patients, A is required to pay nothing because of the terms of his contract.

Please bear that reduction in mind. It is the basis of everything I will now say.

B was not as lucky as A. He made an average of only $4,000 during his lifetime. He's now 68 and his income is down to $2,500. He has not had enough income to buy good Blue Cross health insurance coverage or any other sort of coverage.

Last month he had exactly the same ailment as A did and got exactly the same hospital bill as A. However, the cost to him is much different. It was for the full amount, $6,591.

Blue Cross and the hospital will claim that this "saving" to the Blue Cross policyholder is based largely on administrative savings made possible by mass coverage.

But let's look at the practical effects of this discriminatory policy.

Where hospitals have been supported by local taxes or assisted by Hill-Burton funds, I would assume their primary purpose would be to assist the medically indigent, into which category would fall a great number of our older citizens. Because of this insurance arrangement they are being discriminated against. Their bills are higher because of the advantage given to Blue Cross patients. I would like to have permission, Mr. Chairman, to submit the following documents to support the position reflected.

In regard to the $4 billion cut, this could be accomplished by seeing that medical services are provided for all of the people at a level of their justifiable needs, with the hope that charges could be based on identical services received rather than on the type of insurance one might carry.

The $4 billion has been developed by fringe benefit costs, present-day hospital costs, productive time loss from work as a result of sickness and injury, as well as wages; the overcharge for inferior insurance benefits, as well as costs that have to be consumed by the general public for the overall abuses.

Hospitals presently are entering into banking arrangements where loans to meet bills and other medical charges are being made—at a regular 6-percent interest rate—to individuals who are not even able to pay their insurance premiums.

I believe wholeheartedly in continuing the principle of Lincoln: that it becomes the Government's responsibility to provide for the needs of the people when other sources have failed.

The country owes a great debt of thanks to such distinguished Senators, as you, who are willing to provide the time and research necessary to establish the truth on behalf of those citizens whose voice otherwise might not be heard.

Senator McNAMARA. We have the statement of the gentleman who was not here, Professor Van Dyke and we will include that at this point in the record.

PREPARED STATEMENT OF PROF. FRANK VAN DYKE

Senator McNamara and members of the subcommittee, my name is Frank van Dyke. I am associate professor of administrative medicine of the Columbia University School of Public Health and Administrative Medicine. The opinions I express are my own.

I appreciate very much your invitation to appear and speak today. You may recall that I testified before the Special Committee on the Aging several years ago in support of Federal legislation which would employ the mechanism of the social security system to pay for certain hospital benefits to OASDI recipients. What I have to say today simply brings up-to-date what I had to say at that time. The burden of my remarks then was that Federal hospital insurance for those 65 and over was needed first of all because many old people

do not have enough money to pay hospital bills, and second, because the insurance companies and Blue Cross plans were unable to provide insurance at a cost older citizens could afford. Insurance company nongroup premiums are excessive for the amount of protection they afford, and Blue Cross nongroup premiums are much higher than they need be if the level premium concept of insurance were employed. The need for this legislation has increased as hospital costs continue to mount. The device for charging higher rates for those who use hospitals more than the general average is experience rating. Experience rating is increasingly being employed by Blue Cross in place of the broad-based community rating which many subscribers have had. As a case in point let me cite the New York City Blue Cross plan, with more than 7 million subscribers.

This plan is in several respects one of the best of any of the Blue Cross plans. It is efficiently managed, has a low overhead cost, and despite many serious gaps in benefits provides a reasonable level of short-term hospital care to many of its subscribers in the 17-county metropolitan area. The 21-day contract, however (plus 180 "half days"), does not meet the needs of many elderly people. Faced with an increase in hospital costs the management of Blue Cross has requested the New York State superintendent of insurance to approve a plan of compulsory experience rating. At the present time New York City Blue Cross has three basic premium rate methods. One is for nongroup subscribers; a second is for community-rated group subscribers; and a third set of rates is for business or labor organizations which prefer to be experience rated. Each of the experience-rated groups has a premium based upon how much hospital care members of the group received. So far as these groups which are voluntarily experience rated are concerned, the Columbia University prepayment studies for the State of New York (pertinent excerpts from the study are appended) recommended that Blue Cross return to the practice of selling only community-rated coverage to new groups. New York City Blue Cross now proposes to replace this rate structure with the rather complicated rate plan described in appendix I of this testimony. Without going into any detail here, it can be said that the effect of the new rating plan will be to charge groups which tend to have high hospital use, higher rates than those which use hospitals less. Which groups use hospital care more than average? Your committee has volumes of testimony on this point. Groups which have a high proportion of the elderly use hospital care more than most other groups.

According to New York State Insurance Department figures, a given health insurance contract pure premium cost of $15.90 per year for a 25-year-old man would cost a 55-year-old man $45 and a 65-year-old man $72.90. A community-rated plan averages out these costs I have cited, so that one premium is charged for each of these three men, if all of them have Blue Cross group coverage. A young man would pay higher than age-specific rates and an elderly man would pay less. This is community rating. It has required social foresight for Blue Cross to, in effect, say to the young "pay more when you are young, so that you will not be priced out of the health insurance market when you are old." The New York City Blue Cross plan and the other plans which have adopted or are moving in the direction of experience rating are depriving elderly people of an opportunity to pay their own way at premiums they can afford.

Experience rating, deductibles, or coinsurance do not reduce the cost of hospital care. The cost of hospital care may be too high or it may be too low, but insurance devices, gimmicks or advertising, will not reduce the cost of providing a given hospital service at a given standard. This, unfortunately, is not as well understood as it should be. It is possible, of course, to cut premium costs to particular groups through experience rating. This merely means the rate for other groups must be higher. The basic costs to the public remain.

It would be possible, theoretically at least, to employ hospital insurance experience rating as a device to secure better medical care. This could be done by rewarding with lower insurance rates, low utilizers of hospital care who also received medical care of a high quality. Thus the socially desirable goal of a higher quality of medical care would be promoted by insurance. At the present time this would seem impractical on any large scale.

Another unfortunate tendency of experience rating was demonstrated in the New York prepayment study by a review of fluctuations from year to year in experience by size of groups. In the New York City plan, groups with 500 persons or less showed marked changes in hospital experience from year to year compared to very large groups. The practical effect of this is that some groups have less rate stability under experience rating than they would have under

the community rate. The study also demonstrated that welfare fund groups, taken as a whole in New York City for the 5-year period under review, had relatively high experience compared to other general classifications. The reasons for this are unknown.

The reason usually given for the desire of some Blue Cross officials to experience-rate their contracts is competition from the insurance companies. The insurance companies single out the so-called good risks and leave the remainder to Blue Cross. This is undoubtedly so, but it is not the whole story. Many employers and unions do not want to pay the premiums necessary to provide the high level of service benefits available through Blue Cross. They want indemnity coverage because indemnity insurance, by paying only a portion of the hospital bill, can be sold at a lower premium. Blue Cross cannot pick up such accounts unless it abandons service benefits. I would like to discuss, however, the question of competition from a somewhat different point of view than a series of companies with a series of salesmen taking business away from each other in a saturated market. Competition, to be meaningful to the public, should offer a choice. It is painful to a Blue Cross board to lose a large account when it is clear that it could be retained through experience rating. But if Blue Cross abandons community rating, the public is deprived of the choice between a community-rated plan and experience-rated plans. Anyone who wants an experience-rated hospital plan can buy it from an insurance company. Blue Cross is the only plan offering community rating. Looking at it from the public viewpoint, what advantage is it to the public to establish a tax-exempt Blue Cross corporation for the purpose of competing with insurance companies on their own terms? Who gains from such an arrangement?

Experience-rated hospital insurance puts the old, the sick, the unemployed, and the disabled into compartments by themselves. Hospitals which are charitable institutions and the various levels of government are left to cope with the financial problems created by the inability of the community to work out a community hospital plan.

In conclusion, let me say this. The adoption of experience rating by more Blue Cross plans increases the need for Federal hospital insurance for the elderly. The social security hospital insurance plan which has been discussed for the last few years would charge the same premium to the entire working population. Everybody would pay the same rate for the same benefits. The "community pool" for this community plan would be virtually everyone in the country. Entirely aside from the beneficial effects it would have on social security recipients, it would relieve Blue Cross of a burden which it cannot cope with, and release for other socially useful purposes State and local tax funds now spent on hospital care of persons over age 65. It would enable each person to pay his own way through the social security insurance mechanism for needed hospital care in his older years.

APPENDIX I

Eight classes of subscribers to be established under proposed experience rating of New York City Blue Cross plan

	Subscriber contracts
1. Direct payment group conversion subscribers	550,187
2. Direct payment miscellaneous nongroup subscribers	202,205
3. Groups with 3 to 100 subscriber contracts	753,587
4. Groups with 101 to 250 subscriber contracts	168,607
5. Groups with 251 to 500 subscriber contracts	129,049
6. Groups with 501 to 1,000 subscriber contracts	121,075
7. Groups with 1,001 to 1,500 subscriber contracts	44,462
8. Groups with 1,501 or more subscriber contracts	415,521

Rates will be determined periodically by groups and classes for various types of contracts (21/180-day individual, family: 120-day individual, family).

Rates for classes 6 through 8 will be based on the use of benefits by the use of each type of contract within each group; in other words subscription charges will be related to the experience by contract for each group. Groups 1 through 4 will be part of a broader pool by type of contract within each class. For group 5, that is groups with 251 to 500 subscriber contracts, the rate will be based on a combination of group and class experience.

The rates for each of the eight classes would be related to four factors: (1) Benefits used, (2) community support, risk and development factor, (3) additions to statutory reserves, and (4) administrative expenses.

A community support, risk and development factor of 5 percent would be used to: (1) Level the impact on current operations of unforeseen contingencies, (2) minimize subscription charges for high-use groups, (3) stabilize rates for group conversion, and (4) provide support for communitywide activities designed to reduce the cost and improve the quality of care.

APPENDIX II

[Excerpts from "Prepayment for Hospital Care in New York State," Columbia University School of Public Health and Administrative Medicine, 1960]

EXPERIENCE RATING

The aim of the eight Blue Cross plans in the State should be that of their original purpose—the widest possible coverage of all persons in the community, regardless of employment status, health, or age, at a standard of protection that assures not only an essential level of benefits for all persons but also needed hospital service without economic barrier at the time of illness. The practice of a communitywide, uniform rate which is nondiscriminatory and does not give preferential treatment to good-risk groups, is essential to accomplishment of this aim. Experience rating is contrary to the concept expressed.

All eight New York State Blue Cross plans were asked to inform the study staff of their use of experience-rating methods. All of the plans experience-rate the group in the New York State employees' health plan and some of them have an occasional experience-rated contract with an employer or union, where a multiplan contract has been negotiated. None of the eight Blue Cross organizations in New York State, except the New York City Blue Cross plan, offer local employers and unions an experience-rated contract as an alternative to the community-rated contract. However, in the New York City plan 422,529 contracts, covering more than 1 million people, were experience rated in 1958. These contracts were negotiated for 219 groups.

The New York City plan supplied answers to a questionnaire dealing with the problem of experience rating. The complete reply to this questionnaire is found in appendix H tables, except for that part of the questionnaire which names the experience-rated groups and which gives the actual experience of each group for the 6-year perior 1953–58. (One copy of the experience reported by group has been furnished to the department of insurance.) Summaries of these data are used in the following discussion.

EXPERIENCE RATING AND ITS EFFECT ON THE COMMUNITY

For the purposes of this study, experience rating may be defined as the practice of setting a rate for an individual group based on the benefits paid in behalf of that group. Prospective experience rating adjusts future premiums on the basis of past experience and benefit utilization. Retrospective rating determines the rates for a given period from the actual experience of the group in that period.

The purposes of experience rating have been summed up as follows: To correct rate inequities, to stimulate hazard prevention, and to serve as an instrument of competition between carriers.[1]

Utilization of health services for early diagnosis and prompt and adequate treatment of disease or inquiry is one of the major goals of preventive medicine.[2] Experience rating, with its promise of lower premiums for reduced use of health benefits, can have the effect of discouraging needed use of health services, if the group members are made to feel that hospitalization is frowned upon except in the more serious cases. For some types of insurance, the hazard prevention function of experience rating may have a salutary effect. When experience rating, for example, encourages fireproofing of structures or encourages the introduction of safety devices through the incentive of lower insurance premiums, positive savings to the community may result. But the introduction of experience rating in health insurance shifts added social and economic costs to the community groups not experience-rated and to the community as a whole, which must, through taxation or otherwise, meet costs of care to those unable to pay for it at the time of illness.

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[1] Kulp, C. A., "Casualty Insurance." 3d ed., New York: Ronald Press Co., 1956, p. 489.
[2] Hilleboe, Herman E., M.D.; Larrimore, Granville W., M.D., editors, "Preventive Medicine: Principles of Prevention in the Occurrence and Progression of Disease," Philadelphia, W. B. Saunders Co., 1959, pp. 1–9.

A. Reynolds Crane, M.D., president of the Philadelphia County Medical Society, in commenting upon the recent introduction of experience rating by the Philadelphia Blue Cross plan, expressed an adverse opinion of the value of such experience rating.

"It places the penalty and the greatest burden on those who can least afford it since the sick person has frequently already suffered loss of income and earning power.

"It will discourage persons from submitting to early treatments of their ills because (*a*) they face an increase in their insurance rate; (*b*) by submitting to hospitalization they will incur the ill will of their fellow workers whose insurance rate will alo increase; and (*c*) it will unfavorably affect their desirability as employees.

"It will discourage the employer now favorably disposed to the employment of the handicapped because of the increased rates to which he (or his employees) may be subjected." [3]

Experience rating also tends to bar groups with lower income and higher utilization from access to voluntary health insurance. As one study has pointed out:

"* * * In fulfilling its social responsibility, a medical care plan needs to view the entire community as the group rather than specific subgroups selected for their ease of enrollment.

"Departures from this concept of social responsibility, the broadest possible pooling of risks on a communitywide basis, are seen in their most extreme form in experience rating. The differential pricing of premiums, whereby the cost of protection is lowered for select or favorable risk groups and raised for subscribers in unfavorable risk groups, is socially unsound. Lower premium rates can be offered to persons who have less need for medical care. But lower premium rates for good risk groups mean often prohibitively high premium rates for those groups requiring more medical care.

"A more fundamental point is involved. Experience rating or discriminatory pricing of premium means that favored groups in the community obtain a valuable social service at the price of disenfranchising other groups from that service at the same premium. The social meaning of prepayment for health care lies in the principle that no one segment of the community profits, by reason of a preferred premium, at the expense of any other segment." [4]

A similar view has been expressed by the authors of a study of Blue Cross nongroup enrollment in summarizing Blue Cross goals.

"To realize the community purpose of Blue Cross and to maximize potential coverage, the risks and costs of hospitalization should be pooled for all segments of the community's population. Equal benefits at equal rates should be made available to all segments, assuming that reasonably representative selection within segments can be obtained." [5]

Commercial insurance companies reject the concept of uniform premium rates as "proposals to transfer income from one group to another," and therefore "extraneous to the insurance operations on which they would be grafted."

"If an insurance organization attempted to overcharge one group of persons in order to provide benefits at less than cost for another group, a competing insurer could be expected to enter the picture and offer the first group of persons the same protection at a lower price. The original insurance organization could not then continue to offer protection to the second group of persons on a less-than-cost basis, but would be compelled to increase premiums to a self-supporting rate." [6]

This conception combines a prediction with a value judgment. It is possible that although the value judgment may be unsound, the prediction may unhappily be proven correct. This is one of the reasons why, if the community rate is to be maintained, there must be a continuous and intensive public education program on the reasons for its use.

Dr. James P. Dixon, then commissioner of public health, city of Philadelphia and now president of Antioch College, Ohio, speaking on behalf of the American Hospital Association at the congressional hearings on the Forand bill in 1958,

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[3] New York State Joint Legislative Committee on Health Insurance Plans, "Health Insurance Newsletter," vol. 2, No. 9, Sept. 1, 1959, pp. 2–3.

[4] Darsky, Benjamin J.; Sinai, Nathan; Axelrod, Solomon J., "Comprehensive Medical Service Under Voluntary Health Insurance," Cambridge, Mass., Harvard University Press, 1958, p. 234.

[5] Levine, Sol.; Anderson, Odin W.; Gordon, Gerald, "Non-Group Enrollment for Health Insurance," Cambridge, Mass., Harvard University Press, 1957, p. 5.

[6] Health Insurance Council, "Health Insurance Story," New York, pp. 28–29.

has illustrated some of the consequences of competition that weaken the community rate. According to Dr. Dixon:

"The Blue Cross plans, in accord with their philosophy of community service have permitted thei rmembers to continue coverage into retirement without increase in rates commensurate with their increased use of services.

"The excess cost of covering the aged, over and above the premiums charged them, has had to be distributed over the membership at large.

"The insurance industry has generally not followed this practice of unlimited duration of coverage and the resulting competitive pressures make it more difficult for Blue Cross to adhere to its concept of lifelong protection." [7]

A result of inadequate coverage for the aged has been pressure for passage of governmental programs to finance health care of the aged. It is obvious that if each category of risk is rated separately, some groups such as the aged and the unemployed, must pay substantially higher premiums than those paid by more favored groups.

"The great danger with these (uninsured) groups is if the State eventually has to provide payment for their hospital care on a full-cost basis at the time service is provided, the State is quite likely to suggest that if they must pay for the care of the poor risks throughout the country, they should also have any advantages that may accrue from insuring the good risks, thereby achieving a common underwriter for all. Herein lies the greatest potential danger from the experience-rating practices of the commercial and, to a degree, some of the voluntary carriers. The only outstanding result of a Government-sponsored plan is the achievement of a common underwriter for all the population and a complete return to the communitywide pricing principle, one of the original cornerstones of the Blue Cross movement. If retention of a voluntary prepayment system is to be achieved, some means must be developed to meet this need, and all the voluntary carriers must apply revolutionary thinking to certain underwriting practices now in effect." [8]

Organized labor is divided on the question of experience rating. While some welfare fund administrators have been among the main protagonists of experience rating, certain labor leaders have condemned the practice. For example, Walter Reuther of the United Automobile Workers, testifying before the House Ways and Means Committee in July 1959 in behalf of the Forand bill, stated that the "practice of experience rating has done more harm than any other single factor in keeping satisfactory health insurance out of their (the aged's) reach." [9]

Dr. Margaret Gordon, associate director, Institute of Industrial Relations, University of California, has brought out some of the defects of experience rating. Speaking before the Senate Subcommittee on Problems of the Aged and Aging (the McNamara subcommittee) she stated:

"We have been doing some studies of the operations of the health plans under collective bargaining at our institute and we have found that a growing problem of very great concern for many people is the impact of experience rating under the programs. A group which has a larger than usual proportion of older workers will be exposed to higher costs in providing a given level of health and welfare benefits, whereas a group which is predominantly made up of younger workers will benefit from lower costs.

"Now this has come in with the growth of insurance plans, but it is having its repercussions on independent group practice plans, because where there is any element of choice, the high-cost group will try to get its insurance through one of the independent group practice plans, and this is creating a situation in which these plans are getting a disproportionate share of the high-cost groups and are wondering whether they are able to maintain their uniform rates for all people." [10]

A representative of management also has noticed that choices which seem to have no community consequences often do have an impact on the community. As

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[7] "Social Security Legislation," hearings before the Committee on Ways and Means, House of Representatives, 85th Cong., 2d sess., June 1958, p. 859.

[8] Martin, Stanley W., president of the Canadian Hospital Association. Address at meeting of the American Hospital Association, August 1959, p. 2 of text.

[9] "Hospital, Nursing Home, and Surgical Benefits of OASI Beneficiaries," hearings on H.R. 4700 before the Committee on Ways and Means, House of Representatives, 86th Cong., 1st sess., July 1959, p. 401.

[10] "The Aged and the Aging in the United States," hearings before the Subcommittee on Problems of the Aged and Aging of the Committee on Labor and Public Welfare, U.S. Senate, 86th Cong., 1st sess., June 1959, pp. 222–223.

Malcolm Denise, general industrial relations manager for labor relations of the Ford Motor Co., said recently:

"In our capacity as a 'consumer' of medical services through contributions toward the cost of selected hospital-medical care benefits for our employees, we are not over in a separate compartment completely walled off from that labeled 'community citizenship.' On the contrary, in the consideration of such programs we have kept very much in mind their relationship to and impact on the community." [11]

Experience rating is a response by carriers to demands of groups, which believe they are favorable risk classifications, for a closer relationship between claims paid and premium charges to the account. But the reasons and rationale behind experience rating in one insurance context do not necessarily apply in other contexts. The trend toward experience rating may be stimulated by competition among carriers seeking leeway in their rating practices in the expectation of attracting new business. This often leads to experience rating of very small groups, a tendency which seems to make little sense because the smaller the group, the greater is the instability from year to year. Even where the hazard reduction incentive of experience rating is supposed to apply in such fields as workmen's compensation, the actual claims that occur are often due to factors beyond anyone's control. When experience rating is effective in reducing amounts paid in benefits, the question must be asked whether the result is beneficial to the community at large; should voluntary prepayment rating practices, for example, discourage the hiring of persons such as older people whose use of needed services affect the group costs adversely?

When an insurer adjusts rates for a specific group, this may lead to unequal treatment of groups because of such factors as the pressure of agents, or the bargaining power of large policyholders. That this may sometimes occur was demonstrated by the welfare and pension plan investigation conducted several years ago by Senator Douglas and his staff. According to this Senate Labor Subcommittee report, in one major insurance company the committee staff was able to uncover "little evidence that there was a uniform company policy on retentions and experience rating refunds." [12] At times experience rating refunds were found to be made only after the policyholders or agents applied pressure on the insurance company. As one official of an insurance company noted: "The squeaking wheel gets oil." [13]

Blue Cross plans have been given a favored legal status by the legislature (see ch. 4). The legislature, at the same time, imposed some restrictions on the freedom of action of the plans. The Blue Cross plans cannot change rates without approval of the State insurance department. Commercial insurance rates are adjusted upward without the publicity accompanying Blue Cross plan rate adjustments.[14]

Great expense and much effort are required to prepare for public hearings. Delays in the approval of rates are also a problem for Blue Cross plans. In some cases, a request for a rate increase follows almost immediately after the last rate-increase approval, because of the lapse of time between application and approval.

Nationally, some Blue Cross plans appear to have adopted experience rating as a means of avoiding specific approval of rate changes and periodic public hearings. Recently, for certain reasons which are now past history, one New York State plan came very close to adopting a policy of experience-rated contracts exclusively for the first time. Extensive experience rating would place Blue Cross in the same position on rate changes as now prevails for the insurance

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[11] Denise, Malcolm L., "Management Views Financing of Hospital and Medical Care," Journal of Michigan State Medical Society, vol. 58, No. 6, June 1959, p. 958.

[12] "Welfare and Pensions Plans Investigation," final report of the Committee on Labor and Public Welfare, 84th Cong., 2d sess., Report 1734, Subcommittee on Welfare and Pension Funds, p. 228.

[13] Ibid., p. 229.

[14] The following statement is from the 1958 annual report of Continental Assurance Cos., Chicago:

"The very satisfactory gain indicated above was achieved in spite of the fact that in one area of the company's operations it suffered a substantial loss. The group accident and health experience for the year was the worst in the company's history due in large part to the rising costs of medical care. These increased costs took place so rapidly that they outran temporarily the company's ability to establish premium rates adequate to support the benefits provided. Because of a consistent program of rate increases carried forward throughout the year, the company's position was much improved at the year end and appears to justify the expectation of future satisfactory operating results in this field."

companies. Such a destruction of the community purpose of Blue Cross would properly raise questions as to the public need for the plan and its favored status.

Insurance companies cannot be expected to use the community-rate principle. One of the ideas underlying the necessity for the establishment of Blue Cross was, in fact, the inability of the commercial insurance industry to act as a community service agency.

Senator McNAMARA. I want to thank everybody for their cooperation and this concludes this series of hearings. After the subcommittee and the staff has a chance to digest the great mass of material we have we will decide whether or not to carry on additional hearings.

Thank you very much.

(Whereupon, at 2:30 p.m., the hearing was concluded.)

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