for the contributors and beneficiaries of the program. The Council does, however, want to call attention to two respects in which improvement should be made.

Military service after 1956 is covered in the same way as is all other work in covered employment, and social security employee and employer contributions with respect to military service are paid into the trust fund by the Federal Government just as are the contributions of private employers and employees. For service prior to 1957 (and after September 16, 1940), however, noncontributory wage credits were provided, and, in addition, benefits were provided for the survivors of certain World War II veterans who died within 3 years after discharge. Social security contributions were not paid with respect to those special wage credits and benefits.

The social security system has been reimbursed from the general fund of the Treasury for the cost resulting from the special benefits paid through August 1950. The authorization for such reimbursement was repealed by the 1950 amendments. In 1956 the law authorized reimbursement of the system for the cost resulting from the payment of the special benefits from September 1950 on and for the cost resulting from the noncontributory wage credits for military service. Although the 1956 legislation authorized such reimbursement beginning in fiscal year 1960, no reimbursement has yet been made.

The Council views the reimbursement owed the trust funds by the United States Government for benefits arising from noncontributory military service credits in the same light as social security contributions payable by employers generally, and therefore urges that the Government as the employer of the servicemen discharge its obligations to the trust funds just as it requires employers generally to meet their obligations. The Council also believes that this reimbursement should begin without delay.

The Council notes also that, although the Board of Trustees is directed to review the general policies followed in managing the trust funds, there is no specific requirement in the law that it review the way in which administrative costs incurred outside of the Social Security Administration—for example, by the Internal Revenue Service in the collection of social security taxes and by the Treasury Disbursing Office in issuing benefit checks—are arrived at and charged to the funds, nor has any other agency of Government been assigned this responsibility. Many of these costs, unlike those of the Social Security Administration, are charged to the trust funds on the basis of estimates rather than of actual cost. The Council believes that there should be a review of such charges and that the Board of Trustees should do it.

The Council does not believe that the Board of Trustees should be required by law to meet every 6 months, as it now is. The Council has been informed that important financial policy issues suitable for consideration by the Trustees do not come up every 6 months. The Council recommends that the law be changed so that the Trustees would not be required to meet more than once every year.

PART II. HOSPITAL INSURANCE FOR OLDER PEOPLE AND THE DISABLED

In its examination of the adequacy of social security protection for the aged and the totally disabled the Council came to the conclusion that cash benefits alone are not enough. Monthly cash benefits, if adequate, can meet regularly recurring expenses such as those for food, clothing and shelter, but monthly cash benefits are not a practical way to meet the problem that the aged and disabled face in the high and unpredictable costs of health care, costs that may run into the thousands of dollars for some and amount to very little for others. Security in old age and during disability requires the combination of a cash benefit and insurance against a substantial part of the costs of expensive illness.

The Council's Position in Brief

Essentially the problem is this: Incomes decrease sharply upon old-age or disability retirement, but the incidence of costly illness increases. During their working years, when ill health is less frequent, employed workers can generally meet costs of current care for themselves and their families—directly or through insurance—out of their current employment income, often through an employee-benefit plan and with the help of their employers. The situation of the aged and disabled is quite different. Not only do they have the higher health costs associated with old age and disability but their incomes are greatly reduced because they are no longer working.

The solution, the Council believes,[12] is to apply the method of contributory social insurance, which underlies the present social security program, so that people can contribute from earnings during their working years and have protection against the costs of hospital and related services after age 65 and during disability without having to pay contributions at the time when income is generally curtailed. Contributory social insurance, the Council believes, offers the only practical way of making sure that almost everyone will have hospital protection in old age and during periods of long-term total disability.

It is not proposed, however, that social insurance cover all the costs of illness during old age and long-term total disability. The American approach to income security has traditionally involved a partnership of private effort and governmental measures. For example, old-age, survivors, and disability insurance is supplemented by employer and trade union plans, private insurance, and individual savings and investments. All contribute to the common goal of personal and economic independence. Backstopping this combination of measures for individual self-support are the Federal-State public assistance programs.

We believe this same pluralistic approach can be used effectively in meeting the costs of illness during old age and disability. With social security meeting just about all of the costs of hospitalization, which, on the average, represent at least half the costs associated with the more expensive illnesses, the person who is old or totally disabled will be in a much better position than he is today to meet, on his own and through private insurance, the costs of physician services, drugs, and the other elements of complete medical care. Also, with social security providing basic hospital protection, it should be practicable to improve the Federal-State public assistance programs to make them serve more effectively in meeting the health costs for older and disabled people whose needs are not met in other ways.

The Need for Protection Against the Cost of Hospitalization

Older people and disabled people have a special need for protection against the cost of hospitalization and related services—they need more care and they have less money to pay for it.

As one would expect, health care expenditures on the average are much greater for people past 65 than for younger people. Total health care expenditures for the aged, in fact, are twice as high, and in the case of expenditures for hospitalization, the ratio is about 2¾ to 1. Older persons go to the hospital more often and have to stay much longer than those under 65.

The cost of hospitalization affects practically all older people. Of every ten persons who reach age 65, nine will be hospitalized at least once during their remaining years and most will be hospitalized two or more times. In the case of aged couples, the chances are about even that the husband and wife will each be hospitalized two or more times.

Not only is hospitalization a virtually universal occurrence among older people but there is a high correlation between hospitalization and large total medical expenses. Older people who are hospitalized in a given year are the ones who have the big expenses. While medical care costs for all aged couples averaged about $442 in 1962, the medical expenses of aged couples with one or both members hospitalized averaged $1,220; for nonmarried elderly people, average medical expenses for the year were $270, whereas for those who were hospitalized, the average was $1,038.[13] Both the averages and the differentials would be even higher now.

Hospital expenses are a serious problem for the totally disabled too. Like the aged, they too are hospitalized frequently and in many cases their hospital stays are long. According to a survey of workers found disabled under the social security disability provisions [14] (conducted by the Social Security Administration in 1960), about one out of five disability beneficiaries under social security received care in short-stay hospitals in the survey year; and, excluding hospitalizations in long-term institutions, half of those hospitalized were in the hospital for 3 weeks or more.[15]

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[12] One member of the Council does not share in this belief; his reasons are given in Appendix A.

[13] Medical data obtained in the 1963 Survey of the Aged, a study conducted by the Social Security Administration, with the Bureau of the Census carrying out the field collection and the tabulation of the data.

[14] At the time the survey was conducted, the worker had to be aged 50 or over to be eligible for disability insurance benefits. Since the time of the survey, the age requirement for disability beneficiaries has been eliminated, but beneficiaries aged 50 and over still represent about three-fourths of all disability beneficiaries Thus, the data for this age group are representative of the major part of the disability beneficiary population.

[15] Almost 90 percent of the disability beneficiaries in the survey had been totally disabled at least 6 months before the beginning of the survey year and half had been disabled 3 years or more.

The problem now faced by older people and the disabled is going to become even more serious because health costs will undoubtedly continue to rise, probably at a rate considerably in excess of any increase in other prices. From 1953 to 1963 the percentage rise in the consumer price index for medical care items was nearly three times the increase in the over-all index; and the price index for medical care items increased more than that for any other major price-index component. Among the items that compose the medical care segment of the index, hospitalization costs have risen at a much faster rate than other components—hospital daily service charges rose twice as much as medical care costs generally.

Health care has become so expensive that virtually no one, including the relatively well-off person at the height of his earning power, can afford to pay the cost of major, prolonged illness unless he has effective insurance. And the great majority of the aged and disabled are neither well-off nor have adequate health insurance. Older people have, on the average, only one-half as much income as younger people living in family groups of the same size.[16] About half of the aged social security beneficiaries have practically nothing (less than $12.50 a month per person) in continuing retirement income other than their social security benefits; and for all but about one-fifth of the aged beneficiaries, benefits were the major source of continuing retirement income.[17] (Only 15 percent of the aged, for example, have any income from private pension plans and even for this 15 percent the amount from social security is generally larger than the private pension.)

Totally disabled people also have comparatively low incomes, although they more often depend in part upon the earnings of a spouse.[18] Many older people and people with long-term total disabilities must therefore turn to their children and other relatives and to public agencies for aid in meeting the costs of illnesses that require hospitalization.

In the 1960's we have seen a large and growing proportion of those applying for public aid forced to do so only because they cannot meet their health costs. Today over one-third of public assistance expenditures for the aged are for health costs, and such costs have become the most important single reason older people apply for public assistance.

The Role of Private Plans

The hospital insurance provisions we recommend would work in partnership with private plans and individual voluntary effort as social security now does in the field of cash benefits. With social security providing basic protection against the costs of hospital care and related services, and with improved cash benefits such as we recommend in Part III of this report, many people aged 65 and over or disabled who now cannot afford comprehensive private health insurance would be able to afford the less expensive supplementary protection against doctor bills and other health costs which, in combination with social security, would furnish comprehensive coverage. Employers also would find it more feasible to continue health protection for employees into retirement if, instead of having the whole job to do, they could build on the hospital insurance protection furnished under social security. These private measures would be built upon the hospital insurance base, just as the private life insurance and retirement pensions and annuities that many people have today are built upon the base of social security cash benefits.

On the other hand, it is unrealistic to expect private voluntary insurance alone to provide comprehensive protection for the great majority of elderly people and totally disabled people. To a large extent the problem of financing the cost of

[16] Bureau of the Census Current Population Survey income data for 1960 (the most recent available by age and size of family) show median annual income as $2,530 for aged two-person families and as $5,314 for younger two-person families; for individuals living alone the data for 1963 show median incomes of $1,277 for the aged and of $2,881 for the younger persons. The Social Security Administration's 1963 Survey of the Aged shows median income for all aged couples as $2,875 in 1962; no data are available for younger couples as of that date, but Census data for 1962 and 1963 for aged and younger families of all sizes indicate that the ratios between incomes of aged and young families of comparable size have not changed significantly.

[17] Retirement income as used here means all income other than earnings, assistance payments (public and private) and money income from a relative living in the same household. Data shown are derived from the Social Security Administration's 1963 Survey of the Aged.

[18] According to the Social Security Administration's 1960 survey of disabled workers, one-half of the married disability beneficiary units (family units composed of disabled workers and spouses and their children, if any) had income, not counting social security benefits, of less than $170 per month. The bulk of the income for most of these family units came from the earnings of a working spouse. One-half of the nonmarried disability beneficiaries had income, not counting social security benefits, of less than $7 per month (there being no spouse present to work).

expensive illness among people at the younger ages, who are largely dependent on current earnings, is being met by private insurance organizations, but private insurance cannot meet this problem for most of the aged at a price they can afford to pay. Despite years of creative effort and hard work by the voluntary insurance organizations, less than half of the totally disabled and only a little over half of the elderly have any kind of health insurance coverage and most of what they do have is quite limited. The absolute number of older people without any kind of protection at all is nearly as large as it was 5 years ago.

The basic difficulty in relying exclusively on private insurance, of course, has been that the costs of insurance are necessarily high because the aged and the disabled need so much in the way of health care that they cannot pay the costs of adequate insurance from low retirement incomes. Then too, unlike working people, who generally get group health insurance coverage through their place of employment, the disabled and the elderly can ordinarily obtain health insurance only on an individual or nongroup basis. The marketing and administrative costs associated with the individual handling that is characteristic of nongroup commercial health insurance make individual coverage about 1½ times as expensive, on the average, as group coverage offering the same benefits. Because of this consideration, together with the fact that hospital costs for the aged run about 2¾ times as much as those for younger people, the protection provided to an aged person by an individually purchased commercial hospital insurance policy costs about four times as much as comparable protection furnished younger people on a group basis. And relatively few disabled and retired workers have the benefit of contributions made toward health insurance by employers.

As a result of these facts, most voluntary health insurance within reach of the pocketbooks of the aged and the disabled is inadequate in the amounts and types of service covered and in the duration of benefits. In 1962 (the most recent year for which data are available) only 10 to 15 percent of the total medical costs of the aged, for example, was paid for by insurance. Moreover, as hospital costs rise, those who have health insurance policies paying fixed dollar amounts toward hospital care will find that the amounts cover an increasingly smaller proportion of their hospital bills; those who have policies which provide service benefits rather than fixed dollar amounts will be faced with increased premiums.

In the case of Blue Cross, which ordinarily provides service benefits without dollar limits, pressures are heavy to apply experience rating more and more to the high-risk older population in order to be able to offer the young group rates that are more competitive with those for commercial insurance policies. These pressures will continue to apply in the future and the result will be additional increases in Blue Cross premiums for the aged as they are required to pay rates closer to the true value of their protection.

It is also true that most of the aged who now have some form of health insurance are those who are still working, those in good health, and those in the higher income group. To a very large extent those who can be sold voluntary protection have already been sold.

For all these reasons, in the absence of social insurance taking on a part of the job, the Council believes that in all probability the great majority of older people and disabled people will, for the foreseeable future, continue to be without adequate protection against health care costs.

The Council believes that the extension of social insurance to the costs of hospitalization for the elderly and the disabled will make it possible for the private plans to perform a valuable complementary role. Since hospital insurance protection will be provided without further contributions during old age and disability, more of the retirement dollar will become available for buying current protection covering other parts of the medical bill, and, as indicated above, employers will find it more feasible to carry over health protection for their retired personnel.[19]

The Role of Public Assistance

There will be some disabled and elderly people who are without the means to add other protection to their basic hospital insurance or who have special needs such as

[19] In connection with the continuing role of private insurance in providing health insurance protection for the elderly, the Council would like to call attention to the recommendations of the National Committee on Health Care of the Aged. This was an ad hoc committee, with expert membership, which Senator Jacob K. Javits initiated and which served under the chairmanship of Arthur S. Flemming, former Secretary of Health, Education, and Welfare. In addition to proposing hospital insurance under social security, the National Committee recommended provisions designed to encourage the setting up of Federally authorized pools of insurers to offer supplementation to the social insurance plan. The Council has not taken any position on the subject of those recommended provisions because it is not within the scope of the Council's assignment. The Council believes, however, that the suggestion is worth the careful consideration of the Congress.

the need for long-continuing custodial care. Public assistance programs will, therefore, have an important continuing role in meeting the total problem. Consequently, the Council favors the improvement of the program for medical assistance for the aged (MAA) and the medical care provisions of old-age assistance and aid to the permanently and totally disabled to provide more effectively for remaining needs after the proposed social insurance program goes into effect. The enactment of hospital insurance provisions for the aged and disabled will save the States some two-fifths of their present medical expenditures for older people and place them in a financial position to improve their medical assistance programs. When the number of those who need help is reduced and when the remainder do not need help with most of the costs of hospital care, because of hospital insurance under social security and because of the spread of effective supplementary protection, the way will be open in many States for much needed improvements in medical assistance for the smaller numbers of people who still need help.

There is abundant evidence, however, that the Federal-State programs of public assistance, without a social insurance program to meet a large part of the cost, cannot do the job of filling the gaps left by private voluntary insurance. Many States either cannot—or, in the light of other financial priorities, will not—put up enough money to meet the need. Despite the fact that the Federal Government will pay, out of general revenues, from 50 percent to 80 percent of the cost of a State program to meet the health needs of the aged, only a few States have developed adequate programs for the very poor, and none has combined both comprehensive care and liberal enough tests of income and assets to meet the health needs of more than a small proportion of the retired aged in the State. Some have no medical-assistance-for-the-aged program at all.

Under a grant-in-aid system the wealthier States are the ones most likely to establish the better programs and most likely to get the major share of Federal funds. Furthermore, States vary in their willingness to apply their resources to a given purpose. As a result, an approach that depends on *State* initiative cannot reasonably be expected to lead to an adequate *nationwide* program. In October 1964, 68 percent of Federal MAA funds went to five of the wealthier States with only 31 percent of the country's aged.

For reasons explained in the introduction to this report, the Council does not, in any event, favor placing a main reliance on assistance in dealing with a problem which is faced by practically all the aged and the disabled. Even an adequate assistance program would have grave drawbacks for the recipient and for our society as a whole when compared with the method of social insurance. The Council believes that to the extent practicable the objective should be to prevent dependency rather than alleviate it after it has occurred.

Yet in some circumstances assistance will continue to be necessary. This is why the Council recommends that the Federal Government give continuing support to improvements in the medical provisions of assistance programs so that all the aged and all the disabled may have their full medical needs met through a combination of social security, private protection and savings, and, as a last resort, for the unusual need and circumstance, through an improved and generally available assistance plan.

Basic Elements of the Recommended Plan

The Council recommends that the core of protection be coverage of the costs of hospital care, subject to a small deductible. Coverage of three additional types of services, which can frequently take the place of inpatient hospital care, is also recommended: (1) extended care, following a hospital stay, in a hospital-operated or hospital-affiliated facility capable of providing high quality convalescent and rehabilitative services; (2) organized home nursing services which are medically supervised and are provided by organizations staffed and equipped to offer coordinated services sufficient so that an individual who is confined at home, but not in need of round-the-clock services, could receive substantially the full array of nursing services and therapeutic services (not including those of a physician) needed to care for him at home; and (3) subject to a small deductible, hospital outpatient diagnostic services covering the full use of the hospital's facilities and personnel but not covering the diagnostic services of the patient's personal physician.

A major principle that guided the Council in developing its recommendations is that health services should be tailored to the health needs of the patient. Provision for the four types of benefits—hospital care, extended care following the care

given in the hospital, organized home nursing care, and hospital outpatient diagnostic services—would enable the older or disabled person, together with those who participate in planning for his care, to have available the kinds of services, and a level of care, most appropriate to his individual need. Particularly for the aged, the next step in the care of a person who has been hospitalized for a serious illness may be a period of medically supervised treatment in an extended-care facility rather than continued occupancy of a high-cost bed normally used by acutely ill hospital patients. The benefit structure should cover a continuum of institutional and home nursing services and should provide an appropriate level of care for individuals who require convalescent care of somewhat lesser degree of intensity than that provided for hospital inpatients.

The coverage of important alternatives to hospitalization would help subordinate financial to medical considerations in decisions shared in by the doctor, patient and institution on whether inpatient hospital care or another form of care would be best for the patient. The recommended benefits would give financial support to the provision of institutional and noninstitutional services at the most appropriate level of intensity for patients who require care of extended duration. Covering each of the stages of required care is conducive to careful planning of the long-range treatment of those suffering serious illnesses.

In the course of formulating the proposed hospital insurance provisions for the aged and disabled, the Council was mindful of the increasing interest that the community as a whole has demonstrated in seeing to it that high quality health services are provided and that full value is received for the health dollar. Reflecting this community interest, many State and local hospital planning groups, private health cost prepayment organizations, and others have called attention to the effects of inadequate planning of facilities, excess capacity, inefficient operation, and unneeded services, any of which, whenever they occur, can result in an increase in health costs far beyond that attributable to medical and scientific achievements. The work of these groups shows that there is real promise for an improvement in the quality of care and at the same time improvement in the efficiency with which the services are provided.

The Council believes this matter to be of such widespread concern that it recommends the creation of a commission, its members to be appointed by the President, composed of experts in the fields of health care and hospital planning, of representatives of groups and agencies purchasing health care on a large scale, and of the general public, for the purpose of enhancing the effectiveness of our hospitals throughout the country in the provision of high-quality health care. The recommendations of such a commission would be of benefit primarily to the population as a whole but would, of course, also be of long-run importance to the hospital insurance program for elderly and disabled people.

1. INPATIENT HOSPITAL BENEFITS

The proposed hospital insurance for people age 65 or over and the disabled should cover a number of days sufficient to meet the cost of inpatient hospital services for the full stay of almost all beneficiaries.

The Council believes that the number of days for which inpatient hospital benefits are paid should be enough to cover the full hospital stays required in nearly all cases. Sixty days of coverage for each spell of illness would accomplish this purpose. Sixty days would cover the full stay of all but about 3 to 5 percent of the stays of older persons. Moreover, it is quite possible that with coverage in extended-care facilities, such as we recommend, many of those who would otherwise stay in acute general hospitals for over 60 days could be transferred to extended-care facilities.

The Council holds the view, which is shared by many experts on hospital insurance, that the availability of hospital coverage for a substantially longer period may, especially among the aged, result in excessively long hospital stays and therefore unnecessary cost to the program. We therefore believe that it is desirable to place a limit on the number of covered days in the acute general hospital and, at the same time, provide for extended care in less expensive facilities.

The Council believes that the proposed hospital insurance should not include any provision under which beneficiaries would choose among various combinations of benefits of the same actuarial value but with a varying number of days and higher and lower deductibles. The Council sees little gain in such a choice and, on the contrary, believes that for most beneficiaries the need to make a choice would be confusing and upsetting and that widespread dissatisfaction could be

expected among the large number who would later discover that they would have been better off with a different choice. Any attempt to meet this dissatisfaction by allowing people to change options would significantly increase the cost of the program for the whole group of contributors by giving an unfair advantage to those who could anticipate the need for a specific type of protection.

2. OUTPATIENT HOSPITAL DIAGNOSTIC SERVICES

Payment under the program should be made for the costs of outpatient hospital diagnostic services furnished beneficiaries.

Recent progress in science and medicine has resulted in the development of complex services and equipment for the more accurate and more timely diagnosis of disease. Because of the cost of the equipment and the need for specialized personnel to operate it, the hospital has increasingly become a diagnostic center which is used when expensive and complex tests are required. Providing for the payment of the cost of expensive outpatient hospital diagnostic services should help to encourage early diagnosis of disease by removing financial barriers to the use of such services. Payment for outpatient hospital diagnostic services would also help to support the efficient provision of care by eliminating a financial incentive for hospital admissions to obtain diagnostic services.

3. DEDUCTIBLES

Hospitalized beneficiaries should pay a deductible equal to the cost of one-half day of care—$20 at the program's beginning. In the case of beneficiaries who are provided outpatient diagnostic services, this deductible amount should be applied for each 30-day period during which diagnostic services are provided.

The Council believes that beneficiaries who are hospitalized should be required to pay a small amount toward the cost of their hospital stay. Such a deductible amount might help to reduce unnecessary hospital admissions. On the other hand, we would not favor a deductible amount of substantial size since such a deductible might well deter many beneficiaries from seeking needed care. In the Council's judgment a deductible amount which is equal to about a half, or even three-fourths, of the national average cost per patient day of hospital care would not be so large as to represent a significant impediment to needed care. Such a deductible amount—$20 to start—would, moreover, make it possible to provide, within the funds available to the proposed program, more extensive protection against catastrophic health costs than would otherwise be possible.

Provision for a similar deductible amount in the outpatient diagnostic benefit would limit coverage to diagnostic procedures with a significant financial impact. It should also have the effect of excluding from the coverage of the program the type of routine laboratory and other diagnostic procedures that are customarily furnished in or through the physician's office.

4. SERVICES IN EXTENDED-CARE FACILITIES

The cost of post-hospitalization extended-care services in facilities which provide high-quality rehabilitative and convalescent services should be covered so as to pay for a minimum number of days after hospitalization in all cases, with additional days of extended-care services being paid for if the patient has not used all of his inpatient hospital coverage.

The services that would be covered would be those furnished to patients in extended-care facilities which are under control of a hospital or affiliated with a hospital and which are designed primarily to render convalescent and rehabilitative services. Care in such a facility will frequently represent, particularly among the aged, the next appropriate step after the intensive care furnished in a hospital and will make unnecessary the continued occupancy of a high-cost bed normally used by acutely ill patients.

Services of this kind are essential in the overall treatment of many illnesses following their acute stage and prior to the time a person can return to his home or transfer, in some instances, to an essentially custodial institution. And, of course, extended-care coverage, even for a limited duration, will also be of benefit to many older patients with chronic or terminal illness who can be transferred from intensive care in acute general hospitals.

Since the proposed program is designed primarily to support efforts to cure and rehabilitate, and since "nursing home" care, in many cases, is oriented not to curing or rehabilitating the patient but to giving him custodial care, the Council does not propose the coverage of care in nursing homes generally.

In order to provide an incentive for transferring a patient from a hospital to an extended-care facility at an early point, when such transfer is medically desirable, the Council believes that coverage should be provided for 2 additional days of extended care, if needed, for each day the patient's hospital stay is less than 60 days. A minimum of 30 days or so might be covered in all cases.

The Council recognizes that hospital-affiliated facilities which provide post-acute convalescent and rehabilitative care do not exist in many communities and that the services therefore may not be available immediately to many of the beneficiaries who might need them. The Council believes, however, that the coverage under the proposed program will encourage the development of such facilities and that, with the help of other programs designed to assist directly with construction, such extended-care services can be made generally available within a reasonable time.

5. ORGANIZED HOME NURSING SERVICES

Insurance coverage should be provided for organized home nursing services.

As a fourth element in the protection it proposes, the Council recommends the coverage of organized home nursing services—that is, services provided on a visiting basis in the patient's own home. Coverage of medically supervised home nursing services provided through qualified nonprofit or public agencies would encourage the establishment of organized home care programs. Experience has shown that such visiting programs can bring high-quality care to the patient in his own home, thus avoiding the need for hospitalization altogether in some cases or facilitating the discharge of patients not only from hospitals but from extended-care facilities. The Council believes that a substantial number of professional visits a year—in the range of two to three hundred—should be covered in order to make organized home nursing services a real alternative to institutionalization.

Organized home care services sometimes include the services of hospital interns and residents-in-training. We believe that payment should be made for their services when furnished but only if the services provided are part of a professionally approved training program for such individuals.

6. PAYMENTS ON THE BASIS OF REASONABLE COST

The extent of hospital insurance and related protection should be specified in terms of the services covered rather than in terms of fixed dollars, and covered services should be paid for on the basis of the full reasonable cost of the services.

The Council recommends that protection should be in the form of service benefits, with payments for covered services made directly to the institution or organization furnishing the services rather than payments of fixed dollar amounts to the beneficiary receiving the services. Service benefits would provide more secure and reliable protection for the patient and enable the program to promptly adjust payment to hospitals in accordance with changes in hospital costs resulting from the acquisition of new equipment, the adoption of new health practices, and the general improvement of services. The inpatient hospital benefits should cover all hospital services and supplies ordinarily furnished by the hospital for necessary care and treatment of its patients, except that accommodations more expensive than semi-private accommodations would be paid for only if medically necessary. Luxury items would not be included.

The hospital or other provider of service should be reimbursed for the reasonable cost of services provided. Payment on a reasonable cost basis would be in line with the recommendations of many expert groups, including the American Hospital Association. The established practices of most Blue Cross plans are generally in line with this recommendation.

It is likely that no single formula for estimating the cost of services will prove best under all circumstances, and provision should be made to permit variations in hospital practices and services to be taken into account.

7. HOSPITAL STAFF REVIEW OF UTILIZATION

Hospitals should be required, as a condition of participation, to establish professional staff committees to review the services utilized.

Procedures for medical staff review of hospital admissions, length of stays, the medical necessity for services provided, and the efficient use of services and facilities are coming into use in many hospitals, and the experience with some of these procedures has been promising. Procedures for the recertification of the

continued need for service by the attending physician have also been adopted in some hospitals.

The Council believes that all participating hospitals should be required to have staff committees to review the utilization of services and that consideration should be given to certification procedures. The structure and responsibilities of the staff committee should be left to the discretion of the hospital and its medical staff. However, such committees should be required at least to conduct sample reviews of hospital admissions among the beneficiaries of the program and to review long-stay cases. The professional judgments obtained through the use of such a staff committee would provide a safeguard against the improper use of services.

8. ADMINISTRATION

The proposed hospital insurance provisions should be administered by the same Federal agencies which administer the social security program but in carrying out this responsibility the Federal Government should use private and State agencies to the extent that these agencies can contribute to efficient and effective operation.

The Council recommends that the Federal Government have over-all responsibility for the operation of the proposed hospital insurance program but that it use both qualified private organizations and State agencies for the performance of certain functions where such use would contribute to the efficiency of administration.

Many of the functions necessary to the administration of the proposed hospital insurance provisions would require little, if any, additional effort since they are now being successfully performed under the social security program and would simultaneously serve the purposes of the hospital insurance provisions and the existing cash benefit provisions. These functions include the collection of contributions; the maintenance of earnings records; the establishment of age, disability and the status of dependents; the determination of whether insured status requirements for eligibility are met; and the maintenance of current records of eligibles under the program.

The Council recommends, however, that the authority given to the Federal administrator should be flexible enough to permit him to determine whether or not to use the help of private and State agencies, and to what extent. Included among the functions which might be carried out by private agencies are those related to arranging for hospitals and other providers of health services to participate in the program and handling the payment of hospital bills covering costs insured by the program. State agencies which license health facilities could be used, for example, to assure that health facilities desiring to participate in the program meet the requirements for participation. The Government might find that functions such as these could be carried out better, or at less cost, if instead of performing them directly it arranged to have them performed by private and public agencies with experience in similar functions.

9. THE BASIS OF ELIGIBILITY FOR BENEFITS

Hospital insurance benefits should be provided for aged and disabled beneficiaries of the social security program, and special provision should be made for the next few years for those who have not met the requirements of eligibility under the program.

In the long run all people age 65 or over and all people with long-term total disabilities who have worked long enough to become entitled to monthly social security cash benefits will have paid hospital insurance contributions as well as contributions for cash benefits and will be entitled to both types of protection on the basis of the insured status provisions of present law.

The Council believes that the hospital insurance benefits should also be available to people who are age 65 or over, or who will become 65 in the next few years, whether or not they have made significant contributions toward hospital insurance and whether or not they are entitled to social security cash benefits. Such persons have not had the opportunity to gain protection by contributing to the hospital insurance program but their need for such protection is equally great.

People who attain age 65 after a specified date should be required to have a gradually increasing number of earnings credits under social security, and the number required for eligibility for hospital insurance should ultimately be the

same as that required for social security cash benefits.[20] The cost of the protection provided under this provision should be met from general revenues, as explained below in the recommendation on financing.

After consideration of all possible alternatives, the introduction of hospital insurance by making it part of the ongoing social insurance system seems to be highly desirable in social, economic and administrative terms.

10. FINANCING

The proposed hospital insurance program should be financed by a special earmarked contribution of 0.4 percent of covered earnings from employees and from employers, and 0.5 percent from the self-employed, with an 0.15 percent contribution from Federal general revenues to cover the cost of benefits for those already retired or disabled.

The contributions for hospital insurance should be an earmarked percentage of covered earnings, established as a new tax, separate from the taxes in the Federal Insurance Contributions Act that support the present social security cash benefits. The proceeds of this new tax would be kept separate from the taxes which finance the present social security program. These proceeds would be deposited in a newly created hospital insurance trust fund separate from the old-age and survivors insurance trust fund and the disability insurance trust fund. However, the employment and earnings coverage and the maximum on covered earnings to which the new tax would apply should be the same as those to which the present social security taxes apply so that the recordkeeping tasks of employers and the Government would be largely unaffected by the establishment of a separate contribution for hospital insurance.

Hospital insurance financing separate from that of old-age survivors, and disability insurance should allay any concern that the hospital insurance program might in any way impinge upon the financial soundness of the OASDI trust funds. Furthermore, identifying the contribution as a hospital insurance contribution will tend to increase the contributor's sense of financial responsibility for the benefits provided.

Several members of the Council, however, while believing in the value of a separate trust fund, are of the opinion that it is not necessary to have a new and separate tax either to allay possible concern about the financial soundness of the social security program, to maintain the identity of the hospital insurance financing, or, in general, to accomplish the objectives of the proposal.

The contribution rates should be 0.4 percent of covered earnings each for employees and employers and 0.5 percent for the self-employed.[21] It is assumed that these contributions for hospital insurance would go into effect at least 6 months earlier than the first hospital insurance benefits were paid. For example, if the plan were enacted in 1965, the contributions might go into effect in January 1966 and benefits might first be paid in July 1966.

In addition to the earmarked contributions there would be a contribution from Federal general revenues to meet the cost of hospital insurance benefits for those already retired or disabled. The Government contribution would be justified in terms of the health and welfare of the Nation's aged and disabled and the reduction in general revenue costs that will follow as social insurance reduces the need for public assistance. It is proposed that the cost to the Government be met by annual and automatic appropriations over a 50-year period. The Government's cost on this basis is estimated to be 0.15 percent of covered payrolls.

The recommended contribution rates are designed to be sufficient to cover the estimated costs of the proposed benefits both in the short run and over the long run. Because sound financing depends on the validity of the cost estimates used and this in turn depends on the validity of the assumptions which underlie the estimates, the Council believes it to be in order for this report to contain a statement of the assumptions it has directed be used in making the cost estimates.

[20] For example, the provision might be as follows: Uninsured people who reach age 65 in 1966 or before would need no quarters of coverage; those who reach age 65 in 1967 would be deemed to be insured for hospital insurance if they had at least 6 quarters of coverage (earned at any time). For people who reach age 65 in each of the succeeding years, the number of quarters of coverage needed to be insured for hospital insurance protection would increase by 3 each year. The provision would not apply to people who reach age 65 in 1971 (or later), since, under the Council's recommendation, in that year the number of quarters that would be required under the special provision would be the same as the number required for regular insured status.

[21] For the same reasons that the Council has recommended that the contribution rate paid by the self-employed toward old-age, survivors, and disability insurance be set in the long run at no more than 1 percent of earnings higher than the employee rate, the Council recommends that the rate paid by the self-employed for hospital insurance be a comparable 0.1 percent above the rate paid by employees. (See p. 72.)

As in the case of estimates of the cost of cash benefits under the social security program, assumptions underlying hospital insurance cost estimates can vary widely and still be reasonable. For hospital insurance the range over which cost assumptions may vary and still be reasonable is somewhat greater than for the cash benefits. For this reason, we have taken great care to assure that the assumptions used in estimating the costs err, if at all, on the conservative side.

Clearly, the cost of the proposed program, expressed in dollars, will be an increasing cost. One important factor which will tend to increase the cost of the program over time will be the rising cost per day of hospitalization. Another factor tending to increase costs will be the growing number of people who are eligible for hospital insurance. A third factor is the increasing average age of those who will be protected.

Since the income to the system will come from a percentage of covered earnings, and since over the years it can be expected that more and more people will be employed and that earnings levels will rise, the income of the system will also increase. To take into account both rising costs and rising income, the analysis of financing is done in terms of costs as a percent of covered (taxable) earnings. Thus, the Council's assumptions concerning future hospital costs are stated in terms of the expected future relationship between rising hospital costs and rising earnings—of how increases in hospital costs will compare with increases in covered earnings (and therefore with increases in contribution income).

Earnings reflect the increasing productivity of labor. Therefore, on the average and over time, the general level of earnings will increase much faster than the general price level. But in recent years the reverse has been true in the case of hospital prices; they have been increasing substantially faster than the general level of earnings. Obviously, however, hospital costs cannot continue indefinitely to rise faster than earnings; if they did, ultimately no one could afford hospital care. Nevertheless, the financing of the hospital insurance program must make allowance for the strong likelihood that hospital costs will, for a time, continue to increase faster than earnings. A reasonable assumption would be that the differential between the rate of increase in hospital costs and the rate of increase in earnings will get smaller and that eventually hospital prices will increase at a somewhat lower rate than earnings even though at a much higher rate than other prices.

Specifically, our assumption for the relatively short run is that hospital costs will rise faster than earnings for 10 years after the program begins operation, but not quite as fast thereafter. The Council has assumed that until 1970 the differential between hospital costs and earnings will continue to be the same as the average over the last 10 years (2.7 percent) [22] and that in the following 5 years the differential will average half as much.[23]

The Council does not presume to have any firm basis for knowing just how much hospital prices or other prices will rise in the distant future. However, because of the comparatively large component of labor costs which will always be present in health services and because of the cost of increasing quality of care, the Council has assumed that hospital costs will probably rise indefinitely considerably faster than other prices. Therefore, the Council's assumption on the relation of hospital costs to earnings is that after the first 10 years of the program's operation (during which hospital costs are assumed to rise faster than earnings), hospital costs will rise slightly less than earnings but substantially more than other prices. (See pp. 109–110, Appendix B, for further discussion of the specific assumptions.)

The conservative nature of this assumption is made plain when one considers the future price levels it implies. The over-all effect of the assumed price rises, if the past relationship between earnings and the general price level continues, is that in the next 75 years hospital prices will have risen 710 percent while other prices will have risen by about 110 percent.

Another factor that affects the financing of the system is the limitation placed on the maximum amount of annual earnings subject to contributions (the con-

[22] Although figures for the 10 years *average* 2.7 percent, the 2 most recent years for which data are available (1962–1963) show a differential between hospital cost increases and earnings increases of only a little over 2 percent for each of these years. Nevertheless we have used the 10-year average in order to make sure that the cost projections will be conservative. Also relevant is the fact that a substantial proportion of the increases in hospital costs that have occurred over the last 10 years is attributable to a catching up in wages and a reduction in the hours of work of hospital employees, who as a group have been considerably underpaid. The catching-up process will, naturally, complete its course in time.

[23] By way of comparison, it may be noted that the major organization representing the commercial health insurance industry assumed smaller rises in hospital costs for this period in its estimates on the costs of the King-Anderson bill. Specifically, it estimated that hospital costs will rise 2 percent per year more rapidly than earnings from 1963 through 1968 and 1 percent more rapidly than earnings from 1969 through 1978. (Pages 587 and 588 of the record of hearings on H.R. 11865 before the Committee on Finance, United States Senate, August 1964—appendix to testimony on behalf of the Health Insurance Association of America.)

tribution base) and its relationship to increases in earnings levels. As has been noted, income to the system tends to rise as earnings rise. However, if over the long run the maximum on earnings which are taxed were fixed—that is, if the maximum did not rise as earnings rise—there would be an increasingly inhibiting effect on contribution income. More and more people would be paying contributions on the maximum earnings covered, and increases in their earnings would not be subject to the contribution rate.

The Council's assumption is that the contribution base will not remain fixed. In the short run the Council recommends an increase in the base in 1966 and 1968, primarily to take account of the past rise in earnings levels. For the longer run, one of the assumptions made in preparing cost estimates for hospital insurance is that periodically there will be increases in the contribution base if earnings rise. These increases are assumed because the base, which under the cash-benefit provisions is also the maximum amount of earnings creditable for benefits, must be kept generally in line with changes in earnings levels if cash social security benefits are to continue to have a reasonable relationship to the earnings they are intended to replace and if social security contributions are to vary with earnings.

The great bulk of the income from contribution base increases would of course be used to raise cash benefits to keep them in line with higher earnings levels. For example, if hospital insurance contributions are about one-tenth of contributions under the old-age, survivors, and disability insurance program (as the Council recommends) a little over 90 percent of the income from any future increase in the contribution base would go toward old-age, survivors, and disability insurance and a little less than 10 percent toward hospital insurance.

The Council's assumption is, then, that legislative action will be taken from time to time to adjust the contribution base in line with rising earnings. However, the Council recognizes that over the short run the increases which it expects in the contribution base, beyond those adopted concurrently with hospital insurance, may not occur as anticipated. The Council recommends, therefore, that the contribution rates for hospital insurance be designed to provide sufficient income to cover benefit expenditures even if, for a number of years, no further increase in the base is enacted. The contribution rates proposed by the Council are so designed.

In summary, the principles which the Council has followed in making its recommendation for the contribution rates necessary to support the proposed hospital insurance program are as follows: The Council recommends that the income to the hospital insurance program be large enough each year to cover benefit outgo with a prudent allowance for increases in hospital costs as well as for the possibility that the contribution base increases may lag behind rising earnings.

A contribution rate of 0.4 percent each for employee and employer (0.5 percent for the self-employed) together with the 0.15 percent from the Government would be sufficient not only to meet benefit costs but also to build up substantial amounts in the hospital insurance trust fund. The new trust fund would have a sizeable balance from the start, since contributions toward the program would be collected 6 months or so before benefits would be paid.

The recommended maximum amount of annual earnings taxable would be $6,000 in 1966 rising to $7,200 in 1968, a recommendation discussed in Part I. While, as indicated above, it is contemplated that this maximum would rise in the future, the recommended contribution schedule would yield income in excess of outgo for at least the next 10 years even if the base is not increased after 1968.

The following table summarizes the cost effect of the four types of benefits proposed to be covered:

Actuarial balance under proposed plan of hospital insurance

[Costs expressed as percentage of taxable payroll according to intermediate-cost estimates]

Item	*Level-Cost*
Level-Cost Effect of Changes:	
Hospital benefits, 60-day maximum, ½-day deductible	+.84
Extended care services, 30-day maximum [1]	+.02
Outpatient diagnostic services, deductible of ½-day hospital cost	+.01
Home nursing services, 240-visit maximum	+.03
Level-Cost of Proposed Program	.90
Level-Equivalent of Contribution Schedule [2]	.90
Actuarial Balance	.00

[1] With additional days if all of hospital benefits are not used.

[2] The 0.15 percent of payroll from general revenues for 50 years is equivalent to a level rate of 0.10 percent of payroll.

Conclusion: The Council finds that health costs represent the greatest remaining threat to the economic security of our aged and severely disabled citizens. The social insurance approach, the Council believes, is singularly fitted to serve in dealing with this threat. What is needed is an arrangement under which working people, together with their employers, can contribute from earnings during their working years and have insurance protection against health costs in later years, without further contribution, when their health costs will be high and their incomes low. Only social insurance, as typified by the social security program, can assure that such an arrangement will apply to practically everyone who works for a living.

The Council has developed and presented in this report a plan under which the major part of the costs incident to hospitalization and related care in old age or during periods of total disability will be paid for through the contributory social security program. The plan will pay for these costs in a way which is in keeping with the high standards of American health care. The plan will be responsive to changing methods and improvements that are likely to occur in health care in this country. The plan will accommodate the individual's freedom of choice of health care facilities and will in no way interfere with the private practice of medicine or with the independence of our voluntary hospital system. The Council has included recommendations which, if adopted, would assure that the proposed plan of hospital insurance for older people and totally disabled people will be soundly financed through its own contribution schedule and trust fund.

While neither private insurance nor public assistance, alone or together, can meet the pressing need for hospital protection on the part of the aged and disabled, the recommended plan contemplates an important role for both. The hospital protection proposed to be provided under the social security program will serve as a foundation on which individuals can build private health insurance, just as old-age, survivors, and disability insurance under social security is serving as a base on which people build additional protection through private means. With social security providing basic protection against hospital and related costs, public assistance will assume the role best suited for it—that of a program intended to help the members of the relatively small group whose special needs and circumstances are such that they are unable to meet their health costs through social security or through private insurance or other resources.

The Council is confident that the principles of social insurance underlying its recommended plan for hospital insurance for the aged and the totally disabled can be applied successfully as they have been applied to social security cash benefits. Today's social security program assures that the vast majority of older people and totally disabled people will receive a regular monthly income to help them meet the costs of day-to-day living. The proposed provisions for hospital insurance will round out this security by removing the greatest remaining obstacle to the financial independence of these groups. With such provisions in effect, millions of our older citizens will be able to look forward to their years of retirement without the dread of overwhelming costs arising from serious illness.

PART III. IMPROVEMENTS IN THE CASH-BENEFIT PROVISIONS

In general the Council believes that the present program is functioning well and that its basic structure is satisfactory. The most important improvements in the cash-benefit provisions, and particularly in the benefit amounts, that the Council is recommending are designed to take into account recent wage and price changes. The effectiveness of the social security benefits has been diminishing because the benefits for the last 6 years have not even kept pace with rising prices and because the maximum amount of annual earnings that is taxable and creditable toward benefits has not been raised as the general level of wages has gone up.

The Council has also found that although the program is very broad in its coverage—about nine-tenths of the people who at any one time are in gainful employment in the United States are covered—there are some areas where its coverage should be further extended, and that while benefit payments are now provided in most cases in which support is lost when the worker retires in old age, becomes disabled, or dies, there are a few remaining gaps that should be filled.

The improvements recommended by the Council require additional financing; the cost of those improvements and the recommendations for providing the needed additional financing are discussed at the conclusion of this section.

Before the recommendations of the Council are set forth in detail, it may be helpful to summarize briefly the major provisions of the present program.

Monthly benefits are payable under the program to retired insured workers at age 65, and reduced-rate benefits may be paid to them as early as age 62. Benefits

may also be paid to the following dependents: A wife or dependent husband age 65 or over (or age 62 with a reduction in the benefits); children under age 18 or disabled before age 18; and a wife of any age caring for a child entitled to benefits. Monthly benefits are payable to insured workers who have very severe and long-continued disabilities and to the dependents of such workers. Upon the death of an insured worker, monthly benefits are payable to a surviving widow or dependent widower age 62 or over; children under age 18 or disabled before age 18; a mother who has such a child in her care; and dependent parents age 62 or over. A lump-sum death payment is also made.

Benefit amounts under the program are related to the average earnings of the insured worker in covered employment; currently, however, only the first $4,800 of the worker's earnings in a year is included in calculating the average. The minimum benefit payable to a worker who goes on the benefit rolls at age 65 or later is $40 a month and the maximum is $127 a month. A man and wife both going on the rolls at 65 or later receive half again as much. Maximum benefits to a family based on a worker's earnings range up to $254 a month.

Almost everyone who works is covered by social security. The only major groups excluded from coverage are self-employed physicians, Federal employees under the civil service retirement system, self-employed persons with annual net earnings of less than $400, and farm and household workers with irregular employment. Employees of State and local governments and of nonprofit organizations may obtain coverage on a voluntary group basis and almost 80 percent have done so. Railroad employees, through a coordination of the railroad retirement and social security programs, are in effect covered by social security.

The program, then, furnishes basic retirement, disability, and survivor protection to practically all of the American people. The Council believes enactment of the recommendations discussed in the pages that follow will enable the program to do so more effectively.

Social Security Benefit Amounts

The social security program today is the major reliance of most of our people for income security in old age. As indicated in Part II, about one-half of the older social security beneficiaries have less than $12.50 a month in continuing retirement income other than their social security benefits, and for all but about one-fifth of the beneficiaries, benefits are the major source of continuing retirement income.[24] With social security benefits the source of almost all of the regular retirement income received by so many of the older people in the country and the main reliance of so many more, it is essential that the benefit structure be examined from time to time to make sure that benefits are reasonably adequate.

Benefits for a retired worker (men and women) alone average only $74 a month; for an aged couple, $130. Two-thirds of the couples on the benefit rolls are getting less than $158 a month. Even for people now coming on the benefit rolls at or after age 65, the old-age benefits for men alone average $103 a month; for couples, $159. The Council believes that these amounts are too low.

In considering how best, within the limitations imposed by the necessities of financing, to improve benefits for both present beneficiaries and for those who become beneficiaries in the future the Council examined the several factors that determine benefit size—the contribution and benefit base, the provisions for translating the record of credited annual earnings into the "average monthly earnings" on which the benefit is based, the special provisions for reduced benefits for those who retire early, and the structure of the formula for deriving the monthly benefit from the average monthly earnings. As a result of its examination, the Council is recommending changes in three of the four factors and an intensive study of possible changes in the fourth.

The recommendation of the Council for increasing the contribution and benefit base is outlined in Part I of this report (on p. 70) because of its implications for the financing of the program. Raising the base in line with rising earnings has equally important implications for the benefit structure of the program. Social security is important to average and above-average earners as well as to low-paid people. Over the years, the erosion of the base has meant that the protection for the higher earner has significantly deteriorated. For example, a man who was earning $3,000 in 1940 had all of his earnings counted and, looking forward to retirement in 1965, could expect to get a benefit that would equal 21 percent of these earnings; in 1965 a man who was earning $3,000 in 1940, if

[24] See footnotes 16 and 17, p. 75.