Vanderbilt Law Review

Volume 16
Issue 1 *Issue 1 - December 1962*

Article 9

12-1962

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Recommended Citation

Jacob Meerman and Millard Long, Aid for the Medically Indigent, 16 *Vanderbilt Law Review* 173 (1962)
Available at: https://scholarship.law.vanderbilt.edu/vlr/vol16/iss1/9

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Aid for the Medically Indigent

Jacob Meerman and Millard Long***

The authors here discuss the ability of low income groups to purchase needed medical care and consider the various alternatives to governmental action. Professors Meerman and Long review some of the proposals made in Congress to remedy the problem, and then offer suggested legislation which would not only give benefits to the aged, but to the indigent as well.

I. Introduction[1]

In the last 100 years technological change has caused a revolution in medical practice. Doctors, practicing specialties which did not exist a century ago, administer treatments with drugs and equipment only recently invented. The radiologist with his cobalt bomb and the heart surgeon with his pump-oxygenator are able to treat ailments incurable as recently as fifteen years ago. The hospital, too, has changed from little more than a hotel for the sick into an institution at the core of modern medical practice.

The results have been spectacular—the so-called public health diseases have been largely eliminated by vaccination and other controls; maternal and infant deaths have been drastically reduced; and the life expectancy of the newborn baby has increased from under 50 years at the turn of the century to more than 70 today.

On the other hand, modern medicine is very expensive; it takes ten years after college to train the heart surgeon, and many millions to construct a modern hospital. True, the average man is far more apt to benefit from a sojourn in a hospital today than fifty years ago, but his bill will be many times what it was in 1910. The technological developments that have resulted in enhanced health and longer life expectancy have been accompanied by rising costs.

Simultaneous with these developments has been the growth of the conviction among the public that no one should be denied medical care because of inability to pay—or go bankrupt in the process. Although in recent years attention has been focused mainly on the aged, a group with generally low incomes and high rates of sickness, the provision of medical care for the indigent from all groups is widely recognized as a pressing problem.

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1. I gratefully acknowledge the assistance of the Bureau of Ecouomic and Business Research of Washington State University in the latter stages of this manuscript. J.P.M.

In the following paper we discuss the ability of low income groups to purchase needed care, consider the private alternatives to government action, find these deficient, and hence review various proposals made to the Congress. Finally, we examine a proposal which, while originally propounded in the early Fifties, has received little attention in the recent debates. To the authors, it would seem the best approach to care for the indigent.

II. THE PROBLEM OF MEDICAL INDIGENCE

It is not correct to suppose that everyone over 65 is medically indigent or even that the aged are the only ones in need of assistance with their health bills. However, since they do form the age group in which medical requirements are greatest and income lowest, it is understandable that as a category they should have received a major share of the attention given to the problem in recent years. As a group they require twice the care of the rest of the population—*e.g.*, the aged used 1785.4 days of short term care per 1000 persons in 1957-58, as compared with 851.2 days per 1000 consumed by the country in general.[2] Furthermore, their incomes are lower, an average per person over 65 of $950 against $2,225 per capita for the entire United States.[3] Nor is the argument correct that the aged can use assets rather than income to pay their medical bills. While it is true that they do have some capital, this is almost always tied up in a home, with financial assets usually being negligible.[4] Complicating the problem is the fact that most of the aged do not carry health insurance; in 1959, 46 per cent carried hospital insurance, 37 per cent had surgical coverage, and only 10 per cent were covered for physician's visits.[5] The evidence indicates, moreover, that even with insurance, benefits are often inadequate to meet the needs of this group.

The problem, however, is not basically one of being old, but of having large medical bills and little income, facts often, but not exclusively, associated with those over 65. For many with low incomes, medical outlays are a heavy burden. In 1958, families with incomes under $2,000 spent 13 per cent of their aggregate income on health services, while those in the $7,500 and over category spent

2. U.S. PUBLIC HEALTH SERVICE, HEALTH STATISTICS FROM THE U.S. NATIONAL HEALTH SURVEY, SERIES B-7 at 7 (Dec. 1958).

3. ECONOMIC REPORT OF THE PRESIDENT 1962 at 226-27 (1962); Epstein, *Sources and Sizes of Money Income of the Aged*, in 25 Social Security Bull., Jan. 1962, p. 16.

4. *Medical Care Costs of Aged OASI Beneficiaries: Highlights from Preliminary Data, 1957 Survey*, in 22 Social Security Bull., Apr. 1950, p. 3.

5. U.S. PUBLIC HEALTH SERVICE, HEALTH STATISTICS FROM THE U.S. NATIONAL HEALTH SURVEY: INTERIM REPORT ON HEALTH INSURANCE 2 (1960).

only 3.9 per cent.[6] Moreover, it is important to separate the individual from the average; high costs are not spread evenly over a given group but are concentrated among a few unfortunates. For the year between June 1957 and June 1958, 46 per cent of those over 65 had total outlays on medical services under $50, while 15 per cent had expenditures of $300 or more.[7] Comparable figures for the under $2,000 income group show the same situation. In short, only a small minority of the population have such high expenditures that they require assistance. To state it differently, while most families had modest expenditures, 6 per cent spent more than 20 per cent of their income on health services.[8] This is the group in need of assistance. Many are aged, but some are not; most are poor, but most of the poor do not require aid; and occasionally there is an individual in the upper income brackets whose medical bills are so extraordinary that he too is in need of financial help.

III. Methods of Relief

The major cause of medical indigence is poverty. In 1959, 14 per cent of American families had incomes less than $2,000; another 21 per cent had incomes between $2,000 and $4,000.[9] With large medical bills, either group will suffer substantial privation in paying them. Given that a substantial redistribution of wealth is not a feasible method of relief, there remain three alternatives: charity, insurance, and government assistance.

A. Charity

In 1959, charities contributed about $700 million in cash for purchase of medical care, amounting to about 2¼ per cent of total medical expenditures.[10] To pay the bills of the medically indigent would require at least a tripling of these cash grants, an unlikely possibility. Considerably larger benefits are received by needy patients in the form of services free or at reduced costs from doctors and hospitals. The contributions of private physicians, often at a sacrifice to themselves, are far from negligible, and it has been suggested that medical indigence might be eliminated by further effort in this direction. Doctor's fees, however, account for less than one third of total medical outlays so that even with maximum contributions the problem would

6. Anderson, Collette & Feldman, *Family Expenditure Patterns for Personal Health Services*, in 14 Health Information Foundation Research Series 8 (1958).
7. *Id.* at 61.
8. *Id.* at 23.
9. Samuelson, Economics 113 (1961).
10. Merriam, *Social Welfare Expenditures*, 1958-59, in 23 Social Security Bull., Nov. 1960, Table 5, p. 43.

remain largely unsolved. Nor is free hospital care an equitable arrangement for providing assistance to the indigent. To remain solvent, hospitals have to recoup the costs of services donated to the poor by higher charges to paying patients. Hence, the solvent patient has to bear the costs not only of his own sickness, but those of others as well. This is inequitable since the paying patient is already burdened with sickness, hospital expenses, and often a temporary loss of income.

B. INSURANCE

Many have argued that the problem can be solved through private insurance, stressing the rapid growth in the insured from 10 per cent of the population in 1941 to 76 per cent in 1961. Even that hard to insure group, the aged, have participated in this expansion. Today ownership of insurance is widespread, but the benefits are not comprehensive: with over three-quarters of the population covered, insurance pays less than a quarter of the total medical bills.[11]

Those with high medical charges fall into two categories, *i.e.*, the aged and those with recognized ailments, and the nominally good risks who have unexpectedly large medical bills in a particular year. The problems of the latter can be handled by private insurance, but whether those of the former can is doubtful. Insurance premiums must cover benefits plus administrative costs, and where expenditures are likely to be large, so must be the premiums. Policies providing comprehensive benefits for the poor risk group would be very expensive, in fact, beyond the means of many in the lower income brackets.

There are two basic types of health insurance ratings: experience and community. The former calculates premiums on the probability that the individual will need services. With the latter, the premiums are uniform over the entire insured population. Community ratings spread the cost of the poor risk group among the insured; with experience ratings the individual's premiums are in line with his own risk. The Blue Cross-Blue Shield plans usually rely on the community approach and private firms on the other. Using experience ratings, the private companies offer preferred risk groups more attractive policies. Hence, better risks are continually leaving the Blue plans, forcing the latter to raise rates to cover the higher per capita charges of the poor risks. To maintain their competitive position, the Blue plans have in some instances adopted experience rating.

The costs of the bad risk group could be spread by community rating. But as mentioned above, this type of insurance finds it hard to compete with the experience-rated plans. Since the better risks

11. *Id.* at 43.

usually leave community plans, the latter tend to evolve into little more than experience-rated plans for the poor risk group. Legislation outlawing experience ratings would be necessary to keep community ratings general in their coverage. Were this done poor risks could be insured at relatively low cost.

However, it is not clear that community ratings are a desirable solution to the problem. They force individuals to bear the burden of the medically indigent in proportion to the amount of insurance held. This approach is equivalent to a tax, and taxes that do not increase with people's ability to pay are not equitable.

To solve the problem of the medically indigent, private insurance must provide adequate benefits at a price that all can afford. Community ratings which do reduce the burden borne by the poor risk group are poor competitors with the experience-rated plans, and do not distribute the costs in an equitable manner. Experience ratings are both feasible and just, but only if government assistance is given to the indigent in meeting their premiums.

C. Government

Since charity and private insurance cannot solve the problem of the inadequately cared for and financially burdened, we are left with the third alternative—government. Germane here is the current role of government in caring for the medically indigent. What proportion of this group is already covered by some government program?

Among government programs, those providing preventive medical services are of major importance. The United States Public Health Service and the local and state public health units provide services of this type through controlling contagious diseases, supervising sanitation in restaurants, and so forth. The "well-baby-care" services provided by public health units also fall into this category as well as the school health programs.

A second function largely taken over by government is care of the chronically ill. Over 80 per cent of the insane are in state hospitals. In fact, most state hospitals either provide services to the insane, those with tuberculosis or "other special health problems."[12] The payments of the federal government to the blind and the crippled are also in this category.

However, government programs also cover acute and chronic patients. Merchant seamen and members of the armed forces receive medical care at government expense; this is also true of Indians on the reservation and Eskimos. The Veterans' Administration provides hospital care for veterans with service connected disabilities as well as for nonservice connected disabilities when the veteran cannot pay for

12. de Grazia & Gurr, American Welfare 349 (1961).

them himself.[13]

State workmen's compensation laws currently cover about 80 per cent of those employed.[14] These laws require that employers pay for medical care made necessary by work injuries as well as make payments for extended time periods when chronic disability results.

Adding the relevant programs together, as in Table 1, we find that most of the public remains responsible for its own medical bills. The number covered is vastly overestimated since most veterans do not attempt to receive free medical care from the government. Hence, less than a quarter of the United States population is not responsible for paying its own medical bills. The problem of medical indigence remains for the majority, and we are left with legislation as the remaining alternative.

IV. SUGGESTED LEGISLATION

A. HISTORICAL REVIEW

Since the 1930's, well over a hundred bills have been introduced in the Congress concerning some aspect of health insurance. Rather than attempt a detailed description of these various proposals, we will outline some of the major approaches.[15]

Unlike the current suggestion to limit assistance to the aged, many of the earlier programs aimed at financing the medical care of the nation, or at least of the entire low-income group. Perhaps the best remembered are a series of bills proposed by Senator Murray and Congressman Dingell. Their original bill, also sponsored by Senator Wagner, was introduced in Congress in 1943.[16] It provided for compulsory coverage of nearly all employees and their dependents; and proposed benefits included almost all physicians', dental, and home nursing services; hospital services for periods up to 60 days per beneficiary per year; prescribed auxiliary services; appliances; and expensive drugs.

The bill did not specify the source of needed federal revenues. However, it is clear that payroll taxation would have been used. The bill provided an annual appropriation equal to a maximum of 3½ per cent of wages up to $4,800 per year per insured employee. With the exception of the original bill, all of the 22 bills submitted in the

13. *Id.* at 383, 405.

14. U.S. Dep't of Labor, BUREAU OF LABOR STANDARDS, BULL. 161, STATE WORKMEN'S COMPENSATION LAWS 2 (1961).

15. A detailed discussion of such proposals is contained in the U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, SOCIAL SECURITY ADMINISTRATION DIVISION OF PROGRAM RESEARCH, MAJOR LEGISLATIVE PROPOSALS FOR FINANCING PERSONAL HEALTH SERVICES FOR THE AGED, 1939-1961 (1962) [hereinafter cited as MAJOR LEGISLATIVE PROPOSALS].

16. S. 1161, H.R. 2861, 78th Cong., 1st Sess. (1943).

Table 1

GROUPS NOT RESPONSIBLE FOR MEETING THEIR MEDICAL CARE PAYMENTS IN 1960

Group	Number in Thousands
Institutional Population	1,897
Indians	300
Merchant Seamen	50
Veterans	20,197
Armed Forces	2,514
Imputed Number Covered Under Workmen's Compensation[a]	21,245
TOTAL	46,203
U. S. Population	178,997

[a] The imputed number covered under workmen's compensation was derived by taking 80% of the average total number employed of 66.39 million during 1960. This overestimates those covered by workmen's compensatiou. However, such legislation covers solely on-the-job injuries, and, since people spend no more than 40% of their waking hours on the job, the 80% of the 66.39 million was reduced to 40% or 21.25. The resulting estimate is clearly an upper limit.

Sources: STATISTICAL ABSTRACT OF THE UNITED STATES, 1962, *passim*. ECONOMIC REPORT OF THE PRESIDENT 1962 at 230.

Congress embodying this proposal saw the federal government as providing funds to the states on the basis of population and varying costs of services. Actual disposition of the funds was left to the states acting in accordance with the law.[17]

Another approach is typified by Senator Hunt's bill, introduced in 1950.[18] He advised the establishment of a national health insurance system with voluntary participation and restricted to families with incomes less than $5,000. per year. Those joining were to pay a premium into a personal health insurance account in the United States Treasury. Proposed benefits were medical, surgical, and dental services; home nursing care; hospital care and related services up to 60 days per person per year; auxiliary services such as laboratory tests, X-ray diagnosis or therapy, optometrists' services, appliances, expensive drugs, and so forth.[19] "Congress was authorized to appropriate additional money to the account when needed to carry out the program."[20]

Many programs have relied upon a combination of state administration and federal financing in whole or in part. Typical of these are

17. BREWSTER, HEALTH INSURANCE AND RELATED PROPOSALS FOR FINANCING PERSONAL HEALTH SERVICES 26 (1958).

18. S. 2940, 81st Cong., 2d Sess. (1950).

19. BREWSTER, *op. cit. supra* note 17, at 20.

20. MAJOR LEGISLATIVE PROPOSALS 15.

the Capper and Taft proposals. The Capper bills of 1939-41 were designed to foster state programs of medical care for lower income workers, enrollment being compulsory. Those covered were to be determined by the individual states. Workers were to contribute to the program according to their income, with federal assistance for those with lower earnings. The Taft bills of 1946-49 included a scheme of matching federal grants for state operated programs. The Taft proposals have certain similarities with the current Kerr-Mills Act, for not only were matching grants proposed, but participation was to be limited to individuals and families unable "to pay the whole cost of needed medical and dental services," in short, the medically indigent. The states were free to choose a variety of ways of providing and paying for services. Moreover, an additional provision of the bill called for "surveys of existing medical, hospital, and dental services for formulation 'in detail' of a five-year plan for extending such services to persons unable to pay."[21]

Not until the 1950's did proposed legislation concentrate on the aged. The first bill to provide hospitalization benefits for the beneficiaries under title II of the Social Security Act was introduced in Congress in 1952.[22] As its major benefit it provided 60 days of short term general hospital care, including those services, drugs and supplies which a hospital usually furnished its patients. Financing would have been through increased Social Security rates for employees, employers, and the self employed. This bill would have used the states as agents of the federal government in paying the hospitals for services rendered.

In recent years the proposals have been mainly of two types; state administration of programs supported by matching grants from the federal government have competed for favor with benefit schemes to be administered through the Social Security system and financed by increased payroll taxes. The current Administration's bill can be considered the most recent member of this latter genre and is discussed in detail below.

Some bills were designed to foster the growth of private insurance, often by subsidizing companies insuring either poor risks or poor people, or both. The Hill-Aiken Bills,[23] for example, provided voluntary health insurance for persons unable to pay part or all of the usual premium. Benefits consisted of 60 days of hospital care per insuree annually; surgical, obstetrical, and medical services in the hospital; and diagnostic and outpatient services in hospitals or

21. MAJOR LEGISLATIVE PROPOSALS 20.
22. S. 3001, H.R. 7484, 82d Cong., 2d Sess. (1952) (Murray & Dingell).
23. S. 1456, 81st Cong., 1st Sess. (1949); S. 2171, 82d Cong., 1st Sess. (1951); S. 93, 83d Cong., 1st Sess. (1953).

diagnostic clinics.[24] Under this program state agencies were to collect that part of the premium the poor could afford to pay and then supplement the funds so that the insurance company would receive a full premium for each insuree. The federal government was to share one-third to three-fourths of the state's costs depending upon the state's financial ability.

The Smathers proposal of 1960[25] provided a direct subsidy to any insurance company in the amount of losses suffered on "approved policies." The approved policies were to provide a minimum of 60 days of hospitalization, 120 days of nursing home care, and $50 worth of drugs per year. Maximum cost for the policy was set at $72 per year. The loss subsidies under this program would have been substantial. There have also been a number of schemes designed primarily to encourage expansion of private insurance by "waiving the antitrust laws so as to permit insurance carriers to pool their resources in developing policies and methods for extending insurance to substandard health risks.[26]

In the last session of Congress, well over three dozen bills concerning care for the medically indigent were introduced. Again, it is possible to consider only the major proposals. To assist in evaluating these bills we have developed a set of four criteria.

B. Criteria

The first criterion is the number of the needy the program would cover. We argue that not ouly the aged require assistance; need is a question of size of medical bills relative to income, not one of age. Hence, restricting coverage to those over 65 is undesirable. A good program would recognize and grant assistance to the medically indigent regardless of age or other characteristics.

The second measure is the extent of benefits. These should not be limited by either type or amount. Aid should be comprehensive, including all the major categories of medical service: doctors, hospitals and nursing homes, drugs, and appliances. Excluding the physician, for example, as the Administration's plan would do, would leave unprotected those with large doctor bills and, at the same time, would encourage a wasteful use of hospitals, as people attempted to substitute the insured type of service for the uninsured. Nor should there be an overall quantity limitation on benefits, *e.g.*, 90 days of hospital care. Costs of the program should be restricted by use of initial deductions and co-insurance rather than by an upper limit on benefits. The argument against deductions (provision for the re-

24. Brewster, *op. cit. supra* note 17, at 10.
25. S. 3646, 86th Cong., 2d Sess. (1960).
26. Major Legislative Proposals 25.

cipient to pay the first of so many dollars of costs) and co-insurance (provision for the recipient to pay a certain fraction of the costs) is that some may not be able to afford even a partial contribution to their care. But restricting length of coverage would be far more burdensome to the sick; patients are even less able to pay after their illness has run for an extended period. If the program provides for 90 days of hospitalization and the individual requires 180 days of care, he will be left in an untenable position.

The rationale behind government assistance should be to provide care beyond what the individual can himself afford. Consequently, public funds should be spent on the large bills of the few, not the smaller bills of the many. If the plan is to pay only part of the patient's expenditures, government should assist with the cost of the last rather than the first unit of care. The justification for co-insurance is partly that it would reduce the public outlay and, more importantly, that it would prevent a wasteful use of medical resources by requiring the patient to assume part of the costs.

Third, the program should be equitably financed. We have argued that certain solutions—such as passing the charges of the non-paying to the paying hospital patient—are inequitable. The costs of a good program should be distributed according to ability to pay; that is, the individual's contribution expressed as a per cent of his income should rise with increasing wealth.

Fourth, the administrative costs of the plan adopted should be reasonable. As much of the funds as possible should be used to pay medical bills; overhead should be minimized.

C. THE ADMINISTRATION BILL

This proposal[27] which follows the suggestions of former Representative Aime Forand, provides payment for hospitals, skilled nursing homes, and home health services for those 65 and over receiving Social Security benefits. In the form presented to the last Congress, the bill provides up to 90 days of in-patient hospitalization in semi-private accommodations subject to a deductible provision of $10 per day for each of the first 9 days of care; up to 180 days of skilled nursing home service for those needing further care after hospitalization; home health services up to a maximum of 240 visits; and hospital outpatient diagnostic studies subject to a deduction of $20 for each complete study.[28]

One argument against this bill is that it would impose restraints

27. S. 909, H.R. 4222, 86th Cong., 2d Sess. (1960) (Anderson & King).

28. The maximum combined hospital and home nursing services would be 150 units of service per year. A "unit" would be either one day of hospital service or two days of nursing home service.

on the necessarily free doctor-patient relationship. Centralized administration, it is argued, is too bureaucratic, and too distant to be responsive to local needs. We are unconvinced that this approach would bring the "intervention of Washington in the doctor-patient relationship." The Government has always been discreet in its widespread contacts with the medical profession. Moreover, the bill lays a specific prohibition against interference by a federal official with the practice of medicine or in the selection, tenure, or compensation of any provider of services, or even against the exercise of any supervision or control over the latter. As the payer of bills, the Government would have the right to see that its money was well spent, just as the Blue Cross-Blue Shield and the private insurance companies have such rights today; but we doubt that this would interfere with the best medical practices.

With regard to the fourth criterion set out above, the program would appear acceptable—the administrative costs of Social Security have not been exceptionally high, and this extension would not add unduly to costs.

As for the other criteria, the proposal is not acceptable. As the plan restricts participation to the aged, it will not assist all those whose medical bills are high relative to their incomes. Excluded from protection are all those under 65, as well as those over 65 who are not covered by Social Security. There are many individuals in both excluded groups who are medically indigent; on the other hand, in a given year the vast majority, perhaps 80 per cent of those on Social Security, have financial resources sufficient to meet their outlays.[29] This bill would assist a large number with low priorities, while leaving unaided many whose needs are acute.

The proposal also falls short on the second criterion—comprehensive benefits. There is both a restriction on the type of service insured and on maximum benefits. Not covered are doctors' fees, private-duty nursing, and drugs provided outside of hospitals or nursing homes. These excluded items comprise roughly two-fifths of all medical outlays.[30] The individual needing help is the one with large expenses and few financial resources. His need is as great whether the bill is from a doctor or a hospital, and increases after he has been in a hospital for an extended period. Limiting benefits will cause hardship for many individuals. To save money, let coverage be restricted to those with the highest priorities; to promote efficient use of resources let co-insurance and additional deductions be introduced. In its present form the Administration bill can only result in a wasteful

29. *Medical Care Costs of Aged OASI Beneficiaries: Highlights from Preliminary Data, 1957 Survey*, in 22 Social Security Bull., Apr. 1959, p. 3.

30. Anderson, Collette & Feldman, *supra* note 6, at 4.

use of resources.

The third criterion was that of equitable financing. The proposed plan would finance benefits by an increased payroll tax. The Administration estimated the costs of the program at $1.06 billion for a full year's operation in 1962[31] and would raise the funds by increasing OASDI[32] deductions by 0.25 per cent for both employees and employers and by 0.375 per cent for the self-employed. In addition, the tax base would be raised from the first $4,800 of wages to the first $5,200.

Whether one regards Social Security deductions as compulsory insurance premiums or a tax makes little difference. Their immediate effect is to increase the purchasing power of the aged by reducing that of the employed. Musgrave estimated that in 1954 social security contributions came to about 4 per cent of income for those with income under $5000. The contribution then gradually fell to 1 per cent for those with incomes over $10,000.[33] Changes in the act since 1958 have increased both these percentages and the differential. Because workers with lower incomes pay a higher fraction of their salaries into Social Security, the burden on the employed of this assistance program is regressive. It would be more equitable to have the costs of the program distributed so that they increased with income.

Our criticism of the Administration bill can be summed up as follows: (1) it would cover many of those who do not need assistance, but more importantly, it would leave unprotected many who do; (2) it would provide the wrong type of benefits, paying the first dollar of medical expenditure rather than the last and restricting the kinds of services insured; (3) it would distribute the costs in a regressive rather than a progressive manner. Thus, even if this bill were passed, much of the problem would remain unsolved.

During the Second Session of the 87th Congress at least three bills were submitted differing from the King-Anderson Bill solely in minor details as concerns benefits and eligibility requirements. We shall not discuss these because the objections to them are the same as those raised with regard to King-Anderson.

D. THE BOW BILL

In the 87th Congress, Representative Bow sponsored a bill[34] providing those 65 and over with a tax credit or certificate of

31. Our own analysis shows this figure to be at least one-third too low.

32. Old Age and Survivors Disability Insurance.

33. Musgrave, *The Incidence of the Tax Structure and Its Effects on Consumption*, in FEDERAL TAX POLICY FOR ECONOMIC GROWTH AND STABILITY 98 (Papers Submitted by Panelists Appearing Before the Subcommittee on Tax Policy, Joint Committtee on the Economic Report, 84th Cong., 1st Sess., Nov. 9, 1955).

34. H.R. 10755, 86th Cong., 2d Sess. (1962).

up to $125 per year for purchasing one of two types of guaranteed renewable health insurance policies. Under one option minimum benefits were to include hospital insurance of $12 per day up to $1,080 in a year; ancillary hospital charges of $120 per year; convalescent hospital room and board of $6 a day up to $186 a year (following release from a general hospital); and finally compensation for surgery according to a fee schedule up to $300 in a year. The second option was to be a policy with deductions and co-insurance features; either a maximum deduction of $100 per year and a minimum life-time value of not less than $5,000, or a plan with a maximum deductible of $200 per year and a lifetime value of not less than $10,000. The individual was to be responsible for not more than 25 per cent as co-insurance. Policies of this latter type would provide comprehensive benefits including physicians' and nurses' fees, drugs, and other requirements. The plan was to be administered by the Treasury Department and financed out of general tax revenues.

Tax credit schemes have already proved themselves administratively feasible and inexpensive. Furthermore, financing through general tax revenues is considerably more equitable than increasing the regressive payroll tax on which Social Security is based. Musgrave's study of 1954 showed that the distribution of federal taxes is progressive, beginning with a 12 per cent rate for those with incomes under $2000 and rising to 33 per cent for those with incomes over $10,000.[35]

As to the question of numbers covered, the bill appears deficient. Those under 65, even if medically indigent, are excluded. Moreover, many of the poor risks over 65, precisely those with the greatest need for health insurance would find that they cannot afford adequate insurance even with the $125 per year credit. Further, benefits provided under the first option are inadequate. The current average cost of a day of care in a general short-term hospital exceeds $33 and surgical fees are often considerably in excess of $300. In the event of serious illness many would still find themselves unable to pay for adequate care. While less than ideal, the second option has advantages over most other proposals. Although still excluding many who require assistance and including many who do not, it would provide for those insured adequate protection when most needed—in the case of medical catastrophe.

E. The Javits Proposals

The Javits Bill has changed considerably since it was first introduced in the 86th Congress. In its original form[36] a system of matching grants from the federal government to the states was

35. Musgrave, *supra* note 33, at 98.
36. S. 3350, 87th Cong., 1st Sess. (1961).

envisaged. These, together with contributions from the aged themselves, were to be used to purchase approved health insurance policies. The aged insuree was to be given a choice between service and indemnity benefits. In current form[37] this bill has little in common with earlier versions. Financing is to be through increased Social Security taxes as in the King-Anderson Bill. Eligible would be everyone over 72 and those over 65 who either were receiving Social Security benefits or had personal incomes under $3000 for individuals or $4,500 for couples. Because of broader coverage than the Administration bill, additional financing from general tax revenues would be required. Eligible individuals may choose one of three options. The first provides 21 days of hospital care per year or, as an alternative, skilled nursing home services at the rate of three days of the latter for one hospital day; in addition, it would provide 12 days of physicians' services, up to $100 of ambulatory, diagnostic, laboratory, or X-ray services and 24 days of organized home health care services.

In the second option the individual must pay the first $125 plus 20 per cent of additional charges. But the federal government would pay 80 per cent of the costs on a maximum of 120 days hospital care, surgical services provided in a hospital, skilled nursing home services after transfer from a hospital, and organized home health care services. The final option provides for federal payment to an insurance carrier of premiums up to $100 per year on a renewable private health insurance policy that provides benefits which the Secretary of Health, Education, and Welfare determines to be of value not less than the value of benefits under the other two options.

Because of the "tripartite" nature of this bill it is difficult to evaluate. It is an improvement over the Administration bill in that it would include all the aged. Nevertheless, the medically indigent under 65 are still excluded. Financing would be primarily through the Social Security mechanism, a method we consider undesirable because it falls so heavily on lower income groups. As to benefits, the second option appears more attractive than the first, even though benefits are far from comprehensive. While covering initial expenditures, the first plan would leave the patient in dire straits in event of a serious illness. The third option caunot be evaluated without knowledge of how it would work.[38]

37. S. 2664, as amended May 2, 1962, 87th Cong., 2d Sess. (1962).

38. As of July, 1962, Senator Javits, with Senator Clinton Anderson, sponsored a "bipartisan compromise" bill. S. 3565, 87th Cong., 2d Sess. (1962). Attached as a rider to a welfare bill passed by the House, the compromise differs from the Anderson-King Bill in that those aged not eligible for OASDI benefits are brought in. Their costs are to be covered by general revenue funds. In addition, an option is to be provided in the form of allowing the aged a choice between Social Security benefits and enrollment in private health plans. See N. Y. Times, July 8, 1962, § 4, p. E9.

F. The Kerr-Mills Act

The Kerr-Mills Bill was the program which was accepted as a compromise by the 86th Congress and enacted into law.[39] The federal government agreed to assist the states in paying the costs of persons over 65, who, while not on public assistance, had financial resources insufficient to meet their medical bills. It was left to each state to decide on eligibility and on the type and quantity of services to be insured, but it was specified that benefits could not be greater than those provided through the public assistance program. To encourage action in both spheres, the act liberalized the federal government's contribution to the state's medical program for those on assistance. Washington's share of the costs range from 50 to 80 per cent depending upon the state's per capita income.

We approve the basic notion of this act; those who cannot pay their medical bills should have first priority on government assistance. We also think it right that the federal law did not specify an income limitation or establish quantitative or qualitative restrictions on benefits. However, the state legislatures are responsible for determining both eligibility and range of benefits and many have restricted these in ways which do not meet our criteria for a good program. In October, 1961, 21 states with programs provided hospital care. But only 12 provided payments for prescribed drugs or for physicians' services to hospital inpatients, while only 14 states covered the costs of nursing home care.[40] Perhaps the greatest disadvantage of the act is that it relies on the states for ratification and support. Our fears for any program depending on such action have been borne out by the fact that nearly two years after the act's passage, 22 of the 50 states had not established programs.[41]

During the 87th Congress, at least two bills were proposed which would have increased the personal income tax deduction for uncompensated medical expenses. Clearly these bills are not a solution to the problem. Probably most of those in need of assistance do not pay income tax and thus cannot benefit from such programs. Of those in need who do pay income tax, the increased deduction will at best compensate for only a small part of the medical outlays.

V. An Alternative Program

Ten years ago, Professor Harold Groves of the University of Wisconsin made a proposal to the President's Commission on the Health

39. 42 U.S.C. § 301-06 (1958).

40. U.S. Dep't of Health, Education and Welfare, The Health Care of the Aged, Social Security Administration, Division of Program Research 88 (1962).

41. Chase, *The Real Issue in American Medicine*, in The Progressive, May, 1962, p. 27.

Needs of the Nation. Unfortunately, his excellent approach has not received the attention it deserves, for in our opinion his program for aid to the medically indigent is superior to any yet proposed in Congress.[42]

The proposal would involve primarily an extension of existing tax laws. Presently, medical expenses exceeding 3 per cent of adjusted gross income are deductible from the income tax base. This provision allows only fractional reimbursements to those who pay income taxes, none for those who do not. Groves' suggestion with which we concur was to permit the individual to subtract from his *tax obligation* medical expenses exceeding a certain fraction of income. Where the allowed deduction is greater than the obligation, or where there is no obligation, the Government would grant a refund as in the case of an overpayment of taxes. The plan is completely flexible and could provide any desired amount of reimbursement up to 100 per cent.[43]

First priority for government aid should go to those who cannot meet their bills without assistance. Therefore, this program is not designed to protect people against everyday medical expenses, but against catastrophes. To cover the former, the individual would be free to purchase private insurance and to include the premiums as part of his medical expenses. Insurance benefits, however, would be subtracted from the costs eligible as a tax deduction. This feature would enable the individual to provide privately for his general needs, government assistance being granted only in case of financial difficulties.

As to details we would suggest that the individual be responsible for his own medical bills up to an amount equal to 15 per cent of his adjusted gross income, and for 20 per cent of the costs in excess of this. The federal government would pay the difference. Making the recipient responsible for part of the costs would discourage unneeded expenditures. An example would be as follows: with an adjusted family income of $1,500, and medical outlays of $500, the individual would have to pay the first $225 plus 20 per cent of the rest, totaling in all $280.

Financing would be in the form of a credit against income taxes. Our estimate of the costs of this program with an initial deduction

42. When we initially approached this problem we were unaware of Professor Grove's proposal and formulated our own scheme basically identical to his. In the discussion which follows, we refer to it as "our" plan because of the details in which it differs from that of Professor Grove's.

43. On September 22, 1961, Representative Johanson introduced a bill which would have allowed a tax credit up to $100 toward purchase of a "medical care insurance policy for the elderly." H.R. 9387, 87th Cong., 1st Sess. (1961). No payment to an aged insuree who did not pay income tax was stipulated. Since most aged do not pay income tax, little relief could be expected from this proposal. We mention this bill because it is the nearest we have seen to our proposal.

of 15 per cent and an 80 per cent government contribution is $1.56 billion. One way of making up the loss in tax collections would be to increase income tax rates in each bracket by 1 per cent. The estimate, it must be stressed, is a minimum figure based on current consumption patterns. It is quite likely that paying part of the bills of the poor would increase their use of medical services and similarly the costs of the program. But any of the proposed plans would have the same effect. As long as coverage is restricted to the needy this is a benefit rather than a drawback, for it indicates that the number not getting sufficient care has been reduced.

A more complicated, but possibly more equitable, program would be to schedule the rates to vary with income. Table 2 contains such a hypothetical schedule. We have assumed a 20 per cent co-insurance feature for all income levels, though this, too, could be varied.

Table 2

SCHEDULE OF DEDUCTIONS AND CO-INSURANCE RATES AT VARYING INCOMES TO BE USED IN DETERMINING INCOME TAX CREDITS FOR UNCOMPENSATED MEDICAL CARE COSTS

Adjusted Gross Income	*Deduction Rate as a Percentage of Income*	*Co-Insurance Rate as a Percentage of Income*
Under $2,000	5	20
$2,000-$3,999	10	20
$4,000-$5,999	15	20
$6,000-$7,999	20	20
$8,000 and over	25	20

In Table 3 we show the share of payment between family and Government at different incomes when the annual family medical bill is $1,000 in excess of that paid by present insurance. As can be seen, at very low income levels most of the costs are handled by the Government, but as the ability to pay increases, the burden is shifted to the family. Even under the suggested program the family's medical bills remain relatively heavy. They would be reduced by a smaller percentage deduction and co-insurance feature, but this, of course, would call for a larger government outlay. Our suggested programs—covering all of those in need—would cost approximately the same as the plans now before Congress.

Table 3

SHARE OF UNCOMPENSATED MEDICAL CARE COSTS BETWEEN FAMILY AND GOVERNMENT AT DIFFERENT INCOMES ACCORDING TO SCHEDULE OF TABLE 2

Adjusted Gross Income	*Deduction*	*Co-Insurance*	*Total Annual Uncompensated Medical Bills*	*Paid by Family*	*Paid by Government*
$1,000	$ 50	$190	$1,000	$ 240	$760
3,000	300	140	1,000	440	560
5,000	750	50	1,000	800	200
7,000	1,400	—	1,000	1,000	—
9,000	2,250	—	1,000	1,000	—

The approach outlined above meets our test of a good program. All those whose medical bills are high relative to income would receive government assistance regardless of age, but the Government would not be called upon to finance those who could afford their own medical outlays. Whether it was in the future found possible to liberalize the program or necessary to reduce it, with this approach priority would always be given to those most in need.

Benefits would cover all the areas of health expenditures—doctors, hospitals, drugs, insurance, etc. Whatever the source of his bills, the individual would receive reimbursement if the total costs were above the prescribed limits. This is advantageous because the source of medical indigence differs among individuals; some have high hospital bills, for others expensive drugs use up most of their income.

As we have argued above, financing either from general tax revenues or by increased rates on the income tax is more equitable than through Social Security. The overall United States tax structure is not very progressive, and we should be reluctant to reduce this progressivity by greater reliance upon regressive payroll taxes.

Administration of the program would be simple and could be carried out through the Bureau of Internal Revenue. Some people would have to file income tax forms who would not otherwise be required to do so, but under any plan of assistance, some kind of report would have to be submitted. A means test is involved, but one no harder to administer or more degrading than our present deduction against personal income for medical expenses. The Government would be no more implicated in the administration of medicine than is the insurance company today—that is, it would merely seek to prevent fraud and unreasonable charges. Furthermore, only a minimum of paper work for the doctor and hospital would be entailed, since it

would be the responsibility of the individual to deal with the Government. Thus, this plan satisfies our criteria for a good program; it covers the neediest in all age and income groups, provides comprehensive benefits, is equitably financed, and is both flexible and inexpensive to administer.

Another advantage of our plan is its great flexibility. By altering deduction and co-insurance rates, expenditures under the program can be controlled as desired. Moreover, as Table 3 shows, although this scheme would be a substitute for catastrophe plans provided by some companies, the middle and upper income groups would still have strong incentives to purchase health insurance, so the major market of the private insurance companies would not be damaged. With the financial problems of the low income, poor risk patients solved, insurance companies would be relieved of their major headache.

VI. Conclusion

Professor Milton Friedman of the University of Chicago once said: "You cannot save lives, only prolong them." While saving lives is beyond our capacity, the skills learned and the tools discovered in the last hundred years have enabled us to double life expectancy. Unfortunately, the funds necessary to purchase the benefits of modern medicine are often beyond the financial capacity of the poor. Today few in our society would deny the *right* of the individual to the medical attention he requires. And yet a minority of our population are not getting sufficient care, while others get it, but go bankrupt in the process. Probably remedial legislation will be passed in the current session of Congress. Let us hope that the action taken will not leave large areas of the problem still unsolved.