NATIONAL HEALTH INSURANCE PROPOSALS

HEARINGS

BEFORE THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-SECOND CONGRESS

FIRST SESSION

ON THE

SUBJECT OF NATIONAL HEALTH INSURANCE PROPOSALS

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NATIONAL HEALTH INSURANCE PROPOSALS

WEDNESDAY, NOVEMBER 10, 1971

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in the committee room, Longworth House Office Building, Hon. Al Ullman presiding.

Mr. ULLMAN. The committee will be in order.

Our first witnesses this morning are a group of distinguished physicians from the American Medical Association.

It is my pleasure to welcome back to the committee the chairman of the board of trustees, Dr. Max Parrott, who is an outstanding physician in my State, very active in the board of the AMA.

We are certainly very happy to have you here Dr. Parrott.

I would like to recognize my colleague, Mr. Schneebeli to make another introduction?

Mr. SCHNEEBELI. Thank you, Mr. Chairman.

I welcome Dr. Roth not only as a fellow Pennsylvanian but also as a very capable advocate of the position of the American medical profession.

We have had excellent testimony from you before, Dr. Roth and were very impressed. We look forward to your testimony today. Thank you for coming.

Mr. ULLMAN. We welcome you and your other colleague, Dr. Roth.

Dr. Parrott, you have been identified. Will you introduce your other colleague and proceed as you see fit, sir.

STATEMENT OF DR. MAX H. PARROTT, CHAIRMAN, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY DR. RUSSELL B. ROTH, SPEAKER, HOUSE OF DELEGATES; AND HARRY N. PETERSON, DIRECTOR, LEGISLATIVE DEPARTMENT

Dr. PARROTT. Thank you, Mr. Chairman and members of the committee. I want you to know before I start that the condition of my left hand was not gained by fighting. It was an elective operation.

Mr. ULLMAN. We are very happy to know that.

Dr. PARROTT. My name is Max H. Parrott. I am a practicing physician in Portland, Oreg. and I am chairman of the board of trustees of the American Medical Association. With me is Dr. Russell B. Roth of Erie, Pa., the speaker of the house of delegates of the AMA, and Harry N. Peterson, director of the AMA's legislative department.

We are pleased to appear today to testify in support of the Health Care Insurance Act of 1971, which has been sponsored by Mr. Fulton

and Mr. Broyhill. We are indeed grateful for this sponsorship as well as that of 158 other Members of Congress, including additional members of this committee. We believe that this legislation, commonly referred to as the medicredit bill, reflects a sincere desire to meet a pressing social need in a responsible and workable way.

Dr. Roth will discuss medicredit more fully in detail in his testimony. I would like to speak broadly and provide a realistic background against which you can weigh the merits of the many proposals for national health insurance that have been put before this committee.

HEALTH VERSUS MEDICINE: A DISTINCTION

It would be instructive, first, to identify and isolate some of the problems we are attempting to solve. We should keep in mind that medicine is relatively powerless before many of the major health concerns that trouble us all. This is not to say nothing can be done. But I do wish to emphasize, briefly, that approaches other than purely medical approaches can be more effective in raising the level of health in this country than staggering sums of money concentrated on the improvement of medical care. A distinction should be made between health objectives, which depend on preventive efforts, education, public health policy and research, and medical care, which is concerned with a physician's efforts to cure someone who is sick.

Let me give you some examples to highlight this distinction, to illustrate how some problems can be attacked through health care measures rather than medical care. Accidents in our homes, in our factories, and on our highways take more than 100,000 lives a year and send 8 million people annually to a hospital or a doctor's office.

Bear in mind this is the most highly industrialized country in the world. It is the mostly highly mobile country there is. And it may well be the most violent. Such factors not only affect our health statistics. They also place a great strain on our medical system and add tremendously to our medical costs.

The choice of lifestyle also plays an important role in our health statistics. The sum of many millions of individual decisions as to health habits and risks have a profound effect on our overall health standards. To give you just one example of the way life style rather than medical care can affect things, you might consider what's happened to our venereal disease rate. We know how to prevent venereal diseases. We know how to diagnose them, we know how to treat them, and we know how to cure them. Fifteen years ago we almost had them on the way out. But a changed lifestyle in a new generation has driven our venereal disease rates to the highest level since World War II. Venereal disease is pandemic in this country, despite proven cures and simple preventives. It is pandemic, not because of any failing of medicine, but because of a change in life style.

Medicine can ease these problems, and medicine is properly concerned with them. But, the point is this: No matter how drastic a change is made in our medical care system, no matter how massive a program of national health insurance is undertaken, no matter what sort of system evolves, many of the really significant, underlying causes of ill health will remain largely unaffected. They will respond to public education and to research as much as they will to any sort

of medical care program, no matter how well-intentioned or how generously financed. To tell the American people anything else is to mislead them.

Before turning to my next point, I should say a word about our organization and its membership. It is said that the number of our dues-paying members is only about half the number of physicians in the country. The truth is that not all physicians are eligible for membership in the AMA. Nor are all of our members charged dues. But, of the active, private practice, office-based physicians in this country, the men or women you usually see when you want to see a doctor, 82 percent of these people belong to the AMA. I might add further that informal polls of doctors taken by two publications independent of the American Medical Association, one the independent Medical Opinion and Medical Economics, indicate support for the legislative point of view we are advocating here today and by a substantial majority of these polls.

ACCESS, COST, QUALITY

Success in reforming, modifying, or improving any system of medical care depends basically on balancing three strong and competing dynamics. One of these is the desire to provide universal access to medical care, to make medical care available to all. The second dynamic is the desire to control cost. For many reasons, among them new capabilities for treatment, costs of medical care have risen sharply. Of this we are well aware. The third dynamic is the desire for high quality of care. High quality demands a high professional standard for both the physician and the health care team, and the technology available to them.

Now, when you devise a system of medical care and emphasize any two of these three dynamics, the two tend to work against the third. For example, a system which combines universality of access with very tight cost controls can easily affect the quality of care. This combination reduces quality of care mainly because it causes a shift in medical priorities; it diverts a finite number of medical man-hours away from the sick to the well or the worried-well. This created quite a problem for the Kaiser-Permanente plan, and I would like to read you something on the subject written by Dr. Sidney Garfield, one of Kaiser-Permanente's founders. I am quoting Dr. Garfield here.

> Elimination of the fee has always been a must in our thinking, since it is a barrier to early entry into sick care. Early entry is essential for early treatment and for preventing serious illness and complications. Only after years of costly experience did we discover that the elimination of the fee is practically as much of a barrier to early sick care as the fee itself. The reason is that when we removed the fee, we removed the regulator of flow into the system and put nothing in its place. The result is an uncontrolled flood of well, worried-well, early-sick, and sick people into our point of entry, the doctor's appointment, on a first-come first-serve basis that has little relation to priority of need. The impact of this demand overloads the system, and, since the well and worried-well people are a considerable proportion of our entry mix, the usurping of available doctors' time by the healthy people actually interferes with the care of sick.

Moving on to another combination of dynamics, let's see what happens when you link the quest for easy and universal access with a

desire to maintain quality of care. That combination of factors works against cost. This has happened in at least two instances I can think of. During the years 1950 to 1966 Sweden, under its system of government control and financing, increased health expenditures by 614 percent while ours were only rising 174 percent.

I would also call your attention to the rise in hospital expenditures in Canada under a compulsory hospital insurance program. Between 1950 and 1967 per diem hospital expenditures rose 213 percent in Canada compared to the rise here in the United States of 148 percent.

Both experiences strongly suggest that when you link a desire for universal access with a desire for at least good medicine the combination works against costs, even within the framework of tight, government controls. Containment of costs does not automatically result from government controls. To argue this way is far too simplistic.

Finally, if you link high quality with vigorous efforts to control costs, then there has to be pressure on access. This may explain what has happened to medicaid in many States as deductibles have been put in effect or as the income levels for those eligibile have been raised.

The search for a perfect health care system, an ideal harnessing of the three dynamics, a magic troika, if you will is not impossible. But a system that encompasses universal access, low cost, and high quality is difficult. No one that I am aware of has melded all three dynamics harmoniously and applied them successfully to a broad, across-the-board population base to the satisfaction of all, consumers, doctors, and cost accountants. It is for this reason, I think, that we have evolved a pluralistic system of medicine in this country, and I feel we should continue with this pluralism, this diverse approach, until there is clear evidence that something will work better.

Mr. ULLMAN. Dr. Parrott, you said that the combination of the three was not possible but your text said that it was possible.

Dr. PARROTT. It is possible; yes, sir. Thank you for correcting that. I think it is possible. It is difficult is the point I wanted to make.

MEDICREDIT

This philosophy underlies our own medicredit proposal for national health insurance encompassed in H.R. 4960. Medicredit replaces most of medicaid, virtually removing the economic barriers between the poor and good medical care. It provides incentives for everyone to seek health insurance and provides generous benefits to middle income families. And it protects everyone against catastrophic costs. No family should have to suffer a financial disaster because of an accident or illness.

Most important, medicredit preserves the flexibility of our medical system, the freedom so necessary to innovation, to evolution, and to experimentation. It avoids the mistake inherent in proposals such as H.R. 22, which would lock medicine into a rigid, monolithic, no-choice, bureaucratic system before there is any real evidence that it would make things better.

Medicredit, while expensive, would be affordable. The Federal cost would be some $15 billion a year, far less than H.R. 22 which under the guise of free medicine, would cost at least $60 billion a year. H.R.

22 would tax the average American family $1,271 a year according to one HEW estimate.

A vast, monolithic, federalized health care system such as envisioned in H.R. 22 could easily warp our social priorities, take funds from programs for housing, education and welfare, establish a new bureaucracy, and create new, and highly unpredictable costs. It would be a creation almost impossible to change, a decision almost impossible to reverse, an undertaking full of early promise but empty of lasting benefit.

THE PLURALISTIC APPROACH

What has evolved in this country is a pluralistic system of medicine, just as we have a pluralistic educational system, a pluralistic agricultural system and a pluralistic economic system. And it is no wonder, for our country is a unique country. It is continental in size, varied as to climate and heterogeneous in background, with a population partly indigenous but drawn also from Europe, Latin America, Africa, and Asia. We have population areas of high density and we have counties where the population density is less than one person per square mile. Medicine has to meet diversive needs in diverse ways, for what works in rural Alabama may not work in eastern Oregon, and what is efficient in urban Newark may not be efficient in urban Los Angeles.

Those who criticize our system of medicine imply that it is static and must be replaced. Let me call your attention to some of the salient accomplishments of our pluralistic medical system, accomplishments that are often obscured in the radical chic, by a disaster lobby which stridently proclaims the need for revolutionary change.

Probably our highest achievement is in the quality of medical care in this country. The world standard of medicine is here. American medical schools produce men and women with the best medical education there is in the world. Our technology is unsurpassed. The ranks of allied medical manpower continue to grow in terms of both size and sophistication of training.

STRENGTHS, ACHIEVEMENTS, AND PROGRESS

Success, may I remind you, can never be complete in medicine, because we are all mortal. But we have made dramatic strides in increasing the number of years of useful life. Let me mention a few: Intensive care facilities and new surgical techniques prolong the lives of heart disease victims. We have in this country developed the most sophisticated cancer detection procedures that exist and we have led the advance in using high energy physics for the treatment of cancer.

In dealing with accidents, we do better than anyone in repairing the human damage, in mending the wounds, in physiotherapy, plastic surgery, and skin grafting. The new knowledge about the physiology of the kidney and the management of kidney failure have come from American medicine and research. New techniques of anesthesiology have originated here that have increased the safety factor in all types of surgery. Amniocentesis—diagnosing genetic defects of babies still in the womb—is a product of American medicine. Vaccines that have virtually eliminated polio, and new therapeutics, especially the steroids, like cortisone, have emerged in the context of our pluralistic approach to medicine and medical research.

Maybe I should say a word about infant mortality since that is frequently, though incorrectly, offered as an index of how efficiently a nation's health system functions.

First of all, it is idle to argue whether it is the quality of medical care or the quality of a child's environment that is the more important factor in infant mortality. These cannot really be separated. No matter how good the medical care system is, mortality rates cannot be lowered below a certain point unless improvements are made in the social environment.

Nonetheless, you might consider the U.S. record in infant mortality.

In 1940 there were 47 infant deaths per thousand live births; in 1950, 29.2; in 1960, 26; and in June 1971, 19.2.

That is better than a 25-percent drop just in the last decade.

We might look briefly at longevity, also. In 1940 the life expectancy of a child born in the United States was 62.9 years; in 1950 it was 68.2; in 1960 it was 69.7; and today it is 70.8 years.

Such figures argue, and argue cogently, that American medicine, our pluralistic, evolving, pragmatic system, is changing things for the better, that we are making progress. We are making dramatic progress in many areas, and Americans born today, both black and white, are not just living longer than their parents, but growing bigger and living longer than their older brothers and sisters.

EDUCATION AND COSTS

Change and progress can be observed in other areas, too, areas that relate more directly to the problems that are of immediate concern to this committee.

Not too long ago a medical education fell into rather neat compartments, 4 years of undergraduate work leading up to a bachelor's degree, 4 years of medical school leading to a M.D., then a year as an intern sometimes leading to practice and sometimes leading to another 3 to 7 years in residency before the person practices.

The once visible dividing lines are blurred today. Some students now complete in college the basic science training once given in medical school. Others now enter what used to be part of the internship while still in medical school. What is taking place is an almost revolutionary telescoping of the traditional medical education. And the result, under many programs, is a physician equally or better trained than his predecessors but with a year or 2 years or sometimes 3 shaved off the time that it took for him to become a doctor.

Simultaneously, there has been a sharp growth both in the size and number of medical schools. In 1967 there were 89 medical schools in the United States with a first year enrollment of about 9,000 students. This fall there were 108 schools, 20 percent more, with a first year enrollment of 12,000 students. By 1975 with 10 or more new schools opening their doors, five of them next fall, the enrollment should come to 15,000. This is probably a conservative estimate.

Now and in recent years we have been sharply increasing our physician population, adding some 8,000 doctors a year net, constantly increasing the ratio of physicians. The physician population of this country is growing at a rate more than double the general population rate.

As you know, special health manpower legislation, already passed by the House and the Senate, will provide even greater impetus to medical education. The conference report resolving the differences between the House and Senate action has already been approved by the Senate, and I understand that yesterday it was approved by the House. This legislation will provide greatly expanded training capability for physicians and other health personnel. It will carry greater funds for operation of medical schools, special assistance for schools in distress, and start-up funds for new schools. This legislation provides incentives for schools to shorten their curricula, thus enabling physicians to be trained in a shorter time. It provides increased financial assistance to students through larger support for scholarships and loans, and it carries financial incentives to encourage students to be recruited from shortage areas and, hopefully upon completion of their training, to practice in shortage areas. It provides special assistance for the training of family physicians, for the training of physician's assistants, and for a veriety of innovative training and health delivery projects.

I think it should be part of the record that the AMA has vigorously supported this legislative response to the manpower problem. As your colleagues will tell you, we have raised a strong voice in urging the passage of this legislation.

Next to questions about the number of doctors, the issue uppermost in the public mind is probably the matter of cost. Here again I think you should be aware of some things the profession itself is doing in response to the need for better controls. Again, I want to call your attention to some of initiatives that have been undertaken already, some of the ways in which our pluralistic system is responding to its challenges.

PEER REVIEW

The broad principle involved is peer review, practicing physicians evaluating the quality and efficiency of services rendered by other physicians. Peer review is the means by which doctors themselves can question the necessity, quality and cost of a medical procedure. Peer review works in many ways and has for some time, and I might add that peer review is an innovation of the physicians of this country and innovations are still being made by them.

I want to draw your attention to a somewhat new and rapidly spreading application of peer review. This is the medical society foundation, which offers highly visible means of controlling costs. Foundations can and are screening hospital admissions. Other procedures work to reduce the number of days a patient stays in a hospital. Some foundations screen claims for commercial insurance programs, and when claims go beyond predetermined norms, the computers reject them and flag them.

These claims then become the subject of peer review. Here physicians can examine all the circumstances and make the determinations that, in the long run, only physicians are qualified to make.

Medical society foundations are not all alike. They serve different communities in different ways, and there is no standard model of a foundation which can be applied universally. Yet they have proven effective in many localities. Foundations may not be the total answer

to cost control. But they do represent an answer. They give further evidence that our pluralistic system is responding to changed conditions, to new needs, in this case, the need to control rising costs.

To sum up now, I do not want to suggest to this committee that our present system of health care is perfect. It is not. It needs modifications and change. And it will serve people better with the kind of Government-supported health insurance we propose in our medicredit bill.

On balance, we have a medical system with impressive accomplishments, a system that is flexible and innovative, a system responsive to the need for change and improvement. In whatever kind of action this committee chooses to make, the American Medical Association strongly urges that you build on the very real strengths that now exist.

Mr. Chairman, this completes my testimony.

I would now like to call on Dr. Russell B. Roth, speaker of our house of delegates.

Mr. ULLMAN. We would be happy to hear from you, Dr. Roth.

STATEMENT OF DR. RUSSELL B. ROTH

Dr. ROTH. Thank you, Mr. Ullman.

I should like first to discuss the point of view of the practicing physicians who will be taking care of people under any program for the provision of medical services which may be devised. I am such a physician, engaged in private group practice.

It is our deep conviction that there are limitations to the capacity of our profession, as it now exists, and as it may be augmented in the near future. Sound planning cannot be based on promises which cannot be kept. By the same token sound planning cannot be based on misconceptions as to the facts of medical practice, nor on medical mythology which has seemed to dominate important aspects of some of the proposals which are before you.

Criticism is frequently leveled in some quarters at the American system of medical care, and various proposals call for a radical departure. References are made to such matters as emphasis on health care rather than sickness care to new technologies that must be installed, and distribution of physicians into ghetto and rural areas.

PREVENTIVE MEDICINE

First I should like to comment on the notion that it is practical or possible to try to restructure the practice of medicine so that there will be emphasis on health care rather than sickness care, and that this may be accomplished by the application of economic leverages.

Preventive medicine is not a new concept. Most physicians are trained to diagnose disease and to treat it, and inevitably, as they deal with individual patients, they do practice and preach preventive medicine. No one, as yet, has pointed out what it could be that the dermatologist, allergist, urologist, neurosurgeon, or orthopedist should do differently under a restructured system. An orthopedist can scarcely ignore his waiting room full of sprains, fractures, and dislocations while he preaches accident prevention. The idea of the legendary Chinese physician who was paid to keep people well is charming, but irrelevant to the fact of life in an age when there are so many useful things to do for people.

Multiphasic health screening, as an adjunct of preventive medicine, is an exciting development in the application of new technologies to the health care field. Techniques of computerization of the recording of medical histories, the use of multichannel analyzers for rapid economical laboratory testing, and the newer developments in electrocardiographic interpretations, plus many other existing or potential additions to the list occupy a great deal of professional attention. The Kaiser program has been pioneering in this field, along with significant projects in industry, in private groups, and in university centers. It impresses us that this new science will mature more rapidly in unrestricted development than under a system circumscribed by the allocation of restricted governmental funds.

It is undeniable that multiphasic health screening has as a long-range goal early diagnosis and economies to be realized through the avoidance of the necessity for treating advanced and extended illness and disability. The short and intermediate terms, however, hold no promise of economy. Quite the reverse. The sophisticated equipment is expensive. New personnel must be trained and employed to operate it. The yield, if the approach is successful, is a significant influx of previously unsuspected disease to be treated as an addition to the burden of already recognized illness.

One should not confuse automated multiphasic screening, which promotes early diagnosis, with preventive medicine. It is true, however, that the individual undergoing the screening process is often an ideal candidate for supplementary health education, and this too is being developed.

It seems certain, however, that all of this is a development which dones not require national health insurance as an economic base. It will progress as a part of what has been called our superindustrial revolution.

SHORTAGE AREA PROBLEM

A mythology has been built up around the motivation of physicians and should be examined. The facts which require examination are that there has been a flight from practice in center city slum areas, from small rural communities, and in truth a flight from the general, primary, family type practice which used to prevail. Quite contrary to most of the allegations, physicians who have been engaged in practice in the center city or the rural areas have left and continue to leave in spite of lucrative practices and good incomes. The usual switch is to a lower income level, in speciality training, research, teaching, occupational or administrative medicine, or simply to premature retirement. There have been many tries to offer economic inducements to physicians to reverse the flow, ranging from free rent, and subsidies of all sorts, to forgiveness of loans. None of these has worked very well. Tradeoffs against potential military service are now being tried. But too little attention has been paid to why doctors move out once they are there, or decline to go there in the first place. Dollars are not the explanation.

The center city has become a depressing, dangerous place to live. Few physicians with their wives and families are insensitive to the environmental disadvantages of the slum, the threats to safety of person and property, the problems of educating the children, schoolbusing drug culture, and the like.

Many rural areas likewise lack educational facilities, as well as the opportunities for cultural activities, professional associations, and modern social exchanges. In both setting the physician finds himself subject to unremitting patient demand from which he finds it very difficult or impossible to escape. His life is not so much one of a 50-, 60-, or 70-hour workweek as it is a 24-hour, 7-day week of unrelieved duty status. He decides that there has to be a better deal.

No slogan, no change in the manner in which the doctor is paid, is going to get at the root of the problem. It is better by far to experiment, innovate, and adapt. Community health centers, satellite clinics, group practice arrangements, suited to the needs of the individual situation, the population involved, and the providers of service stand far more chance of success than does any centrally mandated program. In the rural areas maximal use must be made of improved transportation and modern communications. In both settings new kinds of allied health personnel will play valuable roles in the solving of problems. It should be noted that medical schools and medical societies, in conjunction with hospitals, voluntary health agencies, and the many other cooperating organizations of the regional medical programs are already involved deeply in pilot studies, demonstrations and experimentation in these fields. New legislation would be far less appropriate than support of existing mechanisms. Nothing in any of the existing proposals for national health insurance seems more promising than pursuit of the widespread efforts already underway.

The essential ingredient in any plan for the provision of medical service is enthusiastic acceptance by physicians. This is a lesson which can be learned from looking abroad. Let me quote from David M. Cleary, the distinguished science writer for the Philadelphia Bulletin, who last year spent time in Europe studying a variety of their national health insurance plans. Mr. Cleary has written—

> The most important part of any health care plan, say European planners, is the attitude of the medical profession toward it, since it will be the doctors who must make it work, or can cause it to fail. The biggest task before the United States in its development of national health insurance, the European authorities say unanimously, is to produce a package physicians will accept. Mere grudging acceptance isn't enough, they emphasize. The really good plan is one that the doctors will accept enthusiastically and work at diligently.

So much for the quotation. It would seem that in order to achieve maximum benefits for beneficiaries of any program it should be fashioned to assure fullest cooperation from all its providers.

COST CONSIDERATIONS

Then, of course, there is the thorny matter of the economics of medical care. This is a poorly understood field, and the few economists who have concentrated upon it freely caution against transferring standard economic dicta to the medical care marketplace. The role of the physician is quite unlike the role of almost any other professional when one fits him into the supply side of the usual economic equation, since he acts in a significant sense as the purchasing agent in behalf of his patient, exercising substantial control over the demand for the bulk of the goods and services of the health industry.

In Federal programs, as well as in certain private programs, there has been a focus upon physician fees with the imposition of freezes at

specified payment levels, and an application of arbitrary percentiles on allowable fees. This has accomplished extraordinarily little except to annoy a multitude of physicians. Approximately 13 cents of the medical care dollar ends up as physician income. Even if payments to physicians could be decreased across the board by 5 percent the resultant reduction in medical service costs would be less than seven-tenths of 1 percent.

Meanwhile little has been done to exercise controls on hospital costs, other institutional costs, and administration costs, and those are the areas in which physician cooperation and understanding would be far more desirable than physician estrangement.

Physician fees suddenly increased after the passage of medicare. Interestingly enough figures from the U.S. Bureau of Labor Statistics showed an initial 8.3-percent increase in physicians' fees, which actually masked a 24-percent increase for the one doctor out of three who raised his fee at all, usually by about $1.

In the first few years of medicare, physicians' fees stood out beyond other components of the cost-of-living index, except, of course, for hospital charges. But now many other things has surpassed the 10-year increase rate for physicians. The increase has been greater in the cost of papering a room, shingling a roof, hiring a laundress, or going to a movie to name a few. It is clearly untrue that physician fees are out of line with the rest of the economy.

There has been a spurious assertion that under a restructured system of medical care delivery it would somehow be possible to provide much more preventive and therapeutic care for a great many more people, to be provided by substantially increased number of well-paid physicians and allied health personnel, and to spend no more than is now being spent. This flies in the face of experience and commonsense.

Next it is worth noting that some planners have identified the private insurance industry as being the root of the fiscal trouble in our health care system. We believe that the insurance industry is quite capable of defending itself on that score, but we confess concern over the thought that the employees of a private competitive industry are to be replaced by Government employees in a vast new bureaucracy, of a size that we can only conjecture, with complicated new duties to negotiate in advance with all providers of services concerning budgets, salaries, charges, and the like. Here we would not try to enunciate a principle but would simply recall an old maxim about frying pans and fires.

FOREIGN PROGRAMS

Next, I must comment on what I would call the "greener pastures" approach to medical care planning. Planners so afflicted look abroad to Sweden, Holland, Yugoslavia, or Great Britain. It seems rare for anyone to compare or contrast our medical care with the foreign country that has size and population somewhat akin to ours, and in which all the proposals of our critics have been carried out. That is Russia, where there is a ratio of physicians to population which is roughly double ours; where the profit motive has been so completely removed from medical practice that an airline hostess makes more than a young practicing physician; where there is a tax-paid group ambulatory out-

patient care as the general pattern, and where all the mass communications media—radio, television, Pravda, Izvestia and the rest—preach incessantly to the populace that they have the finest medical care in the world.

Russia, however, is not generally picked for invidious comparison because in spite of all these things their infant mortality is worse than ours and their life expectancy no better. The "greener pasture" people concentrate on a statistic, usually infant mortality. It makes no difference that they are dealing with a small country of rather homogeneous racial characteristics, little poverty, and with abortion available on demand. It makes no difference that, in Sweden for instance, tuberculosis mortality may be worse than ours, as are deaths from ulcers or pneumonia. It makes no difference that the inflationary element of health care costs has far outpaced ours. Sweden is far away, and one may play delightful statistical games. There is much more to be learned from a study of our own statistics, derived from areas of good experience and bad experience in order to identify the factors which can be modified.

If one looks at statistics in respect to the producing of physicians in the Philippines one finds that some 53 percent of the total number of registered Filipino physicians are not practicing medicine at all but have dropped from the labor force or have switched to other lower level occupations for lack of securing satisfactory employment in the medical profession. Notwithstanding an abundance of physicians, one must also remember that the Philippines, in their "out" islands, have a severe lack of physicians.

To be practical one might propound a principle that medical service problems in the United States are peculiarly American, and it may be seriously misleading to seek our solutions abroad.

HMO

We have studied intently the concept embraced in the new slogan, health maintenance organization. Since virtually all of the descriptions of what is meant by an HMO stress that it may range from a Kaiser-Permanente prototype, complete with its own professional staff, hospitals, and the like, through looser organizations such as HIP of Greater New York which subcontracts with outside institutions, and on to a basis of medical society, hospital staff, or even less formal confederations of providers, we can only say that we have always approved of innovation and experimentation.

It should be noted that our financing proposal, the medicredit bill, includes the option of beneficiary enrollment in such prepaid plans if they meet the criteria of approval of State insurance commissions.

In general, it has been inherent in the prepaid group practice approach that there be available to the potential enrollee a choice of coverages. We also favor this, and it implies that medical practice shall not be frozen into a single pattern, as has so often happened abroad. The loss of a competitive factor in our estimation would be bad. Results in terms of quality, efficiency, and economy could scarcely be assessed if there were no other patterns with which to make comparisons.

Our misgivings are based on the fact that no evidence exists to prove tha tthis type of organization guarantees greater accessibility of care,

or better use of scarce professional talents, or that there are adequate safeguards against underutilization. Paramount importance must be attached to the competence and integrity of the administrators of such a program and the physicians working within it. Given this high level of competence and integrity there is nothing to suggest that other organizational forms do not function as efficiently and economically.

AUXILIARY PROGRAMS

The American Medical Association believes that it has a sound overall program for accelerated progress toward the achievement of the agreed upon goal, the day when artificial bariers shall no longer stand between people needing professional medical service and those competent to provide it.

Ours is a program with many elements, attacking many barriers.

In every instance it builds upon the solid accomplishments of the past. It does not promise what cannot reasonably be delivered.

It approaches our manpower problems by supporting legislation which would enable existing schools to survive and enlarge their enrollments, as well as favoring the development of new schools. And in respect to allied medical personnel it is working diligently to construct standards for educational requirements, certifications, and the like to avoid a deluge of inadequately trained paraprofessionals.

It approaches the education of the public through extensive use of the mass communications media, seeking to reduce accidents, improve the environment, and to warn against overeating, oversmoking, overdrugging, overdrinking and underexercising. Its programs on emergency medical services have been making and continue to make significant contributions.

It approaches continuing medical education through promotion of refresher courses and its multiplicity of top quality professional scientific publications, as well as its convention programs, seminars, and the rest.

The AMA champions peer review as the only promising method for application of quality and cost controls and has held regional and national conferences on it, together with the publication of relevant literature.

Constituent and component medical societies are working with enthusiasm in experimental innovative programs applying the principles of peer review. Pending before this Congress is H.R. 8684, our Peer Review Organization Act. This bill, sponsored by the AMA, would provide a system of review of need, cost and quality of medical services provided in Federal health programs. There are many other things that the AMA has been doing and continues to do while others debate and philosophize.

MEDICREDIT

At this point, I want to turn to the medicredit bill, which addresses itself to the important problem of financing health care.

Under its basic coverage, medicredit offers comprehensive benefits in respect to hospital inpatient, with availability of extended care services, and outpatient services, as well as full physician services. It also offers catastrophic coverage, including full hospitalization and additional extended care, with a continuation of outpatient services

and full physicians' services, designed to prevent those few but highly visible disaster cases in which massive medical care costs may exhaust the resources of even the well-to-do.

It puts these benefits within the reach of all Americans under age 65 as a prepaid insurance package. The benefits are uniform for all citizens under the program. For those with little or no income, the cost would be borne by the Federal Government from general revenues. For those with a capacity to pay part of the costs, the program is realistically geared to encourage them to do so.

The motivation for participation would, we believe, be especially strong because of our incorporation of tax credits. It would cover most services now authorized under medicaid. The details, in respect to scope of benefits and range of financial eligibility for full or partial subsidy, are not inflexible. They may be scaled to the willingness of Congress to assume the financing responsibility for those with limited means.

The important principles are that medicredit builds upon the outstanding accomplishments of American medicine which has shown a capability of being the best in the world. It reaches gaps and inadequacies in a constructive way. And it can be put into operation now. It has no dependence on untried theory or dubious economics. It does not require an unreasonable expenditure of Federal dollars, and it would not jeopardize the funding of other vitally necessary programs to improve the Nation's health. It places emphasis on greater financial support for persons needing this assistance. It does not create an unreasonable, unrealistic and burdensome administrative bureaucracy.

With that general description, let me now describe a bit more fully what medicredit does:

It is a program to give every person in America under the age of 65 equal access to high quality medical and health care regardless of ability to pay.

Without disturbing the present medicare program for the elderly, covering services now provided under medicaid for the poor and near poor, it makes available to everyone under 65 a private program of comprehensive medical and health care protection, covering both the ordinary and the catastrophic expenses of illness or accident.

The protection may be in the form of a health insurance policy from a company; membership in a prepayment plan such as Blue Cross and Blue Shield; or membership in a prepaid group practice plan. Choice of the kind of protection desired is made by the family or individual; not by anyone else. All programs offered under medicredit would be approved by the respective States to assure that benefits meet the national standards.

Payment for the private programs of health care protection would come wholly or partly from the Federal Government, depending on the financial condition of the family or individual.

For persons of low income who are unable to buy protection for themselves and their dependents, the Federal Government will pay the total cost of the premium or membership. For persons whose income is higher, the Federal contribution is reduced along a specified sliding scale; as income rises, the Federal contribution diminishes. Every family, however, is eligible for at least a small amount of Federal contribu-

tion to provide an incentive for them to protect themselves with an approved policy or plan.

The complete bill is available for your study, so I will provide only limited additional details. And we have also appended to this statement, for your convenience, a brochure containing a rather complete explanation of the proposal.

Each approved insurance program under medicredit must provide payment of expenses for inpatient care in a hospital or extended care facility; outpatient and emergency care; and physicians' services wherever they are provided. In addition, there is a provision for catastrophic coverage which pays additional expenses beyond those in the basic coverage.

In each case under the basic coverage, the hospital services for which the program pays include all of the services customarily provided, including drugs, supplies, specialized rooms, all forms of care and all needed services.

Under the basic coverage part of the program, inpatient hospital or extended facility care covers 60 days, with 2 days an the ECF counting as only 1 day. For persons who need additional care as an inpatient, the catastrophic coverage portion of the program pays for unlimited hospital days and 30 extended care facility days. Medical services would of course continue under the broad basic coverage.

Catastrophic coverage also extends benefits of outpatient or emergency care to include blood and plasma, after the first three pints, as well as prosthetic aids ordered by a physician. The Federal Government pays the premium for catastrophic coverage for everyone. The Government pays for all or a part of basic coverage depending on the financial condition of the family or individual, measured by Federal income tax liability. If a family owes no income tax, the Government pays the entire premium. As a family's income tax liability rises, the Government contribution reduces from 99 percent to 10 percent, remaining at 10 percent for everyone whose tax liability is $891 or more.

As the income tax liability rises in $10 increments, the corresponding Federal contribution toward basic coverage decreases by 1 percent.

Naturally enough, any broad-coverage insurance policy, prepayment plan or membership group offering as many benefits as those offered under medicredit's approved programs must have financial safeguards built into it. The medicredit deductibles and coinsurance are small, compared with the benefits, but they serve very important purposes. Primarily, they keep the total cost of the program lower. And second, they discourage abuse or overutilization of the program, either by patients or physicians.

There are deductibles and coinsurance in both the basic and catastrophic coverage, but it is important to note that those incurred under basic coverage apply to the deductible corridor required under catastrophic coverage.

Under basic coverage, the patient pays $50 per stay in the hospital as an inpatient. Second, the patient pays a coinsurance of 20 percent of the first $500 of expenses for outpatient or emergency care; and 20 percent of the first $500 for physicians' services. The coinsurance limit applies to the family as a unit.

Persons who need the additional help of hospital or extended care facility catastrophic coverage are required to satisfy a deductible "corridor" of expenses after basic coverage runs out. The size of the corridor is based on the family's taxable income, being 10 percent of the first $4,000; plus 15 percent of the next $3,000; plus 20 percent of any additional taxable income.

In conclusion, the American Medical Association is a responsible organization of responsible professional people dedicating its energies to professional and public education, the upholding of standards of quality, and the advancement on all fronts of the art and science of medicine for the public good. Along with its constituent and component State and county medical societies it strives to enable physicians to discharge those broad societal obligations with which individuals are virtually powerless to cope.

Since part of this responsibility lies in giving public expression to convictions as to what may be constructively achieved by legislation, what may be adversely affected by legislation, and what is not amenable to legislative remedy at all, it has of necessity entered into public debate and the giving of congressional testimony. It has welcomed these opportunities, and it is pleased that there has been widespread approval of its position. It is neither surprised nor dismayed by inevitable opposition from those whose views may differ and who may find the AMA views either too liberal or too conservative. It is our hope that you will find our considerations helpful in your difficult task.

Mr. Chairman, both Dr. Parrott and I want to thank you on behalf of the AMA for this opportunity of expressing our views on the subject of national health insurance. Let me assure you and this committee that the physicians of this country want only the highest quality of health care possible to be available to all our citizens, and we want promises to be capable of fulfillment. We urge your full consideration of the medicredit bill before you, and we sincerely offer our assistance to you in your deliberations on the important subject matter before you.

Thank you.

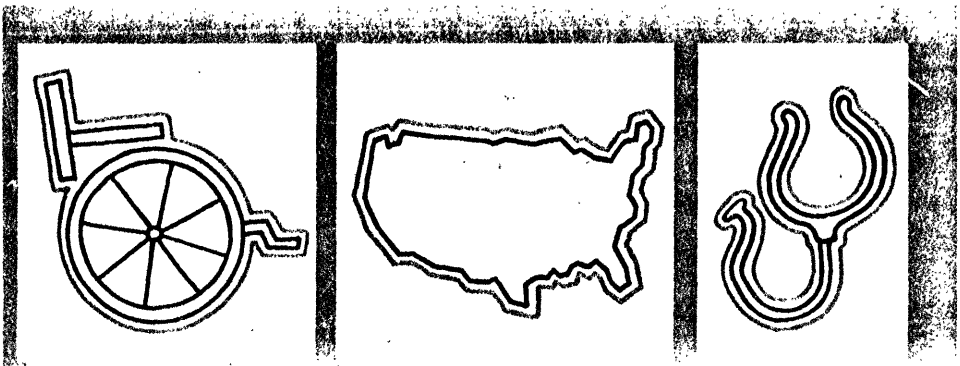
Mr. ULLMAN. Thank you Dr. Roth and Dr. Parrott for very fine, well thought-out statements giving your opinion on this important matter.

The supplemental material you have included contains good information so I ask unanimous consent that the essential parts of this bulletin be included in the record at this point.

(The supplemental material referred to follows:)

1965

MEDICAL & HEALTH CARE FOR ALL



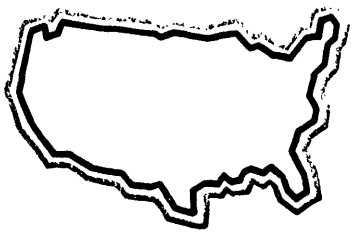
A Description of the Medicredit National Health Insurance Program

American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

1966

It is a basic right of every citizen to have available to him adequate health care; it is a basic right of every citizen to have a free choice of physician and institution . . .; the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person . . .
Health care for the poor should not be disassociated from, but rather should be a vital part of, the over-all health care system.

Policy adopted by the
House of Delegates
American Medical Association
December, 1969



WHY NATIONAL HEALTH INSURANCE?

The policy statement on the opposite page affirms the American Medical Association's long-standing conviction that no citizen of this nation should lack adequate medical and health care because of economic, social or any other reasons.

The AMA clearly recognizes that a significant segment of our population does not share in the over-all national affluence and the impressive advances made in business and industry, science, education, social welfare and most other elements of American life.

But it does not want a special, separate program just for the poor and disadvantaged. The AMA knows they are not the only ones with problems. It recognizes that advances in science and in medical and health care techniques, along with inflation throughout our economy, have driven up the cost of care to the point that even a person of moderate to good income can be left economically drained or seriously in debt after a long or severe illness.

The answer is to make sure that high quality medical and health care are available to every person by removing economic barriers that already exist for the poor, and that can quickly be erected against others by just one catastrophic illness.

The barriers can be removed (and prevented) by passage of a national health insurance program titled the "Health Care Insurance Act of 1971" and commonly called "Medicredit."

SUMMARY OF MEDICREDIT

Medicredit is a program to give every person in America under the age of 65 equal access to high quality medical and health care regardless of ability to pay.

Without disturbing the present Medicare program for the elderly, but replacing Medicaid for the poor and near-poor, it makes available to everyone under 65 a private program of comprehensive medical and health care protection, covering both the ordinary and the catastrophic expenses of illness or accident.

The protection may be in the form of a health insurance policy from a company; membership in a prepayment plan such as Blue Cross-Blue Shield; or membership in a prepaid group practice plan (in which the patient pays a fixed fee per month or year and receives medical and health care as needed from physicians practicing in that group). Choice of the kind of protection desired is made by the family or individual. All programs offered under Medicredit will be approved by the respective states to assure that benefits meet the national standards.

For persons of low income who are unable to buy protection for themselves and their dependents, the federal government will pay the total cost of the premium or membership.

For persons whose income is higher, the federal contribution is reduced along a specified sliding scale. As income rises, the federal contribution diminishes.

Some things Medicredit does not do:

It does not require restructuring the entire health care system, which provides care very well for the vast majority of Americans. Some of the other programs before Congress would dismantle what now exists and rebuild it along untried lines.

It does not hold up group practice—or any other form of medical practice—as the best or only effective system of patient care. Medicredit permits flexibility and innovation in developing new, more efficient ways to take care of people. It permits free choice of physician by every patient, and free choice by every physician as to how he will conduct his practice.

Finally, Medicredit does not obligate the government—the nation's taxpayers—to pay for care of people who can afford to handle most of their medical problems themselves. The cost of Medicredit has been estimated at $14.5 billion for the first year—considerably lower than nearly all other national health proposals. This estimate does not take into account savings from reduced Medicaid expenditures. Nor does it consider savings to the federal government because of reduced income tax deductions for individual medical expenses.

DETAILS OF MEDICREDIT

PROTECTION OFFERED

Basic Coverage: The approved protection (whether insurance policy or membership plan) must provide payment of expenses for these services:

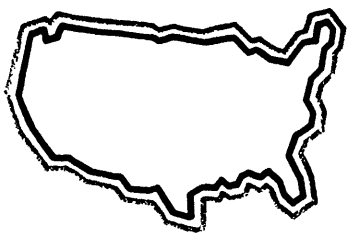
Inpatient care: In a hospital or extended care facility for 60 days during a 12-month policy period, in a semi-private room. Within the 60-day limit, two days in an extended care facility count as only one day.

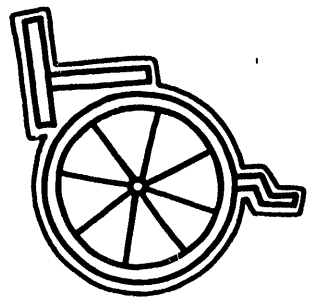
Inpatient hospital services cover all care customarily provided in a hospital, including bed, board and nursing services; drugs and oxygen; blood and plasma (after the first three pints); biologicals and supplies; appliances and equipment furnished by the hospital; surgery or delivery room; recovery room; intensive care or coronary care unit; rehabilitation unit; care for pregnancy or any of its complications and psychiatric care.

Inpatient extended care facility services cover all care customarily provided in an extended care facility, including bed, board and nursing services; physical, occupational or speech therapy; and drugs, biologicals, supplies, appliances and equipment furnished by the extended care facility.

Outpatient or emergency care: The policy or plan covers all care customarily provided as outpatient or emergency care, including diagnostic services—X-rays, electrocardiograms, laboratory tests and other diagnostic tests; use of operating, cystoscopic and cast rooms and their supplies; and use of the emergency room and supplies.

Medical care: The policy or plan covers expenses of all medical services—preventive, diagnostic or therapeutic—provided or ordered by a Doctor of Medicine or Doctor of Osteopathy, whether in a hospital, an extended care facility, the physician's office, the patient's home or elsewhere.





Those services include diagnosis or treatment of illness or injury; psychiatric care; well-baby care; inoculations and immunizations of infants and adults; physical examinations; diagnostic X-ray and laboratory services; radiation therapy; consultation; services for pregnancy and its complications; and anesthesiology.

Also included are dental or oral surgery related to the jaw or any facial bone; and ambulance service.

Cosmetic surgery (plastic surgery) is excluded except when related to birth defects or burns or scars caused by injury or illness.

Catastrophic Coverage: The policy or plan pays all expenses for services described under Basic Coverage in a hospital or extended care facility during days in excess of the 60-day basic limit. Only 30 days are covered in an extended care facility under catastrophic coverage, however.

In addition, the catastrophic coverage includes blood and plasma in connection with outpatient medical services (after the first three pints) and prosthetic aids ordered by a physician.

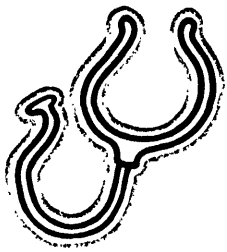
Medical care services are not included under catastrophic coverage because they continue without limit under basic coverage.

WHO PAYS FOR WHAT?

Medicredit is designed to give maximum help to those who need it most, and minimum help to those who are best able to pay their own way. Financial condition is determined solely by the amount of federal income tax a person or family pays whether by withholding or direct payment by the individual when he files his tax return.

Low-Income Families
If a person or family owes no federal income tax for the year—whether because of no income, low income or number of dependents—the total cost of the basic and catastrophic coverage is paid by the federal government. The family would receive a "certificate of entitlement" which would cover the entire premium or membership cost for an approved program from whatever insurance company or plan the family chooses.

All Others: For families or individuals who pay federal income tax, the formula is a little complicated. The cost of the approved policy or plan is divided into two parts. Most of it is for the basic coverage; a smaller portion is for catastrophic coverage. The insurance company or plan will determine how much is for each.



The federal government pays for the catastrophic coverage for everyone.

It pays a percentage of the cost of basic coverage according to the amount of income tax the family or person owes, as follows:

An example shows how the sliding scale would work. A man with a wife and two children who makes $6,100 a year, taking standard deductions, would owe $452 in income taxes. That would put him in the 54% Medicredit category.
(see table).

Income Tax Owed	% Govt Pays	Tax	%	Tax	%	Tax	%
$ 1-10	99%	231-240	76	461-470	53	691-700	30
11-20	98	241-250	75	471-480	52		
21-30	97	251-260	74	481-490	51	701-710	29
31-40	96	261-270	73	491-500	50	711-720	28
41-50	95	271-280	72			721-730	27
51-60	94	281-290	71	501-510	49	731-740	26
61-70	93	291-300	70	511-520	48	741-750	25
71-80	92			521-530	47	751-760	24
81-90	91	301-310	69	531-540	46	761-770	23
91-100	90	311-320	68	541-550	45	771-780	22
		321-330	67	551-560	44	781-790	21
101-110	89	331-340	66	561-570	43	791-800	20
111-120	88	341-350	65	571-580	42		
121-130	87	351-360	64	581-590	41	801-810	19
131-140	86	361-370	63	590-600	40	811-820	18
141-150	85	371-380	62			821-830	17
151-160	84	381-390	61	601-610	39	831-840	16
161-170	83	391-400	60	611-620	38	841-850	15
171-180	82			621-630	37	851-860	14
181-190	81	401-410	59	631-640	36	861-870	13
191-200	80	411-420	58	641-650	35	871-880	12
		421-430	57	651-660	34	881-890	11
201-210	79	431-440	56	661-670	33	891	
211-220	78	441-450	55	671-680	32	and	
221-230	77	451-460	54	681-690	31	Over	10

Assume that an approved program for his family cost $650 and that $600 was for basic coverage and $50 for catastrophic. His Medicredit benefit would be 100% of the catastrophic premium (which everyone gets) plus 54% of the basic premium (which he is entitled to because of the amount of his income tax).

Consequently:	100%	of $ 50	= $ 50
	54%	of $600	= $324
		Total	$374

Of the $650 for his basic and catastrophic coverage, the government would pay $374. He would pay only $276. He could choose a "certificate of entitlement" for the $374 or could subtract it from the income tax he owed. (In figuring his Medicredit benefit, he also is allowed to count a portion of the money his employer spends to buy his approved program.)

To summarize, here is how to figure the Medicredit benefit:

1. Take 100% of the cost for catastrophic coverage.
2. Find the amount of income tax owed in the table to see what per cent of the basic coverage will be paid by Medicredit.
3. Multiply that per cent by the cost for basic coverage.
4. Add the answers to items 1 and 3.

DEDUCTIBLES

Any insurance policy, prepayment plan or membership group offering as many benefits as those offered by Medicredit's approved programs must have financial safeguards built in. The safeguards are almost always in the form of deductibles (or "co-insurance")—amounts the patient pays before the program itself begins to meet expenses.

The Medicredit deductibles are small, compared with the benefits, but they serve very important purposes.

Primarily, they keep the total cost of the program lower. Because most citizens will share that cost with the government, economy is an important consideration. If a program paid every dollar of medical and health care expense, the cost would be higher.

Secondly, deductibles—even though small—prevent abuse or over-use of the program by patients or physicians. The policyholder or plan member knows—and so does his physician—that the Medicredit program will give him a great deal of help. But both also know that he must pay a certain amount before receiving its benefits. So he will not unnecessarily go to a physician "just because it's paid for." Or enter a hospital "just because it's more convenient."

There are deductibles (or co-insurance) in both the basic and catastrophic coverage, but it is important to note that those paid under basic coverage apply to the one required under catastrophic coverage.

Basic Coverage
Under the basic coverage portion of Medicredit's approved programs, there are three deductibles:

1. The patient pays $50 per stay in the hospital as an inpatient.
2. The patient pays 20% of the first $500 of expenses for outpatient or emergency care (maximum of $100) in a 12-month period.
3. The patient pays 20% of the first $500 of expenses for medical care services (maximum of $100) in a 12-month period.

For example, a mother takes her child to the eye doctor. The charge for the office call is $10. Basic coverage pays $8 and the mother is billed for only $2. If a visit to a hospital emergency room cost $27, basic coverage would pay $21.60 and the patient would be billed for $5.40.

All money spent by the patient on any or all of the basic coverage deductibles then applies to satisfying the deductible "corridor" explained in the next section.

Catastrophic Coverage: Persons who need the additional help of catastrophic hospital or extended care facility coverage are required to satisfy a deductible "corridor" of expenses after basic coverage runs out before the catastrophic coverage begins.

(Deductibles under basic coverage are for each person; the catastrophic "corridor" applies to the entire family.)

The size of the corridor depends on the financial condition of the family. The corridor is based on taxable income—the amount left over on the income tax form after all deductions and personal exemptions have been taken. The corridor is computed as follows:

1. 10% of the first $4,000 of taxable income.
2. Plus 15% of the next $3,000 of taxable income.
3. Plus 20% of any additional amount of taxable income.
4. Minus any amounts spent on deductibles under basic coverage.

A low-income family would have no taxable income, so it would have no corridor. As a family's taxable income rose, the corridor also would rise. The family of four in the earlier example, making $6,100 a year and taking standard deductions, would have taxable income of about $2,900. That is within the first $4,000, so the corridor would be 10% of $2,900, or $290.

If the patient had spent the $50 deductible for an inpatient hospital stay, the corridor would be reduced to $240 before catastrophic coverage would begin paying additional expenses. If another $75 deductible for medical service had also been paid under basic coverage, the corridor would be only $165 (the $290 minus $50 for one deductible and minus $75 for the other).

CONCLUSION: SOME COMPANION PROGRAMS

Medicredit was designed to solve the most immediate and most obvious problem relating to medical and health care: making it possible for everyone to seek the attention he needs without regard to his ability to pay.

The program was deliberately limited to that function so it would not become bogged down in details.

However, through the AMA and many others with whom it is consulting, a package of companion programs is now in preparation to help the medical profession, its allies, the government and the people of the nation solve jointly many of the other health-oriented problems facing our nation.

Those programs will deal with such longer-range problems as the quality of medical and health care, the most efficient utilization of medical and health personnel, the need for additional manpower, the distribution of manpower, the cost of providing care and the need for custodial and home care for the elderly and disabled.

Mr. ULLMAN. Are there questions?

Mr. Burke?

Mr. BURKE. Dr. Roth, I am somewhat concerned about your statement on page 20 quoting David Cleary, scientist writer for the Philadelphia Bulletin wherein you state that—

> The most important part of any health care plan, say European planners, is the attitude of the medical profession toward it, since it will be the doctors who will make it work—or cause it to fail. The biggest task before the United States in its development of national health insurance, the European authorities say unanimously, is to produce a package physicians will accept.

What are you implying by this? What do you mean? How far will the doctors go on the national health insurance plan as far as cooperation is concerned and will they go on strike if they oppose a law that is passed here by the Congress representing the people?

Dr. ROTH. Well, Mr. Burke, I would say in the first place that we of course were delighted to find that we didn't need to say anything of this sort on our own initiative. This is a direct quote from an impartial, I presume, observer quoting from European authorities. I think the answer to the second portion of your question, however, is manifest in the behavior of the medical profession in the carrying out of the provisions of the Medicare Act, a proposal which was opposed by the American Medical Association which favored its own alternative proposal, which we called eldercare in those years, proposing to give essentially the same scope of benefits to older citizens but on a different financing base.

Medicare, however, became the law of the land. The American Medical Association and myself as a representative of the American Medical Association worked long and hard with the Social Security administration in the writing of regulations and in the publicizing of the plan and I think it has been generally agreed that, although physicians may still feel that the costs of the benefits have been insupportably high, they have indeed cooperated in the endeavor to make the medicare program a success.

I think I have said that we are a responsible profession and I am certain that whatever is made the law of the land in this respect will enlist the ardent support of the profession to make it a good program. But it would be derelict of us if we did not express our opinions on better plans.

Mr. BURKE. Well, do you endorse this statement by David Cleary, this quotation that European authorities say unanimously. Do you know that everybody over there has made this statement. That seems to be exaggerated. That seems a little farfetched.

Dr. ROTH. We can't do it in the American Medical Association.

Mr. BURKE. Another thing is this. Would you people be willing to comply with the expressed wishes of President Nixon to hold down the acceleration of costs, say to 5½ percent?

Dr. ROTH. We have not had as an association any opportunity to discuss this. I think that I can safely say, however, since I represent a profession which has been singled out for the application of phrases and the application of percentiles with which we have conformed reasonably well, that we will behave responsibly in this area too.

Mr. BURKE. Actually that doesn't answer the question. I assume that most doctors will act in a responsible way but I am wondering

what the views are in the AMA as far as the 5½ percent is concerned.

Dr. ROTH. We have not had any opportunity to discuss this.

Mr. BURKE. Do you endorse that or do you reject it?

Dr. ROTH. As an association I would simply be able at this point to say there is no association position on it. I would be happly to tell you that I personally believe that this is a helpful suggestion and that I see great merit in this if everyone will play by the same rules. We feel that there has been a disparity in the attitude of organized labor between their position on their own economics and those of the medical care marketplace but we have not discussed the matter of the recently announced 5.5 percent goal.

Mr. BURKE. I think what organized labor is complaining about is negotiated contracts that they feel Congress or the administration have not the right to abrogate. You don't feel that any contracts entered into by the medical profession should be abrogated, do you, by act of some agency of the executive department?

Dr. ROTH. I simply have to repeat, Mr. Burke, that we have not discussed this or the economic impact of this as an association and I don't regard myself as a sufficiently competent economist to give you very helpful information.

Mr. BURKE. How does AMA feel about the administration's bill?

Dr. ROTH. The administration's proposal?

Mr. BURKE. Yes.

Dr. ROTH. Obviously, since we offer a more completely unified program with a level of benefits to all classes of a somewhat broader coverage, and a more expansive program, we would like to see the administration's program go further. We do feel that its general philosophical acceptance of the fact that it is better to build on the strong accomplishments of the profession rather than to contemplate some kind of an untried and radical restructuring is sound.

We certainly endorse it from that point of view. We feel that our tax credit mechanism offers a form of inducement to participate which is more effective than the rather diverse financing base of the administration's program, and although we freely accept the desirability of trying out the development of health maintenance organizations, which is sort of a cornerstone of the administration's bill, we are a little bit disturbed about possible overpromise in this area, as I have indicated in my testimony.

Mr. BURKE. Would you accept any parts of the bill that was filed by Senator Kennedy and Congresswoman Martha Griffith? Do you feel there are any good features in their bill that you could accept?

Dr. ROTH. Well, we need to look at the basic allegations for the need for an H.R. 22-S. 3-type of legislative proposal. As I am sure this committee is well aware, the allegation is that the basic necessity is to use economic leverages to accomplish radical restructuring of the medical care delivery system. With this we strongly disagree and therefore any program which is built on that premise is not appealing to us.

Mr. BURKE. I would just like to make the observation that you are almost endorsing the status quo situation. You are really not coming in here with too much to offer to the public as far as health care is concerned.

Dr. ROTH. Mr. Burke, I would like the opportunity to say that I think this is clearly not the case. There has been no maintenance of

status quo in the medical profession in the history of this country. When you look back to the early days of this republic, take the days when Benjamin Rush was the oustanding physician in this Nation, when he signed the Declaration of Independence among other things, when you read his autobiography about all he could do for patients that were ill was to bleed off probably valuable pints of blood or purge them, and there was very little else specific he could do; and the progress that went on, and 30 years ago, 35 years ago when I was graduating from medical school we had a great many more things that we could do.

There were surgeries that could be performed, but we still had nothing for tuberculosis except rest and nutrition. We had no drugs to treat acute infections diseases. We had nothing to do for poliomyelitis exept rehabilitation and in these past 35 years we have made immense progress.

There are two vantage points you can take. You can deplore the fact that there are still tens of thousands of our citizens who are dying because they can't get into our sophisticated coronary care units with all their monitors and defibrilators and so on, there are still people dying of end-stage kidney disease because they don't have available to them dialysis programs and transplants. But the other vantage point, it seems to me, is that you can indeed take solace in the fact that thousands of our people are surviving these serious heart attacks, that we now have tuberculosis distinguished as a plague disease, that polio has almost disappeared, that there are no epidemics of small pox or typhoid fever any more.

Here I think we have a sense of satisfaction and a focus on the fact that our problem is that we don't yet have the capacity to do for the many the useful things we have developed the know-how to do for the few.

In this area we are making tremendous progress. I think no one disagrees with the position that today in this country more people are getting more and better medical care from more and better trained physicians in more sophisticated facilities.

Now, to upturn the basis on which all this was accomplished seems to us to be wrong. There is no evidence of a maintenance of the status quo and there will not be any maintenance of the status quo.

Mr. BURKE. I agree with you that there has been a great deal of advancement made in medical science. Nobody disagrees with that. What concerns me is that hundreds of thousands of people in this Nation cannot find a doctor, that there are areas in this country where there is a lack of doctors as was pointed out in some of your testimony here where they do not want to serve in the urban areas and the inner city areas and where they have concerns about this.

I can't understand why the AMA has not come out for a real program, say, to promote more medical schools and send more doctors into States like Mississippi where Howard University is sending them now.

I can't understand how the AMA could justify its stand during the last 10 years on almost keeping a closed shop in operation where they prevent medical schools from being developed and prevented the cooperation that they need for the development of more doctors and the

spreading of more health care throughout the country. You can't deny that because the facts show it.

Dr. ROTH. Mr. Burke, I would like to categorically deny it and I would like to review with you the facts.

There was one time in American history when the American Medical Association could stand guilty of what you have just said and that was shortly after the turn of the century, in 1910, when the American Medical Association conjoined with the Carnegie Commission for the development and issuance of the Flexner Committee report which studied the some 150 medical schools then in existence in the country, most of which, or many of which, were diploma mills of substandard educational content.

The result of this joint action was an elimination of all of the substandard schools. From that point on the American Medical Association has an unbroken track record of supporting the development of high quality schools.

At the end of World War II there were, I believe, 76 medical schools. As of the current moment there are 108, 103 with medical students in them at the present time.

The testimony states the figures on the numbers anticipated for the next few years. The output of physicians has vastly outpaced the increase in the population growth of this country. In addition, the American Medical Association, through its Educational and Research Foundation, is giving from physicians' voluntary contributions at the rate of $1 million a year to the medical schools of this country for development. In addition to that, our Educational and Research Foundation has developed a mechanism whereby we are guaranteeing loans for some 20,000 students.

We have guaranteed over $40 million worth of loans in support of medical education.

The American Medical Association does not now and never has owned or controlled any medical school. We do not control the admission policies. We do not control the size of the classes but we work diligently with the Association of American Medical Colleges and the other organizations in the educational field to promote this.

We have testified in Congress before both House committees and Senate committees in support of better, more liberalized financial support from the Federal Government to medical schools and I believe that this track record categorically denies what you have just said.

Mr. BURKE. I am only allowed 5 minutes here.

Mr. PETERSON. If I may add one comment to that.

Mr. BURKE. Yes.

Mr. PETERSON. I would like to read a portion of a letter from Representative Rogers to the American Medical Association.

Please convey to AMA's officers and membership my personal thanks and congratulations for being in the forefront in the support of this legislation, referring to the health manpower legislation which the Congress just passed, H.R. 8629 and the Nurse Training Act, H.R. 8630, saying in addition that, the data and expertise of the Association's witnesses were most helpful.

We would be glad to enter the letter into the record.

Mr. BURKE. I will be glad to let it go into the record.

I would like to point out that I am sorry I can't agree with you on the track record that you announce here, I think it is a fair record but a lot more can be done and we would like to pull the AMA into the 20th century.

Dr. ROTH. Mr. Burke, may I suggest that it is rather that we don't happen to feel that a simple production of more physicians is the only answer. It is certainly an expensive and somewhat time consuming answer.

I mentioned Russia in my testimony and I don't want to overdo this because I know no one seriously is suggesting that we take the Russian route.

But, I had the opportunity last year to spend a month there with an HEW mission studying Russian medical services and education. They do have a ratio of physicians to population that is roughly double ours. They have another interesting figure which is often thrown at us when people deplore the fact that there are thousands of eligible candidates for medical school that are rejected every year in this country.

In Russia, in spite of their increased medical education system, they still accept only one out of every seven applicants. No matter how many places in medical school you provide, presumably you are going to have a superfluity, more applicants than you can handle. This I believe is the burden of our observation in the testimony from the Philippines where they are mass producing physicians, where it is one of their major exports now. They are exporting Filipino medical graduates to us and, in spite of this overproduction, their own situation is deplorable, particularly in their out islands. They have the same problems that we have in our out territories.

The answers don't lie in overproduction of physicians, and unfortunately, they don't lie in easy answers like simply holding out economic incentives. We are doing extensive studies on the trade-offs, on the newer technologies which will help, and in working in incentive programs to get physicians there. This was the sense of much of my testimony.

Mr. BURKE. Well, I don't want to prolong it too long, but I just want to point out that your own admissions here today indicate that the doctors wish to serve in the wealthy and affluent neighborhoods in the country and they are somewhat reluctant to serve in rural areas and in inner city areas.

It just takes your own testimony to indicate that.

Dr. ROTH. I think that reads into the testimony something that is not there or not intended. It is not the affluence. There are many other considerations. In fact, doctors, if dollars were the answer, could make better incomes staying in particularly the rural areas and in many of the center city areas. But, you see, a doctor can make a decent living in the center city, with the present welfare programs, if not for any other reason, but the moment he becomes efficient, gathers himself enough office force to process patients to do well, to make himself a decent living out of one of these programs, he finds his income is published in the front page of the paper as an implication that he is somehow or other abusing the program and this doesn't make the situation very satisfactory either to many physicians. It is part of the cause of physicians retiring from this type of practice.

Mr. BURKE. I just want to close by saying that I have the utmost respect for dedicated physicians and doctors, but I cannot understand the attitude of the AMA as far as health care is concerned in this country.

Dr. ROTH. Mr. Burke, we would love to help you fully understand the attitude of the AMA.

Mr. ULLMAN. Without objection the letter referred to will be placed in the record at this point.

(The letter referred to follows:)

HOUSE OF REPRESENTATIVES,
Washington, D.C., June 16, 1971.

Mr. JAMES W. FORISTEL,
Department of Congressional Relations,
American Medical Association,
Washington, D.C.

DEAR JIM: Today the House Rules Committee granted a rule in connection with the Health Manpower and Nurse Training bills (H.R. 8629 and H.R. 8630). Passage in the House in the next several legislative days seems assured.

Please convey to AMA's officers and membership my personal thanks and congratulations for being in the forefront in the support of this legislation. The data and expertise of the Association's witnesses were most helpful. The AMA's governing body wisely included medical manpower legislation as a part of the Association's legislative package. I feel this legislation is a keystone to any additional health programs that may be passed by the Congress. As Chairman of the Public Health and Environment Subcommittee, it is my intention to continue for the balance of this year considering other areas in which the Federal Government might be of assistance, and this will include the several bills before our Committee on Health Maintenance Organizations and various approaches providing better preventive medicine to the public. I am looking forward to continued cooperation from the American Medical Association in these endeavors.

Kind regards and best wishes.

Sincerely yours,

PAUL G. ROGERS,
Member of Congress.

Mr. ULLMAN. Mr. Schneebeli?

Mr. SCHNEEBELI. I would like to address both doctors.

I think you have given us excellent testimony. I think it is going to be helpful. You have been very specific.

To the other side of the aisle I would like to say that I think the AMA in recent years has had an excellent track record and has done a wonderful job.

Certainly any organization can improve itself and I think you people in the AMA are making an honest effort to do that.

Specifically the question of medicare has been brought up and, while it is not a part of our current consideration, I would like to ask you a general question. Do you think medicare has been a success?

Dr. ROTH. Mr. Schneebeli, the AMA has never formally made any evaluation and issued any statement of its performance record but my own feeling, and my type of practice involves care of a great many medicare beneficiaries, has been that medicare indeed has done a great deal of good.

I would put it in this context however. I believe it has done a number of billion dollars worth of good for this country but I think it has cost extraordinarily too many billions of dollars.

I believe that the same good might have been accomplished without such deep economic disruptions.

Mr. SCHNEEBELI. In that connection are there any recommendations that you have that we can learn from our experience with medicare that can be applied to the program we are considering now?

Are there any recommendations that either the association or you personally might have as a result of this experience with medicare as to how we can improve what we are studying now?

Dr. ROTH. We have made a pragmatic and I suppose you might call it a political decision, as inept as such decisions might be on our part, to not suggest a total replacement or a replacement of the medicare program at the present time, which is why we have restricted the provisions of our proposal to the under 65 population.

Mr. SCHNEEBELI. Yes.

Dr. ROTH. I believe it is our hope that if our program is as admirable, as equitable, and as satisfactory as we hope it would be, that that would generate a strong demand on the part of persons who approach the age of 65, hoping that they might carry their medicredit benefits over to their retirement or senior years and perhaps that would generate a pressure for replacing medicare with the principles of medicredit.

Mr. SCHNEEBELI. Don't you think the success of medicare has been a good basis for selling the program that we are considering, that the very fact that it has been successful makes this National Health Insurance program a lot more acceptable to the public and the professions?

Dr. ROTH. I think it should reinforce the confidence of the Nation in its physicians.

Mr. SCHNEEBELI. It has been a good forerunner and a good basis for consideration and I would like to congratulate your association for its very high motivation. I think you have done an excellent job.

Dr. ROTH. Thank you.

Mr. SCHNEEBELI. I think some of the statements made here previously do not necessarily reflect the thoughts of all of the members of our committee. I think you are an excellent organization.

Dr. PARROTT. I might say Congressman that we did testify before this committee concerning costs on medicare before the fact and we did testify to the fact that it would cost more than $1.2 billion, more like $7 billion, so that that track record is available.

Second, if you want our advice on scaled economics, I would think the committee should take a long hard look at cost effectiveness and cost-benefit ratios on any proposed program because I think if this had been done on a truly scientific basis on medicare, there could have been some losses avoided.

Actually the loss to the public in medicare is basically in-hospital and it is the hospitals that have had to bite the bullet on medicare. My own hospital administrator goes in the hole a half million dollars a year on medicare and the people that pay that are the sick people who are off medicare.

Mr. SCHNEEBELI. We have had 4 or 5 years experience with 20-some million people in the medical field in this general Government legislative area of medicare and I think we have so much to learn in applying it to the rest of the population and, if you people have any particular recommendations with respect to the experience from medi-

care, I know we would be very happy to have them in our consideration here.

Thank you very much.

Mr. ULLMAN. Mrs. Griffiths will inquire.

Mrs. GRIFFITHS. Thank you very much, Mr. Chairman.

What does your $14 billion annually pay for?

Dr. ROTH. The $14 billion pays for 100 percent of the cost of coverage for the two-part basic and catastrophic coverage which is offered to those individuals and families who have zero income tax liability.

You probably remember, Mrs. Griffiths, that last year in the last session of Congress our eligibility standard was a little bit higher.

In order to reduce the total costs we put the eligibility down to a zero income tax liability instead of a $300 income tax liability. This is the great bulk of the cost. The rest of it is the proportional share of actual revenue foregone by the Federal Government through income tax collections that is manifested in the tax credits.

Mrs. GRIFFITHS. How much money do you lose on tax collections? How much money would the Federal Government lose?

Dr. ROTH. May I ask Mr. Peterson if we have those analyses with us.

Mr. PETERSON. Well, the Federal cost of the program, $14.5 billion minus the credits that the Government would gain through the reduction of the medicaid offset and other additional factors would result in about a $12.1 billion cost to the Federal Government.

Mrs. GRIFFITHS. You mean we are already subsidizing the rich, right, in their medical programs under existing law?

Dr. ROTH. Under existing statutes there are of course deductibles for medical expense items too.

Mrs. GRIFFITHS. These are largely available to those who either have long illnesses or who are quite wealthy, is that right?

Dr. ROTH. Yes and this would be an offset.

Mrs. GRIFFITHS. How much would the Federal Government lose under your program in tax collections is the question I am asking you.

Dr. ROTH. I recognize that and we have not answered it.

Mrs. GRIFFITHS. Will you answer it for the record if you don't have the answer?

Dr. ROTH. We would be delighted to submit those figures.

(The information referred to follows:)

The loss to the federal government would be the reduced tax revenues arising from the allowance of tax credits. The cost estimate for Medicredit is $14.5 billion in its first year. (This will absorb $1.2 billion of current federal expenditures for Medicaid.) The total figure covers expenditures for "certificates of entitlement" (vouchers) and tax credits. The cost of the full premium vouchers (for the poor with no income tax liability) and the partial premium vouchers (for those with some tax liability) is estimated to be $7.7 billion. In answer to the question, tax credits will result in loss in revenue to the federal government through reduced tax collections, estimated at $6.8 billion (and this may be offset by an estimated $100 million representing an amount of tax savings through medical deductions which taxpayers would forego).

Mrs. GRIFFTHS. Does your program repeal in total medicaid?

Dr. ROTH. No, ma'am.

Mrs. GRIFFITHS. What does it leave?

Dr. ROTH. It leaves hospital care beyond the prescribed limit except as this may be picked up automatically for most of the medicaid

recipients through the catastrophic coverage, which, if you examine the mechanics, comes into play directly since it is geared to net taxable income and these people have no net taxable income.

Mrs. GRIFFITHS. What do you estimate to be the costs to the Federal and State governments of the remaining part of medicaid?

Dr. ROTH. The remaining parts of medicaid that would be left are largely in the area of dental services, outpatient drugs, and extended care.

Mrs. GRIFFITHS. What is the cost of that?

Dr. ROTH. I do not have that figure with me but if we have it available we would be happy to submit that for the record.

Mrs. GRIFFITHS. Otherwise will you have the cost of that supplied for the record?

(Information referred to follows:)

It is estimated that, as a result of Medicredit, the federal cost of Medicaid in 1972 would be reduced by $1.2 billion and the state and local government cost would be reduced by $1.1 billion. Thus, the remaining annual cost to the federal government of medicaid would be $2.0 billion and the state and local remaining share would be $1.8 billion.

Mrs. GRIFFITHS. Does your program repeal the veterans programs?

Dr. ROTH. No.

Mrs. GRIFFITHS. It does not. Do you have the estimated cost of the veterans programs per year?

Dr. ROTH. I am sure we have the VA figures.

Mrs. GRIFFITHS. Would you supply that for the record?

Dr. ROTH. We would be happy to.

(Information requested follows:)

According to January, 1971 Social Security Bulletin, fiscal year 1970 expenditures for "Veterans' hospital and medical care" were almost $1.6 billion. This figure includes the operating costs of all medical care programs conducted by the Veterans Administration.

Mrs. GRIFFITHS. Does your program repeal medicare? It does not, does it?

Dr. ROTH. It does not.

Mrs. GRIFFITHS. It does not. What is the cost of that? I can supply that for you.

In 1970 it was about $5 billion so that this is an additional expense.

Now I would like to know what do you estimate as the cost to the person who is going to hold one of these insurance policies? What will be the average cost for a family of four? Whether you are subsidizing it or not what is the cost?

Dr. ROTH. The calculations were made on the basis of a $650 policy cost. I would really be delighted to provide for the committee our most recent actuarial estimates of the impact of our program in practically all aspects. These have been carried out by Mr. Robert Myers who has acted as our consultant in this area recently.

Mrs. GRIFFITHS. A $650 policy of course covers very little.

Let me point out to you that the insurance companies have already told us that a policy for four that gave anything like comprehensive coverage would cost $300 so that you really aren't covering very much at $650.

Therefore, I think it would be a good idea if you explained exactly what you think $650 per family is going to buy.

Dr. ROTH. Mrs. Griffiths, what you can do most easily, without being an economist, is take 200 million people in this country and apply a cost figure. If you are going to provide them with $300 of health care, it is going to cost the country $60 billion. Our proposal is not offered as an economy program.

Mrs. GRIFFITHS. I see. What will your program do?

Dr. ROTH. Our program is offered as a beginning in knocking down the economic barrier, the dollar barrier that stands between some people and access to care. This is only one of the many barriers that stand between people and care.

It really looks to us as though it might be the easiest one to approach because the other ones depend so heavily on education of the public, education of the profession, remedying manpower shortages, increasing facilities, developing new mechanisms of bringing care to shortage areas and so on.

These barriers are not easy to overcome. Each one has its timetable. The timetable for eliminating the dollar barrier is immediate. This is a program for now on which additional programs can be built. This is why we have enthusiasm for it. We do not suggest that this is all-embracing comprehensive coverage for everyone in the country. We scaled our benefits. We picked 60 days in the hospital instead of 30 or 120 or 365 because, when we got all through balancing the factors of cost and came out with a program in roughly the magnitude of $14 billion, $12 billion to $14 billion, and incidentally the HEW estimates of our program make it much lower, $6.9 billion or something of that sort, we constructed this of a magnitude that we felt might be within the reach of this country at the present time without asking that the country devote all its available resources because we feel that there is so much importance in doing so many other things.

Mrs. GRIFFITHS. One of the things that I think you and HEW should quit talking about is the cost of the program that I have suggested in H.R. 22 as opposed to some cheaper thing that you are talking about because the truth is that any program of health care in this country is going to cost approximately the same thing. Whether you pay it in prices, in taxes or in what, total health care is going to cost about the same.

Your program isn't really cheap. Your program just doesn't furnish that much.

Now I would like to point out a few little problems with your program. Your program is a negative income tax applied to health care. Are you willing to apply that to other things, welfare?

Dr. ROTH. There are other precedents in existing tax law, foreign income credit, foreign dividends credit, and so on which actually provided us with the notion that this could be done. This route is proving very popular.

I see that just recently there has been a bill submitted to Congress in which Senator Kennedy suggested that political contributions may be handled by a tax credit route. There have been very convincing studies done, convincing to me, by the Brookings Institution on the effect of the negative income tax in the welfare field.

I have to confess I think it is attractive.

Mrs. GRIFFITHS. Let me point out to you that last year I believe it was we studied 153 income tax returns in this country of some of the wealthiest people in the country where they paid nothing.

Under your program we will pay 100 percent of their medical care.

Dr. ROTH. This is absolutely true and the fault of course lies not with our program. It lies with the income tax laws.

Mrs. GRIFFITHS. Couldn't you figure out a program that is better than the income tax laws?

Dr. ROTH. Well, the people that are referred to, and this rather small handful of people are frequently referred to, apparently avoid the payment of tens of thousands if not hundreds of thousands of dollars a year. The additional $650 that might be contributed by our program is rather small, but we don't defend it. We think that there should be ways of avoiding this because basic to our program is the philosophy that those who have the capacity for paying for their care either in toto or in part should be asked to pay all that in good conscience they may be expected to pay in this respect.

Mrs. GRIFFITHS. Mr. Byrnes has just pointed out that one of the people that didn't pay any income tax has just died who had a million and a half dollars a year income tax free.

Let me point out another thing to you.

Mr. PETERSON. May I make a comment on that?

Mrs. GRIFFITHS. Yes.

Mr. PETERSON. Under H.R. 22 would these individuals pay for their care?

Mrs. GRIFFITHS. Oh, yes, because they are going to pay on earned or unearned income a tax as they work. If they have any earned income they pay right there just like they pay social security tax.

Mr. PETERSON. Up to what amount?

Mrs. GRIFFITHS. $15,000 just like anybody else.

Mr. PETERSON. You said earned income.

Mrs. GRIFFITHS. Earned or unearned.

Let me point out to you that would have a family of four making $6,000 where the government paid 70 percent of their cost I believe because they are paying a tax of $300. The government picks up 70 percent of the cost for them. But in the State of New York under Mr. Rockefeller they aren't paying anything now. They are being picked up under medicaid.

Dr. ROTH. Yes. This represents one of the basic problems in medicaid, the unevenness, the fact that it has depended on the willingness of State legislatures to come up with appropriations to get their matching Federal grants. In some States this has permitted expensive programs.

There are at least two States I believe that still have none at all which is about as uneven as you can get.

Mrs. GRIFFITHS. This is why I really am for H.R. 22. Unless we do something you are going to have some States with total medical care and the rest of us are going to be paying for it. The program should be national.

Now, I presume that you feel this way too, that whatever we are going to have should be one program. Otherwise you are going to have the taxpayers in some States paying for the taxpayers in others.

Dr. ROTH. This is a principle that we can't argue with I think.

Mr. GRIFFITHS. But your program doesn't really reach the problem. You are not really picking up all of medicaid?

Dr. ROTH. No, ma'am.

Mrs. GRIFFITHS. They will still have it and it is still going to work in some States. Can't you figure out a program that will pick up all of medicaid?

Dr. ROTH. Yes, Mrs. Griffiths, we can.

I would like to point out that this is not a Johnny-come-lately concept. Some of us have been working within the American Medical Association for almost 15 years on an implementation of the basic philosophy of the medicredit bill. But when we came to structuring a bill to put into the previous Congress we used a consultant firm of actuaries of great competence and we drew up all sorts of alternatives with various packages. We had it costed out to include dental benefits, to include outpatient drugs, to give almost unlimited hospital care, to give extended care facility coverage and, when we added it all up, we felt, as a command decision, that this was too big and too unrealistic.

Now, we would be pleased, if in the wisdom of this committee, it was felt possible to add such things as dental benefits, outpatient drug coverages. I think this would not offend us in the least. We did, however, decide that the more modest program was a better one to submit as a beginning, without any illusions that it covers the entire field.

Mrs. GRIFFITHS. One of the other problems of your program is that it is a disincentive to work and I am for everybody working.

Dr. ROTH. Would you elaborate on that please, Mrs. Griffiths?

Mrs. GRIFFITHS. The mere fact that you had some money and had to pay a tax would cause people to lose some of the value of their medicare program.

So that to that extent it is a disincentive and this is one of the real problems in welfare and, high as the hospital bills in this country are, the greatest problem in the country is welfare.

Dr. ROTH. I must confess I don't follow this.

Mrs. GRIFFITHS. So that I would think you would have some real problem with it. If you had to start paying anything why not just quit working before you hit that point? That is what people do now.

Dr. ROTH. The curve of tax credit, its beginning point and ending point, is carefully constructed to do several things: in the first place, to avoid that which you have just mentioned; secondly, we don't want to interfere with the group practice pattern as it exists, mostly under collective bargaining, by giving an advantage to the employee if he declines the group coverage offered by his employer saying that he can get a tax credit by buying this himself. We have that actually quite well taken care of.

Mrs. GRIFFITHS. I don't think that is responsive to the suggestion I made. May I ask you how do you expect your program to hold down costs or do you expect it to?

Dr. ROTH. The medicredit bill is purely a suggestion for a financial mechanism. There is our companion peer review organization bill which is the manifestation of our profound belief that the medical profession has the obligation, the responsibility to do this if not on any other basis than for the simple one that unfortunately, unhappily,

most of peer review or most of cost control and quality evaluation cannot be done by anybody else.

Mrs. GRIFFITHS. May I ask you, do you know of any medical society that has expelled a doctor for gang visiting in either hospitals or nursing homes where in fact he didn't even show up but charged for it? There are many, many cases. There is probably not a city in this country that doesn't have documented cases of doctors drawing pay for visiting in nursing homes where they weren't there at all.

Have you ever expelled anybody for it?

Dr. PARROTT. The medical society could expell people but it wouldn't make any difference. They don't license the people. If we expell people what difference?

Mrs. GRIFFITHS. Have you asked that their licenses be suspended?

Dr. PARROTT. Yes we can.

Mrs. GRIFFITHS. Will you list the cases in which medical societies have asked that the licenses of doctors to practice be revoked where they have charged for visits that they never accomplished.

I think it would be very simple for the medical society to check on this and it seems to me that this is a sort of peer review, isn't it?

Dr. PARROTT. Certainly, but again I go back to the original question. The medical society does not submit the license.

Mrs. GRIFFITHS. Then let me change the question. Have you asked that those licenses be revoked?

Dr. PARROTT. I am sure that there have been a number of cases. You are asking for an across the board——

Mrs. GRIFFITHS. Across the country, and I would like you at your leisure to list them in the record where the medical societies have asked that licenses be revoked of doctors who have charged for services just for visiting the patient. This is a simple one, a real simple one because they have been proved in every case.

Dr. PARROTT. What you are talking about is a tempest in a teapot. You are propagandizing over an infinitesimal figure. I submit that you are.

Mrs. GRIFFITHS. There is no need to be annoyed about it?

Dr. PARROTT. I submit that you are because you obviously are annoyed by it.

Mrs. GRIFFITHS. We have case after case after case where doctors have been charging for visits that just didn't occur.

Dr. ROTH. Mrs. Griffiths?

Mr. GRIFFITHS. Yes.

Dr. ROTH. You asked if our medical societies have intervened in cases that may involve nonmembers or not even members of the medical profession and I would say probably the answer is no, not in respect to nonmembers of our associations.

But have the agencies, the carriers or the people who develop the evidence and the information on these things, which is generally not given to us even on our request, we have asked for this and even have asked for listings of people involved in these things and have been denied access to the information so that we could find out whether they are our members or not. Have the Government agencies or the carriers proceeded to prosecute under the fraud provisions of the general code?

Mrs. GRIFFITHS. That is my real objection. The carriers have never done anything as far as I know. That is why I think that when you

rely upon the insurance companies to police these things you are relying upon a slender reed indeed.

What I am interested in is how are you going to pay the insurance companies? How can you get away from the fact that the insurance companies are going to be paid a percentage of the business they have done, of the costs?

Maybe you have some system but nobody else has produced it and the real truth is that you are going to give them some sort of administrative fee that is in relation to the costs of the business they do so that there is nothing built into that system that urges them to reduce the costs. They do not have to go out and check, are these doctors really there, was this thing really given, was this thing really necessary? Then how do you do it with Peer Review?

Dr. Roth. I submit to you that we are setting up one of the roughest competitive markets that you can imagine when we allow the allegedly more efficient economical prepaid comprehensive group plans to be part of our system.

When an HMO is tooled up and in operation it would be admissible under our system if indeed the insurance commission of a State would agree that it was a feasible operation.

There would be the voluntary prepayment plans and the private insurance industry all offering minimum basic benefits that would conform with set standards. If this is not competition then I have a misunderstanding of what competition is. All any company has to do to guarantee a high administrative return that is out of reason is just offer it competitively and find that it has no takers. It seems to me that in the tradition of American free enterprise and the competitive enterprise system that we are making a major contribution which has the additional effect in the insurance industry of chasing out the incompetents, the ones that have excess administrative costs, small volume, poor payments, and so on, and none of us in the medical profession or in the bulk of the responsible insuruance industry defend them either.

Mrs. Griffiths. I really don't think the insurance industry is that competitive. I think they are competitive in seeking out the business but not necessarily in lowering the costs and this is the thing that I think is really essential. You just have to look at it.

If you are going to ask the Government to subsidize these insurance policies, then somehow or other you have to set up a system that sees that the insurance company can't charge for everything under the sun and they can't charge any old price they want to.

You will have to set up in my judgment a better system than that. I would like to go back to this fact and then I am through. One of the things that I think everybody ought to quit saying is that anyone of these systems is more or less expensive than something else.

The truth is that any system that amounts to anything is going to try in some way or other to see to it that everybody is taken care of. The truth is that what you are trying to pay for is total medical care in the United States and total medical care is going to cost. It is costing now more than $60 billion a year whether you are paying for it through taxes or through your own private income or through insurance and no system that has yet been suggested is going to reduce any of this

cost. H.R. 22 attempts with realism to put a lid on this and nothing else that I have seen does. I am sorry.

Dr. ROTH. May I say amen to the point you have just made?

The emphasis should not be on how much it costs or even on the financial mechanism. This is not the No. 1 point, and I would like to make it perfectly clear for the record that the objections of the American Medical Association to H.R. 22 are not based primarily or even importantly on its cost. There are more pervasive changes in the health care delivery system which are encompassed in the philosophy of H.R. 22. We agree completely.

We ran for examination the recent HEW cost estimate study, which I am sure is familiar to you and the committee, which starts with the basic assumption or calculation that, if no new bill is introduced, the cost of care in 1974 is going to be something of the magnitude of $105 billion.

Mrs. GRIFFITHS. Of course.

Dr. ROTH. Our program makes a small addition to this and your program makes, I will agree, also a small addition, slightly larger, but this is not the issue. This is not the point. Health care is expensive. No one is more unhappy about the spiraling cost of medical care than the physicians themselves. They have a vested pocket interest in it of only 13 percent. Thirteen cents of the health care dollar is in physicians' pockets.

I am sure that if one wanted to be grasping and avaricious about it, the physician would wish that the hospital component was much smaller and that the other administrative components were much smaller because it would leave more for them, but I think this is not the point either.

We have a role in this country in the medical care field that has really never been developed, Mrs. Griffiths. It is inherent in my statement that the physician acts in a very real sense as the purchasing agent on behalf of his patient. He mandates the hospitalization. He orders the extras, the laboratory tests and so on.

Now, no purchasing agent would last 2 days in industry if he didn't know the costs of the things he was buying. We have a great educational project before us in this country to develop economic awareness in the medical care field. It is not taught in medical school. It wouldn't make much difference if it was because of our influx of foreign physicians who come in and who know very little about American dollar expenses or values, particularly in this field.

We have an obligation to teach them and I think it is a role for involvement of physicians. I think physicians will do it much more cheerfully if they are doing it under a program for which they have appetite rather than one for which they have distaste.

I see it as a major role for county and State medical societies and the AMA to develop these programs. It can be done at hospital staff levels. Then and only then will we have meaningful control over expenditures. We have very little control over the costs of medical care. Those are matters of paying wages, of paying for the utilities, of paying for the supplies. The costs are not within our control but the expenditures of our patients are. This is the great white hope. . . controlling costs. . . to be done by a responsible medical profession. It cannot be legislated upon them.

Mrs. GRIFFITHS. We had a bill up here to try to get doctors to prescribe not a certain bill——

Dr. ROTH. Generic versus non-generic prescribing.

Mrs. GRIFFITHS. Yes. Did you support it?

Dr. ROTH. The American Medical Association, for reasons totally divorced from cost, does not support mandated generic prescribing.

Mrs. GRIFFITHS. It has nothing to do with costs but costs would enter.

Dr. ROTH. They may or may not. I will have to admit that I am going outside of my field of competence here but generic prescribing simply means that if you go out to buy a dog, you don't buy an airedale or collie or a specific kind of dog.

Now when I have a prescription in my hand that generically says tetracycline, which is one of the broad spectrum anti-biotic, anti-infection drugs, if it just says 250 milligrams of tetracycline that is generic prescribing.

However, if I prescribe achromycin or sumycin, those drugs must be supplied. I take that generic prescription into the drugstore and that is a license to the druggist to give me whatever he has on his shelf because it fits the prescription. It is not necessarily a help to the patient.

Your point is absolutely correct if you are doing mass buying for a hospital pharmacist. This is a very complicated situation which we with our Council on Drugs have examined closely. We have put out recently from the American Medical Association a drug compendium giving the most advanced information on drugs and the appropriateness of their prescriptions and we feel that there offsetting disadvantages to a mandated required generic prescribing that do not justify such things at present time.

Mrs. GRIFFITHS. You could, of course, prescribe the lowest priced, whatever it is.

Dr. ROTH. This is by brand name prescribing. If I keep myself informed, as I try to do in my own practice, to learn the good drug produced by a good reliable company and prescribe that by its brand name, then I know the patient is getting the lowest possible cost for that kind of medicine.

Mr. GRIFFITHS. But doctors don't have that much time, sir. Doctors are busier than most people.

If I were you I wouldn't raise too much fuss about the fact that you are getting so little of the medical dollar.

Dr. ROTH. We are not fussing about it at all.

Mrs. GRIFFITHS. Because the truth is that you are the highest paid professionals in the world. The mean average wage I believe of the family physicians is $40,000 a year and of the specialist it is $90,000.

Now, you know if you want to get right down to brass tacks why should the rest of us have to worry over this. But that is neither here nor there. We won't raise that question. I won't hit too high on that.

Mr. ULLMAN. Mr. Broyhill?

Mr. BROYHILL. Dr. Roth and Dr. Parrott, as a cosponsor of the medicredit bill I should like to commend the American Medical Association for its constructive progressive approach to this particular problem. I don't think you need any defense from me or from any member of this committee in light of the great contribution that AMA

has made and the confidence that the American people and the Congress place in the AMA.

I think this is very well reflected in the fact that you have 160 cosponsors of this medicredit bill. I dare say that most are sponsors not because they had read this particular proposal and compared it with numerous other proposals, but because they had confidence in the ability of the AMA to propose a proper type of solution for this problem.

Now, I don't think there is any great argument among any of us as to the desirability of doing whatever is necessary for the low-income people. As I understood your testimony, your answer to Mrs. Griffiths' question was that the medicredit proposal is designed to take care of low-income people and that you would be agreeable to any amendment to make certain that those additional benefits were provided, is that correct?

Dr. ROTH. I believe that is perfectly correct, Mr. Broyhill.

Mr. BROYHILL. There is no reason why we can't just abolish the medicaid program entirely, and adopt an approach wherein an individual would not have to take a pauper's oath in order to be eligible for medicaid but would have a built-in provision to identify him as being eligible for this type of benefit.

Dr. ROTH. I believe this is absolutely right, Mr. Broyhill. I think maybe I fell into a semantic trap because our program would, of necessity, eliminate medicaid as it now stands as a law because, with just these leftover areas to cover, obviously the requirements for a qualifying medicaid program could not be complied with.

What I meant to imply was that our bill, your bill, makes no pretense at being totally all-inclusive at this time and there need to be provisions, which we think probably can be remanded in large part to State government at a substantial reduction against what they are putting out now in their medicaid programs.

Mr. BROYHILL. Since we agree that we should take care of the low-income people, the question is finding the most efficient and economical formula for doing so.

A group that we also are very concerned about includes that middle-income person who wants to pay his own way, does not want to take a pauper's oath, does not want to be a burden to society and yet has health problems come up which could cause him embarrassment, and, as you point out, place him into bankruptcy.

What we are trying to do is help that person with respect to the base of his ability to pay. And I think there is only one place where the wealthy person is really taken care of. That is in the Kennedy-Griffiths bill. There has been criticism of this in that some higher income people who don't have a tax liability will get a free ride.

We have tried to correct that sort of thing in this committee through tax reform legislation, but we have not been perfect in closing all loopholes. I would suppose, however, that we could find language somewhere to make certain that the person who makes a million dollars a year and has been efficient in getting out of paying income tax does not get a free ride in any health insurance bill we report.

Dr. ROTH. We recognize we had that problem early in our deliberations. I will admit that I made a proposal to our committee structuring this bill in its earlier phases that didn't seem to be unreasonable. It was

that you required the applicants to sign a little statement that they did not have any untaxed income in excess of some sort of amount. But this was ruled out by a majority of the committee as being something not practical. I agree with you that there must be some answer to this because, as you point out, the big problem, one of the big problems that is with us yet in spite of all the accomplishments of the insurance industry and the Federal Government in aid programs is that the insurance in general is at the wrong end of the risk.

The big expenses that can really ruin a family go uninsured. Traditionally we started insuring the smaller and more expensive end of the risk. Medicredit attempts to improve that situation with its catastrophic provision to cover the big end of the risk and it is the least expensive end to cover. It gives protection to these middle income people who are still the ones, and there are so many of them, that it is still the biggest part of the problem.

Mr. BROYHILL. Dr. Roth, I think we have a serious problem in writing this legislation when the committee goes into executive session. The problem is in assuring ourselves that the medicredit proposal will be given equal consideration by this committee. Now, we have on this committee some of the most capable and dedicated Members of Congress, and there is no question in my mind that if the committee is left alone to work its will, it will come up with a very effective and sound piece of legislation.

But traditionally when this committee has gone into executive session—and I believe this is the only committee of the Congress that operates that way—we have this room filled with bureaucrats, representatives of the executive branch of Government. This might be necessary when it comes down to the details of tax legislation, where we need a lot of experts, but we have experts on our staff who are equally, if not better, qualified than some of the representatives from the executive branch.

With all due respect to the proponents of the administration's proposal, there are only six or seven sponsors of it, and there are 160 sponsors of medicredit. But we will have about 50 experts on the administration's bill, and if any supporter of medicredit or of Mrs. Griffiths' bill speaks up in trying to put across a particular part of either of these bills, our colleagues will not be the ones who rebut the suggested proposal, but it will be the bureaucrats from the executive branch.

Therefore, your proposal with 160 sponsors will not be able to get the same type of presentation and deliberation as the proposal of the executive branch.

Do you have any suggestion or comments on that? I know that you have a lot of experts in your shop that are better qualified than some of the bureaucrats down in HEW.

Dr. ROTH. The only thing I am relatively sure about, Mr. Broyhill, is that passing an AMA resolution on the subject isn't going to help much.

Mr. BROYHILL. I want to hear your comment on that particular situation with which we are confronted.

Dr. ROTH. It violates my sense of what an executive session normally amounts to, but I am sure that I have no ready off-the-top-of-my-head solution, potion, or pill for that.

Mr. BROYHILL. It's really not an executive session in the true sense of the term, because the committee room is practically full. Would you think it would be fair if we had some representatives of the AMA here to have at least an opportunity to get involved in the cross-examination in considering the various alternative approaches?

Dr. ROTH. If we may secure the courtesy of equal time, I assure you we will provide the expertise.

Mr. BROYHILL. Thank you.

Mr. ULLMAN. Mr. Broyhill, I don't think you want the record to indicate that the administrative respresentatives in executive session are allowed to speak at will. The chairman wields a rather tight gavel over the executive agencies, and the purpose is to get expertise in the room on subjects that are very complicated and very extensive in the nature of their effects.

Mr. BROYHILL. Let me try to clarify the record a little further as the acting chairman has. I did not mean this in criticism of our distinguished chairman or of any member of the committee. I do feel, however, that we are getting a rather biased expert observation of many of the proposals we have before this committee, and when we have so many cosponsors of alternatives, I suggest that experts be present in their behalf, too. By having the HEW here we have legislation. I don't think they are doing it from lack of sincerity, and I certainly support the chairman in wanting to have experts here during our deliberations.

Mr. ULLMAN. But I don't think you would want the recommendation that we have private people representing private interests in our executive sessions as now constituted.

I think there is a great difference between having Government employees who are responsive to the public interest and having those who represented any special interest segment in our society.

Mr. BROYHILL. I would say, Mr. Chairman, that I would prefer that the committee enlarge its staff to have sufficient experts and not have to have any representative of the executive branch here in executive session.

Mr. ULLMAN. This is committee housecleaning. You injected something in the record that I thought needed some correction.

Mr. Vanik?

Mr. BYRNES. Mr. Chairman.

Mr. ULLMAN. Just on this point.

Mr. BYRNES. Yes. I don't know how germane this is to the problem we have before us, which is certainly extensive enough, but I do want to say that I think the members of this committee have the competence, individually, to judge the credibility and competence and expertise of anyone who may make representations to them or to the committee on matters within our jurisdiction or under discussion.

Mr. ULLMAN. I think you have contributed to the record.

Mr. Vanik will inquire.

Mr. VANIK. Mr. Chairman, with respect to the discussion we have just had, if my colleague desires, I would be very happy to support a motion that all of the proceedings of this Committee be made public. Our work should be done right out in the open.

I would say, gentlemen, that you have submitted a proposal which deserves the very careful consideration of the Congress and this committee.

At a time some years ago when most Members of Congress were thinking in terms of medicare as a means of providing a hospital insurance program for the people of America, your suggestion of eldercare had a great deal to do with the development of part B. I certainly want to express my gratitude for your contribution to the development of part B, because if you hadn't suggested it at the time, it might not have become law.

Now, my question deals with the $14½ billion estimate of the proposal you support. Our big concern here is going to be the matter of cost.

Mrs. Griffiths has asked very properly about a breakdown of that cost, but I would like to have something more. I would like to know how much medicredit would cost within that framework, how much by way of tax loss, how much would catastrophic coverage cost, and how much do you estimate is the cost of the poor for coverage within the $14½ billion figure.

I think we ought to have these separate items so that we can consider them in full perspective. I would also like to have a 5-year projection of these costs, because I think that anything that fails to give us an estimate of cost over a period of time might be very misleading.

Can you provide that sort of information?

Dr. Roth. I will be happy to be, I think, fairly fully responsive to this. I believe we have the figures available to this committee and will see that they are submitted. Most of them are part of Mr. Myer's most recent analysis.

Mr. Vanik. He is one of those bureaucrats that you have picked up to help you.

(The information to be supplied follows:)

The total cost of the program is estimated at $14.5 billion.

Using the "Family Health Insurance Plan" definition of "poor" (Individual =Income of $0–$2500; Two individuals=Income of $0–$3400; Family of three =Income of $0–$4200; and Family of four=Income of $0–$5000), it is estimated that the cost of coverage under Medicredit for the "poor" through issuance of certificates of entitlement and tax credits would be $8.3 billion.

The tax loss through credits against tax is estimated at $6.8 billion. (This figure could be reduced by an estimated $100 million representing an amount of tax savings which taxpayers would forego as medical deductions.)

Catastrophic insurance cost, as an element of the $14.5 billion estimate of total cost, is figured at $.8 billion.

Projections of cost over a five year period would be speculative and could be significantly affected by changes in levels of income which could be due to general economic growth, price inflation, unemployment rate, population growth, and other general economic factors.

Mr. Corman. Mr. Vanik, would you yield on the estimates?

Mr. Vanik. Yes.

Mr. Corman. How many people will be eligible for the tax credit, and how many people do your statisticians think will take advantage of it, because I think that is a fairly important part of revenue loss.

Mr. Vanik. We would also like to know how many people are going off the tax rolls.

Dr. Roth. I will certainly give you our estimate basis. I can tell you that the reason that there is a difference in the HEW estimate of the costs of medicredit and our own estimates is largely on this very point. Now, it might surpise Mrs. Griffiths, and I am sorry she is not here to hear me say it, but we feel that the most recent HEW appraisal of her program somewhat overstates its cost.

I will be glad to submit for the record that analysis to which I refer. (The information referred to follows:)

The tax revenue loss is estimated earlier in this testimony as $6.8 billion against a total cost of $14.5 billion for the program. The tax loss figure may be reduced by $100 million of tax savings through taxpayers foregoing medical deductions.

According to available data, it is estimated that there are 68.3 million medical care purchasing units (families or single persons) in the U.S. under 65 years of age. It is estimated that 89.1%, or 60.9 million, of these purchasing units will be involved in (or take advantage of) Medicredit by either receiving certificates of entitlement or securing tax credits. The estimate of the number of units which will receive certificates of entitlement for the full amount of premium is approximately 11 million. Thus, those medical care purchasing units which would participate in Medicredit via tax credits (or certificates of entitlement for a part of the premium) would number 49.9 million.

The number of people who would need to file tax returns would not be affected by the enactment of Medicredit. What would occur, of course, is that for lower income individuals the amount of their income tax credit would exceed or equal their income tax liability. Thus, under Medicredit, although still filing an income tax return, approximately 10.5 million households or individuals filing 1970 income tax returns would not have to pay any income tax. The loss of tax collections from these taxpayers is a part of the $6.8 billion of total estimated revenue loss through tax credits.

By the same token, we fell that the HEW estimate underestimates participation in ours and therefore gives it a lower cost. HEW gives ours a cost of, I believe, $6.3 billion. We will stick with the $14½ billion as being our idea of a somewhat more realistic figure because we think we are going to get a widespread participation of the public, about 90 to 91 percent estimate of the portion of the public will take advantage of our plan.

Mr. VANIK. In your pamphlet describing the plan, in the last sentence on your second page you say, "nor does it consider the savings."

You have talked about the cost of the plan, and say, "nor does it consider the savings to the Federal Government because of reduced income tax deductions for individual medical expenses."

Dr. ROTH. This is correct.

Mr. VANIK. My question is: Do you suggest that the savings by reason of reduced income tax deductions for individual medical expenses will be greater than the loss of money by Treasury in the medicredit deduction?

Dr. ROTH. If I understand your question, we do not suggest that. We have simply not included as an offset in total cost the fact that, obviously, if our program is in effect, particluarly with its catastrophic provisions, individuals will not have these large amounts of money which become deductible under present statutes and therefore the Government will not lose that much income revenue.

Mr. VANIK. I understand that, but there will be a substantial Treasury loss in Medicredit?

Dr. ROTH. Oh, yes, sir. I think we don't intend to imply that this is not so.

Mr. VANIK. I am very much worried about this, because just yesterday the Senate Finance Committee provided something that was very good, a deduction for child care that we have been trying to get through the Congress for a long time. It would provide a $400 per month credit to a working couple with income up to $12,000 with a scaled-down credit up to an income level of $21,000.

This proposal will create new jobs and taxpayers and will make it possible for both partners in a family situation to work, if they choose to work.

But we have to add to that the investment credit and the accelerated depreciation, so that I am beginning to wonder about who is going to be left on the tax rolls.

My next question is this: If this program is adopted with these Treasury losses, do I understand that your organization would support increased individual income taxes which will probably become necessary in order to keep us a viable government?

As we write off $5 billion and $6 billion worth of tax reductions for business, as we do other things for medical patients, do I take it that you would be willing to support a program of individual tax increases to help make up the deficit?

Dr. ROTH. I will just have to let you draw your own conclusion about that, sir.

Mr. VANIK. I think it is something which your board ought to consider because we are faced with a realistic problem of trying to run the government and, with more and more deductions and with more and more revenue losses, I am just worried about how we are going to manage the shop.

Dr. ROTH. Well, Mr. Vanik, we do attempt to be as constructive as we can. I think there has been a dichotomy here between Mrs. Griffiths' advice to us that we should quit talking about the costs, at least of her program, maybe it is all right to talk about the costs of yours, but I assure you we will continue to give you as extensive analyses as we may based upon the most reliable projections that we can make and recogizing that these are not always very reliable things.

Mr. VANIK. To what extent have doctors' costs risen because of the malpractice problem, and the cost of malpractice insurance?

Dr. ROTH. We can give you a multiplicity of figures as to malpractice. As to how this has been an element relating to the increase in physicians' fees, I think we have no relevant or factual material.

Mr. VANIK. Could you estimate the increased costs? This cost is always stated as a reason for escalating charges.

Dr. ROTH. It very well has been, and figures on this are highly unreliable and in some respects not available. Our problem as a responsible medical association was that we had entire States in which doctors were finding it impossible to obtain professional liability insurance coverage. This situation has been remedied. The American Medical Association has an active but incomplete program offering coverage to virtually all physicians but at ever increasing premium rates.

So that the answer that we have is only a partial answer, and really not the most important part if we are going to eliminate this because we are getting into circumstances where the young physician graduating from his residency and stepping out to practice wouldn't dare, if he is an anesthesiologist, put his first patient to sleep unless he had his insurance coverage with a tremendously expensive premium.

Mr. VANIK. Has there been any consideration of no-fault health insurance? I think that the people who are involved in the health fields are dedicated people. I think accidents happen as they happen in all walks of life. Have you considered the possibility of some kind of no-fault coverage which would take care of the situation and help hold down the premium costs?

Dr. ROTH. Mr. Vanik, we have certainly considered this. We have considered any idea that anybody will come up with. One of the things that we are looking at now is compulsory arbitration requirements in insurance policies.

Mr. VANIK. And medical disputes?

Dr. ROTH. To be done by unbiased third-party arbitrators and so on. We are exploring all these things.

Mr. VANIK. Under your plan, where there is a government premium paid and a government policy issued, how would the doctor be paid? He would be paid through a carrier as you are through medicare, would he not?

Dr. ROTH. This would operate about as we are operating under present insurance programs.

Mr. VANIK. Supposing the doctor doesn't feel he wants to take the amount that is allowed by the carrier and there is a dispute. Does the individual patient have to carry on the difference in the cost as he does today?

Dr. ROTH. Mr. Vanik, our proposal specifically spells out that payment shall be the physician's usual fee as this has come to be defined. I can't see any excuse why a physician who is paid his usual fee should want to levy any increased or surplus amounts.

Mr. VANIK. I have a problem on this under medicare. The doctors in my community are not very anxious to take assignments. I think the percentage is the lowest in the United States. So I have a problem in which the people of my community are denied the medical service or have to pay for most of it themselves, because of the reluctance of the doctors to take assignments under medicare.

Won't that problem continue under the proposal that you make?

Dr. ROTH. I think to a very much less degree and hopefully not impressively. On the matter of assignments, however, Mr. Vanik, and I know you are from Ohio, you can count me in my group practice among those who, not for financial reasons, but for administrative reasons, are very much against the taking of assignments unless we absolutely have to.

This is a technical problem on which I don't think I ought to spend the time of your committee, showing how many times you have to send bills out if you accept an assignment, and then have to bill extra for the 20-percent coinsurance, and have to find out from the carrier what has happened to the $50 deductible, and then you have the misunderstanding on the part of the patient who gets a copy sent to the doctor and believes it has been paid in full. This is just a nightmare, and if you don't take assignments, you miss it all.

Mr. VANIK. This is what we ought to be learning about. It is still going to be a problem under the medical program. We ought to find out how we can help solve some of the redtape and reluctance there is in the assignment problem. This goes to the matter of cost and service. It is a basic issue.

Mr. CORMAN. As I understand the response, under medicare the doctor is paid the normal fee in the community. Under the medicredit plan, he is paid his normal fee so that he might not be so reluctant.

Dr. ROTH. No, sir. If I may correct that, when you are speaking of the physician's own individual fee, the terminology of the Medicare Act has now come to identify that as the usual fee. You are referring

to the customary fee which is the fee which applies to physicians of like competence, training, and so on, in the geographic area.

Now, we in the medicredit bill use the terminology that payments shall be by usual, customary, and reasonable, very much as the medicare bill originally defined them. Now, there have been circumscriptions on this which have been put on by subsequent regulation from the Social Security Administration, as I am sure you are well aware, and the application of percentiles which were never mentioned in the original medicare legislation.

Mr. VANIK. I have just one other statement, and I was prompted to ask this question because of what you said. You said the physician acts as a purchasing agent for his patient.

Recently I had to purchase some medical care, in which there were some laboratory fees which were worth about $25, but they were billed to me at about $137. Do you as a matter of policy feel that the services of other people who render health care should be included in the doctor's bill with a markup above their actual cost?

What is the attitude of the American Medical Association on this point?

Dr. ROTH. A very clearly defined attitude, sir. Our principles of medical ethics say that the doctor should derive his professional income from only services which he renders personally.

Mr. VANIK. Right here, and throughout the country, one of the reasons these services are included on the doctor's bill is in order to get them compensated. For under many plans, the cost of laboratory services and other things that are acquired are not collectible, so that I can see where a great many of these billings have gotten onto the doctor's bill to provide for their collectibility.

Do I understand that your association takes the position that these things should be allowed as separate payment items under insurance programs?

Dr. ROTH. Yes, sir. I am sure you are aware, or I hope you are aware, that that has been a thorny problem approached in many different ways. For example, New York State passed a bill which required that the laboratory, not the doctor's office laboratory, but the commercial laboratory doing work, would need to bill the patient for the services, or at least notify him of the services. This sounded good until it became law and it became incumbent upon the laboratories to do all the paperwork to do that billing, and it immediately ran up the costs of medical care by doing this.

For this reason we opposed such a similar proposal in Pennsylvania. There needs to be a way to do this and there is no excuse ethically, it may be legal but it isn't ethical, in the medical profession to get any kind of rebate, kickback, and so on and so forth in this field.

Mr. VANIK. Or imposing a charge for the service rendered by anyone else but the doctor.

Dr. ROTH. This is correct.

Mr. VANIK. I thank you very much.

Mr. ULLMAN. Due to the quorum call, the committee must adjourn now. Can you be back with us at 2 o'clock?

Dr. ROTH. I can.

Mr. ULLMAN. Can you, Dr. Parrott?

Dr. PARROTT. Yes; I can be back.

Mr. ULLMAN. We will appreciate it very much.

The committee will stand in recess until 2 p.m.

(Whereupon, the committee recessed, to reconvene at 2 p.m., the same day.)

AFTERNOON SESSION

Mr. CORMAN. The Committee will resume its hearings.

Gentlemen, we very much appreciate your patience and willingness to come back this afternoon. I think it is apparent that this committee greatly respects your store of knowledge, and we are all searching for some answers to a very complex problem.

STATEMENT OF DR. MAX H. PARROTT, CHAIRMAN, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY DR. RUSSELL B. ROTH, SPEAKER, HOUSE OF DELEGATES; AND HARRY N. PETERSON, DIRECTOR, LEGISLATIVE DEPARTMENT—Resumed

Mr. CORMAN. Do you have questions?

Mr. PETTIS. No, no questions.

Mr. CORMAN. Mr. Gibbons regretted he cannot be here this afternoon, and he asked me to pose two questions to you which you may be prepared to answer now, or for the record.

There was a reference on page 3 to the effect that life style plays in health statistics, and you discussed venereal disease. You also agree that smoking is a good example in this area.

Would the American Medical Association support more action to reduce smoking in the American population?

Dr. PARROTT. I didn't understand the last phrase.

Mr. CORMAN. The question is, Would the American Medical Association support more Government action designed to reduce smoking in the American population?

Dr. PARROTT. Well, I think we would encourage it. What the American Medical Association may or may not do depends on the House of Delegates. I think the question is to what extent life style has effect. Of course, basically, smoking has one—has two or three relationships to health.

Cigarette smoking, particularly, has to do more with emphysema and with lung cancer, really, than it has to do with heart disease, but nobody at any level in medicine proposes that smoking does any good. But it is not the most important defect in our life style as far as health is concerned.

Probably the most important as far as degenerative disease is concerned has to do with nutrition, over nutrition, and excesses in overeating, alcohol, and underexercising. These are relative to degenerative diseases such as heart disease and vascular disease.

Mr. CORMAN. Off the record.

(Discussion off the record.)

Dr. ROTH. Mr. Corman, may I comment that the American Medical Association is well aware that its involvement in the smoking problem has been widely misinterpreted, based on an early decision that it was probably not going to be possible, and certainly no one was going to try, to legislate smoking out of existence in the way we tried to legis-

late drinking out of existence at one time in our history. Since people insisted on smoking, it might be a contribution if ways could be found to modify the smoking habit, or produce things that might conceivably be safe to smoke, or at least less deleterious to smoke, and so we went into a promotional role in research to see if we could help to underwrite, and we acted as middleman for money from the tobacco industry, to farm this out to unbiased, competent, research centers to work on this.

This was interpreted as some kind of queasiness on the part of the AMA, collusion with the tobacco industry, and so on. It was almost made to seem that we were in favor of smoking and to the tobacco interests.

I think this was clearly not true, and our statements, as Dr. Parrott has indicated, have been that this is a role for education, that physicians can play a major part in it. I think we would need to examine very carefully any proposal for legislation in this area.

Mr. CORMAN. Thank you.

The other question, Mr. Gibbons wanted asked was, Would you be able to supply for the record the number of members of the American Medical Association who are graduates of foreign medical schools and the number who are not now citizens of the United States?

Dr. ROTH. I believe we can do this with the greatest of ease. We certainly will try. I think we have a pretty close answer to this in our files.

Mr. CORMAN. Thank you.

(The material referred to follows:)

According to *Foreign Medical Graduates in the United States, 1970*, a recent publication of the AMA Center for Health Services Research and Development, as of December 31, 1970, there were 57,217 graduates of foreign medical schools (excluding Canadian) in the U.S. Of this number, 22,335 were members of the American Medical Association.

There are no available data on foreign medical graduates by country of citizenship. However, according to *Foreign Medical Graduates in the United States, 1970*, 5,792 of the 57,217 foreign medical graduates were born in the United States.

Mr. CORMAN. Gentlemen, I would like to learn a little more about peer review, because I take it almost everyone concedes that it is a useful tool in almost anything that the Government does in the field of medicine. We place great reliance on peer review. Does peer review attempt to influence both the quality of the medical delivery service and the cost, or only the former?

Dr. PARROTT. It goes both ways, Congressman. Peer review, of course, is a thing that was created by the medical profession itself. It comes out in our organizational situations with names like the tissue committee, names like insurance review committee, and names like utilization committee, names like the grievance committees.

These committees are designed in one area for fee review, and in other areas for quality and service review.

Now, this is the genesis of peer review. It started with societies, and the word "peer" is reference to other doctors, if you are talking about quality of mechanistic medical care.

If you enter the fee end of it, of course, insurance people are involved and other people who handle statistical intermediary situations.

If you are talking about health care, which is a little bigger than mechanistic medical care, then maybe other people could be involved.

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*Editor's Note.—Page 2101 follows.

But our position has been that if you are talking about medical care, the peer should be another physician.

Mr. CORMAN. That is the area, about which I want to learn a little bit. I take it that you recommend this, because from time to time you discover that there is poor quality of care, overutilization by a doctor, or improper procedures or something of that sort. Is that true?

Dr. PARROTT. That is correct. I don't think that the medical profession is any different than any other profession, that we have all graduations of excellence of care. It is very had to define quality, because the bell curve works with us, as it does with lawyers, or ministers, or whatever.

Mr. CORMAN. You may be unique among professions, though, in that you apparently have some mechanism for some review. I am not sure that is true with all the professions. I am a professional man myself, and I never have a feeling anybody is looking over my shoulder.

What do ethics demand of you when you discover that there has been improper care delivered? Are you obliged to notify the patient?

Dr. ROTH. Well, I think that if there are any semblances of legal problems, this would be a necessity. The general context or setting in which a matter appears for peer review, or has traditionally, was on the basis of some formal presentation of a complaint, a question about appropriateness of care or the charges made, and so on.

Now peer review, although it still is fairly embryonic, is not yet a very sophisticated mechanism, in most parts of the country. But it is being aided and abetted by electronic data processing which is essential if peer review is to reach the full spectrum of medical care services.

You see, it was developed largely for institutional care review in hospitals. It becomes more and more difficult the further away from the hospital you get. When you get into the physician's office, when you get into home care, there are real problems about what you review, what you look at, what the records are, and so on.

So that nowadays the peer review system is becoming more and more dependent on programing computers to recognize acceptable norms, and to throw up a red flag or toss a claim out for a harder look when it is outside any of the norms.

This does not necessarily mean that there may not be explanations, perfectly adequate explanations, of why it is outside the norm, but you have got to look at it, and this requires the physicians to review it.

Dr. PARROTT. If they are dissatisfied, we would prefer to have them come through the grievance committee. I have sat on the grievance committee in our county, and the grievance committee finds against the doctor just about as often as they find for him. If you are asking about how they discipline the doctor, most of the time the doctor will conform to the opinion of the committee, even though they find against him, and if he reappears too many times, then disciplinary action is taken, and has been taken.

Mr. CORMAN. It seems to me as government and/or insurance companies get more deeply involved in paying for medical services that the peer review system is going to have a broader opportunity for application than it does at this point.

It seems to me you almost have to have that third party factor in there, because that is the only way we are going to have some records

But I am still trying to find out just what the situation is, and what you think it ought to be in the way of your taking affirmative action to inform the patient, first, about overcharging, and, secondly, about what you determine, as doctors, to have been either over-utilization or actual poor care. Have you gone out to tell the patient, without the patient's ever having come to the board with a complaint?

Now in direct response to your question, "What did ethics require?" The ethical principles that bear on this are that a physician should most assuredly not abuse the trust that is placed in him and treat improperly or with undue frequency. It may be excellent treatment, but maybe he just goes and sees a patient with a cast on his leg every day, and charges for it, which is not bad care but it is certainly an abuse of the system.

I think the review committees would take action on evidences of this sort, and they certainly tell the third party payer in the case what they think is a defensible level of charges. If the matter goes to court, the review committee is prepared to testify in behalf of its judgment.

Mr. CORMAN. We always seem to be, it seems to me, almost entirely concerned about the financial circumstance, whether the Government or the insurance company, but the patient has a stake in the charges, too, and that is why I am wondering: Is the patient notified, as is the insurance company, when you find a case where there has been overcharge?

Dr. PARROTT. If you come from a big metropolitan county such as I do, you do have the grievance committee. I have advised patients who were dissatisfied, both with somebody else's care or with my own, to go to the grievance committee. Most patients don't realize that these committees exist.

Mr. CORMAN. Yes, sir. That is what I was wondering, of what use to the patient peer review would be.

Dr. ROTH. My reaction to that is that I would agree with you completely. If this is a concern, obviously there has to be a patient at the bottom of the concern, whether it is the computer that throws up the case and there is an adjudication in it, I don't know. I have known of no reason why the patient would not be fully informed, and I think he should be.

Dr. PARROTT. One of the read difficulties, sir, is how do you define poor care.

Mr. CORMAN. I don't mean that. That is what you are telling me. You don't want me to do that, you want to do that.

Dr. PARROTT. It is very difficult. People get the idea that things are black and white in this sort of thing, and they are really not because, yes, we can peg poor care in the hospital, and usually that disciplinary action is taken on hospital staffs, but there are all graduations of care, and a hospital is a big, complicated organization, and to define or set the guidelines is not easy. It is complicated.

Mr. CORMAN. Yes, sir?

Dr. ROTH. I was just going to comment that on this very question, the Federal Government has now acted. I sat with a regional council yesterday, regional medical programs, and learned this has been put officially and formally in their lap to try to develop some guidelines,

some parameters by which one may judge this very question. They, too, were coming to us for help because this is a very difficult area.

Mr. CORMAN. We had testimony before this committee at one time that because of the computer records, it surfaced that one doctor was performing most of the tonsilectomies although there were fifty doctors in the system. They decided that the doctor was takiing out tonsils that probably should not have been taken out.

My question is, Is the patient informed of that fact, the patient who has had his tonsils out? Does anybody let him know that there has been a question raised concerning the care given to him?

Dr. ROTH. I am sure you recognize, Mr. Corman, that what comes generically under the term "peer review" is not at all uniform. The foundations vary considerably among themselves, now that foundations have become so popular. They are in various stages of development all across the country.

But peer review is supplied in the original foundation in the San Joaquin Valley in California, and that differs considerably from peer review as it is performed in Allegheny County, Pennsylvania's 10th Regional District, which was really, I believe, historically speaking, the originator of peer review. That was the first program. It is different in Nassau and Suffolk Counties in New York.

So I think there is probably no single answer. There may well be places where there is an automated, depersonalized thing where patients are not involved, but I believe peer review puts the patient very much into the question.

Mr. CORMAN. After there is a final determination made that there has been either improper care or overcharge, are those records made public by the peer review board?

Dr. ROTH. I do not know the answer to that.

Mr. CORMAN. Do you think they should be? I am not talking, now, about during the investigating process. Obviously, there is a good reason for those being non-public, but once a conclusion is reached by a competent peer review board, should that be made public?

Dr. ROTH. One of the major benefits from peer review is inevitably physician education. This crops up in several cases, several instances, several varieties of ways.

The average hospital which institutes a utilization review committee finds that there is, just by the sheer existence of the committee, some improvement in the habits of the staff in terms of discharging patients on time, as early as is consistent with good care, and various other things.

But if you have a physician who is doing things that fall outside the prescribed norms and he is brought before a utilization review committee and educated in the possibility of doing things better, one might be better off by keeping yourself alert and watching him for a while, to assure he does do better. There might be more to be gained from this than publicizing his record and somehow or other estranging him with his patients. I don't know——

Mr. CORMAN. But you would agree that the patient should have access to the information?

Dr. ROTH. The patient in the cases in question, I believe, certainly should know.

Dr. PARROTT. With threatened litigation, most States have a statute of limitations that runs from the time the patient receives the informa-

tion. In other words, if a mistake is made in surgery, you have to inform that patient in order to have the statute run. I think this is done, as a matter of self-protection, I think the profession does this pretty routinely.

As far as medical care is concerned, in the office, that is another game in another ball park.

Mr. CORMAN. Can we turn just a minute to how medicredit could affect what I guess we can assume is the typical median income family.

As I recall, median income in this country is $9,000 a year for a family of four, but the figures in the report are for a family of four with an income of $10,000.

He would have a tax liability of $891. The medicredit insurance policy would cost him $650, and so he would have a $65 credit, tax credit toward that $650.

Mr. PETERSON. Mr. Corman, if you are referring to the 10 percent tax level, the 10 percent would apply toward the basic portion, if you are looking at that, which would be $600 on the cost of the policy, so that it would be a $60 tax credit.

Mr. CORMAN. $600 instead of $650.

Mr. PETERSON. And then the $50 attribuable to the catastrophic fee would be paid entirely by the Federal funds.

Mr. CORMAN. So he has a tax credit of $60 toward the tax he owes of $891.

The policy, however, is purely optional with him under your proposal, is it not?

Mr. PETERSON. That is correct.

Mr. CORMAN. Isn't it going to take a fair amount of education or selling on the part of the insurance company to convince a man living on that income that he ought to spend $540 of his own so that he will have that coverage available to him?

My next question, and you can comment on both of them at the same time, is: Isn't the selling cost of the voluntary insurance coverage going to consume a pretty good chunk of the dollars we take from him?

Dr. ROTH. Well, we would hope not, and we feel we have fairly good reason to think not.

We believe that the great majority of people in this income class are employed, and the overwhelming bulk, 90-plus percent, of people who are employed in this category have health insurance protection already supplied for them by their employers.

Now, you are dealing, then, with a relatively small number of people, presumably mostly self-employed, who would come up against this question. The option would not belong or remain concealed from them, because the moment that they started filling out their annual income tax form, certainly if they used any kind of assistance in this, the tax man is going to say, "Where is your health insurance receipt, how much did you pay?" Or ask him a question so that he could file for that $60, and if he learns they have no such thing, he can point out to them that they are really missing quite a bargain, because for the $540 that they would have to send in, they then get a basic policy, but they also get the catastrophic coverage, which is quite a bargain.

Mr. CORMAN. You mean they do not have catastrophic coverage unless they buy the other policy?

Dr. ROTH. Our catastrophic coverage is an integral part of the package. It is our feeling that catastrophic coverage is best when it rests on a firm base of coverage.

Mrs. GRIFFITHS. Would the gentleman yield to me a minute?

I question your statement that so many are covered by employers. There are only a few million covered by employers. That would be the big unions.

In general, that really isn't true. I would think you would have millions and millions of people left to be covered by this, and isn't that really the principle of the President's bill?

Dr. ROTH. Mrs. Griffiths, we were talking specifically about a family with an income of $10,000 a year. My statement referred only to the Congressman's question.

Mrs. GRIFITHS. But half of them are below that, if that is the median income.

Mr. CORMAN. Yes, because the median is nine.

Mrs. GRIFFITHS. So half would be below that. I think there would be quite a few more people than you are estimating who would need to be covered.

Dr. ROTH. I have to confess that I do not have those figures with me, but if you would like, I would be glad to supply to you the figures I am trying to recall. They are not our figures. They are from the insurance industry.

Mr. CORMAN. Thank you.

(The information to be supplied follows:)

Since the IRS presents data by income intervals, it is necessary to estimate the number of persons who had employee-benefits plans at an adjusted gross income level between $9,000 and $10,000 rather than just at the $10,000 level. According to the IRS, 14,182,954 exemptions were claimed between $9,000 and $10,000 of adjusted gross income in 1969. Ths figure slightly overstates the actual number of persons at this level since certain groups of people, such as the blind and aged, receive more than one exemption.

Using both SSA and IRS data, it is estimated that 10,400,000 in that income category had an employee-benefits plan in 1969.

According to the Social Security Administration, an estimated 145,600,000 wage and salary workers and their dependents were covered under employee-benefits type plans in 1969. The SSA defines employee-benefits type plans as those plans whose benefits flow from the employment relationship and are not underwritten or paid directly by Federal, State or Local governments. Of the 145,600,000 figure, 56,800,000 are employees and 88,800,000 are estimated to be the employees' dependents.

Mr. CORMAN. The only value I can see in the Administration's proposal is that it makes the insurance compulsory and by that mechanism removes from the insurance costs the costs of selling. I don't think anyone can quarrel with the insurance industry. For that part of the American people who are not obligated to buy it, somebody has to sell it to them. They estimate for the first year 40 percent of the premium to be the selling cost. I think that is perfectly legitimate, but I am wondering how costly that part of your program is going to be. How much is it going to cost us to get those people to take advantage of this proposal? You realize that in the long run all their dollars are buying them is a certain amount of medical care. When costs go up, they are getting 10 percent off, but they are paying 40 percent in the selling cost.

Dr. ROTH. Well, I might only comment, Mr. Corman, that this gives me a dilemma, because we have been talking about our lack of en-

thusiasm for having our way of providing medical care radically remodeled. However, I think there is inherent in our proposal a radical remodeling in the way the insurance industry is going to do business. This may account for the fact that they have their own bill rather than completely endorsing ours, but there are going to be substantial changes in the marketing of insurance, health insurance, on this basis.

In the first place, there is not going to be wide open competition in advertising among companies and prepaid plans and Blue Shield, Blue Cross, and so on, because only a certain number are going to be doing business in any one jurisdiction, as they are approved by State insurance commissioners, and people in that State, presumably, would only be buying or taking policies from those approved companies.

This eliminates much of the appeal of the mail order advertising, full page newspaper advertising, of health insurance.

You are absolutely correct when you point out that a major cost element in the administration of individual policies is because of ths, the cost of advertising and direct sales, and that this is not normally a feature in group insurance.

These companies don't sell much group insurance by their advertising programs. This is done by dealing with responsible personnel people and business people who are signing up for group coverage. It seems to us that there would be a major reduction in administrative costs, markedly bringing the area of individual policy sales which is most expensive now, down to the level where the private insurance industry has shown itself to be quite competitive with Government. As a matter of fact, I think I would have to defer to the insurance industry on this, but I believe that they can show that their administrative costs in the Federal employees' health benefit program is as good or better than the administrative costs in the portion of the program which is managed by the Government alone.

Mr. CORMAN. Yes, sir, but the people I am concerned about at the moment are those who are going to be buying individual health insurance policies, and I really suspect there are many, many millions of them. They are people who don't work for the Government or large companies nor are members of unions where they get that kind of arrangement. There must be on the whole 200 million people. I guess we are talking about half of them.

With respect to these individual policy cases, I assume the companies would have to have some exclusions of pre-existing medical conditions. For instance, I can't wait until I get emphysema and then go buy into the system.

Dr. ROTH. Our thought is that indeed you could. It is essential that you should be able to, and as a matter of fact, since particularly in the lowest income groups, the really disadvantaged people, the rural people who may somehow or other remain unaware of this program, the first real contact with the system may be when illness develops and someone in that family appears in the doctor's office or is admitted to the hospital. We really envision ways of making this coverage retroactive to cover even this. It certainly makes sense that it should, because of the cost of illness is going to have to be borne in one way or another, and we would rather make it through the program, for uniformity, than to have to set up some additional kind of program to take care of that.

Mr. CORMAN. Then your legislation envisages that we have Federal regulation of the insurance policy that prohibits excluding existing conditions when the beneficiary buys the policy?

Dr. ROTH. That is correct. This would even apply to the patients in the hospital with a disability when they are first covered.

Mr. CORMAN. Did your actuaries take this into account when they estimated the cost would be $650 a year?

Dr. ROTH. Yes, sir.

Mr. CORMAN. That is very difficult to believe. Any thinking American would just wait until he is sick to buy his insurance policy if he has the opportunity to do so, when he knows that his existing condition at that time does not exclude him from coverage.

All of the policies that I know about now just will not insure you against the known problems. They only insure you against the unknown problems, and their rates are really substantially more than this for the kind of coverage that involves, say, 60 days in the hospital or numerous doctor's visits.

Dr. PARROTT. There are many insurances that will give you a waiting period for known diseases.

With a known uterine disease, the insurance company will pay for a hysterectomy after a certain waiting period. They will do the same with other conditions on certain policies.

Mr. CORMAN. Individual policies, or group policies?

Dr. PARROTT. Most of the policies we see are group policies.

Mr. CORMAN. Of course. You can take a group, because they aren't going to have the same thing at the same time. Say, I am an individual, and I make $10,000 a year. By the time I pay my taxes and feed my kids, I don't have much money left. Somebody says, "You ought to have an insurance policy." I say, "I don't need it now. I will wait until I get sick and then buy it."

Under your proposal, I could do that. Am I correct?

Dr. PARROTT. Under this type of program, I believe there is going to be forced upon the insurance situation a State pooling, because we have to cover the bad risks, too, and I think there is going to have to be a way in which insurance is managed to make the insurance work for disadvantaged people.

Mr. CORMAN. I am not disadvantaged. I make $10,000 a year.

Dr. PARROTT. The same thing would apply. It would be an advantage to have this program where you would not have to worry about belonging to a group.

Mr. CORMAN. But I don't want to get into the group until I get sick, because I don't want to be spending $560 a year for something I don't need. If I am well, I don't think I need that coverage.

I am wondering what would happen to the costs if you allow the individual to stay out of the program until he gets sick.

Dr. PARROTT. The program is worked out on the prospect that it would reach near universality.

Mr. CORMAN. But the universality is dependent on the individual decisions. Why should I buy? Not to get the $60 tax credit.

Dr. ROTH. Your point is understood and well taken. This is a problem any time that you try to achieve functional coverage. There is no sense having an insurance program if nobody has the coverage. It is probably pointed out most sharply in the problems that your

committee has been wrestling with as far as the disabled, the proposals that they be covered by extensions of medicare.

This is a population that is, for all intents and purposes, 100 percent a liability to the program so that your policy depends on actuarial calculations recognizing that this is indeed a fact.

Now, $630 is a premium for insurance coverage for a family of four today and will, on a group basis, buy more benefits for a selected group than we have indicated in our coverage.

But this is because our actuaries tell us that we have got these problems to cope with, that we have to accept that we are not covering a selected group.

This is one of the problems of looking at, for example, the Kaiser Permanente experience, which has been so widely quoted. Kaiser Permanente has been, as yet, an across-the-board, all risk type of coverage. It does not accept people from the totally zero income level. It isn't a poverty program. This is the challenge to the HMO, to see whether you can make this kind of thing work.

We believe that actuarily it can be made to work, but I concede to you, sir, that if every person in the country took the attitude that they were not going to buy their insurance until they were ill, we would be in about the same situation as if nobody would buy automobile insurance until they had a wreck. This would be very difficult.

We think there is a sufficiently sound recognition of the insurance principle in this country that we have a sound base on the group insurance experience as it now exists, and that with education and the tax incentives it will indeed spread. We would hope nobody would preach your approach.

Mr. CORMAN. What you really have to hope is that the individual doesn't figure it out more himself. The fellow living on $10,000 a year gives a lot of thought to where he puts $660 of his money and the insurance broker comes around and tells him how great it is to be covered, and somebody else says, "Well, don't buy it this year, you are well; wait until next year, and if you get sick, then buy it." I really think that would destroy the whole theory of insurance.

Dr. ROTH. Am I not correct, however, in recalling that the Health Insurance Association of America's own bill constructed by the people who ought to be the experts in the field has fundamentally this same concept?

Mr. CORMAN. I didn't ask them these questions. Maybe I should have.

Dr. ROTH. I wish you had asked them.

Mr. BURLESON. If the gentleman will yield.

In introduced that bill, and I would say no, it is entirely voluntary in every respect. There is no requirement or any compulsion anywhere.

Dr. ROTH. This is what I mean. This is what I was saying, so that the question that he was directing to our bill would be equally appropriately directed to your bill, is this correct?

Mr. BURLESON. That is true, but in Medicredit you do have a requirement on the employer's part to meet necessary obligations if he is to receive tax benefits. There is a feature of compulsion on the part of somebody, somewhere in the system, and H.R. 43 and 49 is the only proposal which doesn't have a feature of any sort of compulsion.

Dr. ROTH. Our compulsion is on the tax reduction to the employer if his coverage does not meet the specified benefits.

Mr. BURLESON. That is correct.

Dr. ROTH. Thank you.

Mrs. GRIFFITHS. Mr. Chairman, may I ask this:

Wouldn't it be that a family of four doesn't generally pay out $560 a year in health care?

Dr. ROTH. As an insurance premium?

Mrs. GRIFFITHS. No, not as an insurance premium, but just for health care. Isn't the bill generally $250 or $300 for a family of four?

Dr. ROTH. We don't have that figure, Mrs. Griffiths.

Mrs. GRIFFITHS. If it is—I think it is about $300 generally—it would mean that really the family would be just as well off not to have it at all, not to have the coverage at all as to buy $560 worth until they really got sick, after they really needed it.

Dr. ROTH. They would be really well off if they never got sick.

Mrs. GRIFFITHS. If they could wait, as Mr. Corman suggests, that they could wait until they are ill, they would wait until they had an illness that would cost more than $560.

Dr. ROTH. Isn't this the old problem of spreading the risk? If the family could be guaranteed that it was going to be the average family and spend $300 a year, this is absolutely correct, but the insurance principle is for covering the risk, because that family gets hit with the $1,500 where the other families, five other families, pay nothing.

Mrs. GRIFFITHS. But the point of Mr. Corman, as I understand, is that you are not spreading the risk. You are in reality saying to every one of these people, "You don't have to buy until you are sick." Then you don't spread the risk between the sick and the well. Only the sick are going to buy this insurance, and I would assume that this would really be true with big employers. If they are going to negotiate with unions for this coverage, I think they would run a few little statistics of their own and say to the employees, "We will buy it when you are sick," which I think would be really devastating.

Dr. ROTH. Well, it just simply wouldn't work if that were the case.

Mr. CORMAN. I had that feeling when I read the bill.

If I could turn to your closing statement——

Dr. ROTH. I don't think that really is a——

Mr. CORMAN. I think what you will find, if you check with the people who did your insurance estimates, is that they did not anticipate insuring existing conditions immediately, because you are talking about the fact that there was too much money put into the old people's doctor bills?

Dr. ROTH. Well, the principle to which I alluded is that medicare provided coverage for everyone over 65 without any reference to their ability to pay. The insurance companies had provided, had sold, coverage to millions of these people that obviously had some ability to insure themselves against cost of illness in spite of their age. There were many people who probably had that capacity without reference to insurance, and the Federal Government paid all of those premiums.

This is a major difference between the medicare program and our eldercare proposal, because we felt that those over the age of 65 who could contribute to insuring themselves, should.

Mr. CORMAN. Take them as a conglomerate, everybody over 65. This medical bill wasn't any higher or lower because of medicare. It

is just that you feel we shifted the responsibility for paying it in part, at least, to the wrong person—the Federal Government?

Dr. ROTH. This is an important element. We also feel the development of this vast administrative creation has probably been more costly than it might have been if we had followed the eldercare use of existing insurance company mechanisms.

Mr. CORMAN. Eldercare anticipated voluntary purchase of insurance, did it not?

Dr. ROTH. It did.

Mr. CORMAN. Then we get back to the problem of how much of the premium dollar goes for health care and how much for selling insurance.

I think it is probably about the same here, and the argument is really who should have paid for it.

Mr. ROTH. Well, yes. I do not believe the figures show an immense increase in the amount of medical care or the number of patients that were provided care when medicare became available to them. There was a time back there in 1965 when a number of things were happening in the medical care field.

This was about the time that the coronary care units and the sophisticated equipment that I referred to in my earlier testimony was invented. It became necessary for virtually every hospital, if it was going to maintain its reputation and ability, to equip itself with these things. This is about the time that dialysis for kidney disease came along, and this was also the time when the substandard pay scales of the hospital people were beginning to become a major issue, and the effort was made—which is not complete yet—to bring these hospital pay levels up to a standard acceptable level.

All of these things conspired to increase the cost, particularly of hospital care.

Mr. CORMAN. Those costs were not affected by the introduction of medicare one way or the other.

Dr. ROTH. They were not.

Dr. PARROTT. No, they were not. We made a pretty good estimate of what medicare would cost, and testified to that effect before this committee. It didn't come quite that high, but it came closer to that figure than to the $2.1 billion.

Mr. CORMAN. We would both agree that to deliver that medical care to those people would cost $7 billion, regardless of who provided the care. You weren't really quarreling about the fact that the care was needed and the price was reasonable, but the quarrel was who should pay for it.

Dr. PARROTT. That is right.

Mr. CORMAN. Mr. Burleson?

Mr. BURLESON. No questions.

Mr. CORMAN. Thank you very much, gentlemen.

Dr. PARROTT. Thank you, Mr. Chairman.

(The following material was received by the committee:)

STATEMENT OF AMERICAN MEDICAL ASSOCIATION

OPPOSITION TO INCLUSION OF CHIROPRACTIC SERVICES IN HEALTH BENEFITS UNDER NATIONAL HEALTH INSURANCE LEGISLATION

The American Medical Association believes it is imperative that the services provided the public in any national health insurance legislation must be *quality*

health services and we sincerely believe, as do many other national organizations interested in protecting the public health, that these covered services must not include such unscientific cults as chiropractic and naturopathy.

Attention is called to the attached "Brief on Chiropractic" and the leaflet "what they say about chiropractic", in support of this vital position.

BRIEF ON CHIROPRACTIC

The medical profession, the rest of this nation's scientific community and many, many other national organizations interested in maintaining quality health care for the elderly are unalterably opposed to the inclusion of chiropractic in Medicare in any form because such inclusion seriously would reduce the quality of health care provided and increase the cost without any justification. The evidence is overwhelmingly conclusive, documented by independent studies, that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease.

The cost of inclusion of chiropractors on the same basis as doctors of medicine or doctors of osteopathy was estimated in 1969 by the Social Security Administration at 26¢ a month per enrollee or $60 million. Government agencies have estimated that 4 million persons patronize chiropractors annually—or about 2 per cent who patronize chiropractors.

Three government reports, including one ordered by the Congress, have found that chiropractic is not qualified as a health care provider. They are:

HEW study report to Congress entitled Independent Practitioners Under Medicare (December, 1968)

Task Force on Medicaid and Related Programs (June, 1970)

National Advisory Commission on Health Manpower (November, 1967)

In addition, the Federal Government's own Health Insurance Benefits Advisory Council (HIBAC) has advised Congress of its strong opposition to chiropractic inclusion.

This position also is supported publicly by:

The American Public Health Association

The American Hospital Association

The Association of American Medical Colleges

Most health-oriented national organizations

This position also is supported independently by:

The AFL–CIO

The National Council of Senior Citizens

The Consumer Federation of America

The attached leaflet entitled "What They Say About Chiropractic" includes excerpts of these and other public statements in opposition to chiropractic.

The Task Force on Medicaid and Related Programs specifically recommends also that "A legislative amendment should be enacted (by the Congress) denying Federal financial participation in Medicaid payments to chiropractors and naturopaths." This position also is strongly supported by the American Public Health Association, the AMA, the Consumer Federation of America and others.

Inclusion of chiropractic would open the door to inclusion of other cults such as naturopaths and naprapaths and would create administrative chaos.

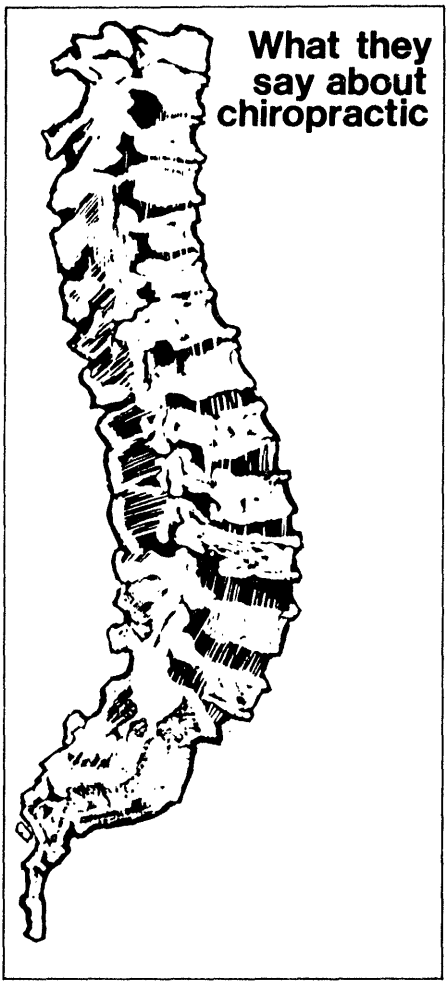
Other documented points:

No chiropractic school is accredited by any recognized educational accrediting agency in the United States.

Chiropractic schools and students are not included in HEW programs such as Health Professions Educational Improvement Grants, Health Professions Student Scholarships, and Health Professions Student Loans.

Chiropractors are not granted commissions in the Armed Forces and are not eligible to practice in VA Hospitals, nor are they allowed to practice in any hospital accredited by the Joint Commission on Accreditation of Hospitals.

Chiropractic has publicly opposed school immunization programs and community fluoridation programs, both endorsed by the United States Public Health Service.



U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
The U.S Department of HEW submitted to Congress findings of an independent, unbiased ,study of chiropractic ordered by Congress under the title of "Independent Practitioners Under Medicare" with a letter of transmittal dated December 28, 1968, and signed by Wilbur J. Cohen, then Secretary of HEW. In regard to chiropractic, the Conclusions and Recommendations of the HEW report were:

CONCLUSIONS AND RECOMMENDATIONS
1. There is a body of basic scientific knowledge related to health, disease and health care. Chiropractic practitioners ignore or take exception to much of this knowledge despite the fact that they have not undertaken adequate scientific research.
2. There is no valid evidence that subluxation, if it exists, is a significant factor in disease processes. Therefore, the broad application to health care of a diagnostic procedure such as spinal analysis and a treatment procedure such as spinal adjustment is not justified
3. The inadequacies of chiropractic education, coupled with a theory that de-emphasizes proven causative factors in disease processes, proven methods of treatment, and differential diagnosis, make it unlikely that a chiropractor can make an adequate diagnosis and know the appropriate treatment, and subsequently provide the indicated treatment or refer the patient Lack of these capabilities in independent practitioners is undesirable because: appropriate treatment could be delayed or prevented entirely, appropriate treatment might be interrupted or stopped completely, the treatment offered could be contraindicated, all treatments have some risk involved with their administration, and inappropriate treatment exposes the patient to this risk unnecessarily
4. Manipulation (including chiropractic manipulation) may be a valuable technique for relief of pain due to loss of mobility of joints. Research in this area is inadequate; therefore, it is suggested that research that is based upon the scientific method be undertaken with respect to manipulation

RECOMMENDATION
Chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment. Therefore, it is recommended that chiropractic service not be covered in the Medicare program.

TASK FORCE ON MEDICAID AND RELATED PROGRAMS
In its report to the U.S. Secretary of Health, Education and Welfare, dated June 30, 1970, the Task Force on Medicaid and Related Programs concluded that payment for chiropractic and naturopathic services "is not an effective use of Federal Medicaid funds." The report recommended: *"A legislative amendment should be enacted denying*

Federal financial participation in Medicaid payments to chiropractors and naturopaths"

NATIONAL ADVISORY COMMISSION ON HEALTH MANPOWER

In its 1967 report to the President, the National Advisory Commission on Health Manpower states, "Although chiropractic is not the only existing cult, it is the only one which still constitutes a significant hazard to the public."

In discussing state licensure of chiropractors, the Commission also says: "Ideally the statutes should be repealed to remove the cult's shield of legitimacy," and adds: " It should be recognized that no matter how high they are set, no matter how strictly they are enforced, licensure standards cannot redeem the scientific invalidity of chiropractic."

In its summary and conclusions, the Commission states "Attempts to control unscientific schools of practice or cultism by licensure cannot give unscientific practices a scientific basis but can endanger the public by giving unscientific schools, such as chiropractic, protection through the sanction of law."

AMERICAN PUBLIC HEALTH ASSOCIATION

The following resolution was approved by the Governing Council, American Public Health Association, November 13, 1969:

"It appears that the practice of chiropractic and naturopathy constitutes a hazard to the health and safety of our citizens The American Public Health Association therefore urges.

"1. That Congress amend Title XIX of the Social Security Act to specify that Federal funds not be used to match State Medicaid expenditures for chiropractic or naturopathic services

"2 That Congress not amend XVIII of the Social Security Act to permit coverage of chiropractic or naturopathic services in the Medicare program

"3 That State legislatures and health agencies not include chiropractors and naturopaths under State health programs

"4. That States reevaluate their existing licensure programs for chiropractors and naturopaths to determine whether such licenses should be further restricted or abolished, and that existing restrictions be more rigorously policed

"5. That professional and consumer groups undertake appropiate consumer education on the hazards of unscientific health care, including chiropractic and naturopathy"

AFL-CIO

Excerpt from "Fact Sheet" submitted by AFL-CIO in connection with testimony by Andrew J. Biemiller, Director, AFL-CIO Legislative Department, before U S Senate Finance Committee, September 15, 1970

"Care of patients should only be entrusted to those who have a sound scientific knowledge of disease and whose experience and competence render them capable of diagnosing and treating patients by utilizing all the resources of modern medicine Since neither chiropractic theory nor the quality of chiropractic education equip chiropractors to do this, the AFL-CIO opposes coverage of chiropractic services in the Medicare program"

CONSUMER FEDERATION OF AMERICA

The Consumer Federation of America, representing 184 local, state and national consumer-oriented organizations with millions of members throughout the nation, adopted the following resolution at its Annual Meeting on August 29, 1970

WHEREAS, CFA is concerned that studies of chiropractics have not produced evidence of the scientific validity of chiropractic theory and practices, and

WHEREAS, CFA is gravely concerned that medicare coverage of chiropractic services would needlessly expose beneficiaries to potential health hazards--particularly the harm which would result when beneficiaries treated by such practitioners delay or avoid seeking proper medical care, and

WHEREAS, chiropractors are not trained to diagnose possible malignancies, diabetes, acute heart conditions or similar systemic diseases which frequently underly the symptomatic complaints of their patients, and

WHEREAS, the aged and needy are most vulnerable to patient management techniques but frequently less capable of judging the efficacy of the treatment they receive, and

WHEREAS, in addition to increasing the health hazards to beneficiaries the inclusion of chiropractic services would add substantially to the cost of the Medicare program,

BE IT RESOLVED, that CFA urges the Senate Finance Committee to reject the inclusion of chiropractic services under the Medicare, Medicaid, and all other federally supported health programs at this time.

NATIONAL COUNCIL OF SENIOR CITIZENS

Excerpt from the *Senior Citizens News*, January 1969, official publication of the National Council of Senior Citizens

"Chiropractic treatment, designed to eliminate causes that do not exist while denying the existence of the real causes, is at best worthless--and at worst mortally dangerous"

AT YOUR OWN RISK: The Case Against Chiropractic

This book (New York City, Trident Press, 1969) by science writer Ralph Lee Smith was written after Mr Smith's penetrating, personal investigation of chiropractic Author Smith concludes that "The theory of chiropractic is scientifically false, and treatments given in accordance with the theory bear no relationship to the cause or cure of human disease Its practice should therefore be prohibited, and its personnel should be retrained to enter other professions."

Mr Smith proposes two steps that he says must be taken by the legislatures in the 48 states that license chiropractors:

"The first step, and one that must be taken immediately, is to prohibit further use of X ray by chiropractors . .

"The next step is for each state to create an orderly program for withdrawing chiropractic licenses."

U.S. DISTRICT COURT (affirmed by U.S. Supreme Court)

A federal court ruled in 1965 that the State of Louisiana could refuse to license chiropractors, holding, in effect, that the state has the right to require chiropractors to meet the same educational requirements as doctors of medicine The U S. Supreme Court affirmed the decision in 1966

The court's opinion, expressing the unanimous ruling by three federal judges, stated, "If the education obtained in chiropractic schools does not meet the standards of. . the United States Office of Education, it may well be that the Legislature of Louisiana felt that in the public interest a diploma from an approved medical school should be required of a chiropractor before he

is allowed to treat all the human ailments chiropractors contend can be cured by manipulation of the spine

In the case, *England v. Louisiana State Board of Medical Examiners* (246 F Supp 993), the court ruled that the state had not done more "than is necessary to protect the health of its citizens. . ."

AMERICAN HOSPITAL ASSOCIATION

In a January 14, 1970 letter from the American Hospital Association to the Ways and Means Committee of the U S. House of Representatives, an AHA spokesman explained, in part.

"The Department of Health Education and Welfare during the preparation of its December, 1968, report to Congress, 'Independent Practitioners Under Medicare,' invited comment by the American Hospital Association At that time we recommended that chiropractors not be considered for inclusion under Part B, Title XVIII of the Social Security Act

"In considering this question one must appreciate that chiropractic would not be just an additional service under medicare, but rather, an alternative form of providing services different from that already approved through the use of Doctors of Medicine and Osteopathy. While chiropractors do not normally practice in hospitals approved for the medicare program or hospitals approved by the Joint Commission on the Accreditation of Hospitals, the AHA's interest in this matter eminates from two specific areas of concern These areas are the delivery of quality health care for patients and the most effective use of medicare financial resources to meet this primary objective for the elderly patient . ."

The AHA letter also pointed out, "Utilization of medicare financial resources for an alternative form of service, chiropractic, would be most unfortunate," and that the HEW report demonstrates expenditures for chiropractic services "would not effectively promote the primary objective of the [medicare] program as established by Congress."

In conclusion, the AHA letter emphasized:

"The conclusions of the subject report regarding chiropractic strongly support the Department of Health, Education and Welfare's recommendation 'that chiropractic services not be covered in the medicare program ' As I have indicated above, this Association supported this recommendation when the HEW report was in preparation and continues to do so "

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Excerpt from letter of January 26, 1970, from the Association of American Medical Colleges to the Ways and Means Committee of the U.S House of Representatives:

". . .The overwhelming evidence of a lack of scientific base, as well as other educational shortcomings, in the training of chiropractitioners strongly suggests that the inclusion of a provision which gives these individuals an opportunity to bill and collect fees under Part B of the Medicare program would not be in the best interests of the beneficiaries of the program. Furthermore, we believe that it is imperative that the program's beneficiaries be assured that the care to which they are entitled conforms to the highest standards. It is our conclusion that this would not be true if chiropractic services were provided with an opportunity to participate in the supplementary medical insurance plan under the medicare program."

HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

The Health Insurance Benefits Advisory Council (HIBAC), which was established in the Social Security Act to serve as an advisory group to the Secretary of Health, Education and Welfare, commented, in part, in a letter to HEW:

"The Council strongly opposes the payment of medicare benefits for chiropractic services. The Council is unanimously of the view that such services have no medical value. Indeed, its encouragement by the Federal Government through recognition of a role for it in medicare might actually result in harm to medicare beneficiaries because they would delay or avoid seeking proper medical care Also, the additional funds necessary to make such payments would add substantially to the financial burdens of the medicare program, and might require another increase in the Part B premium to be borne by all beneficiaries including those who disapprove of chiropractic."

HEALTH INSURANCE COUNCIL
HEALTH INSURANCE ASSOCIATION OF AMERICA

A Statement on "Limited Practitioners" was passed by the Health Insurance Council's Executive Committee on October 1, 1969, and approved by the Health Insurance Association of America's Board of Directors on October 28, 1969. HIAA member companies write more than 90% of the nation's health insurance The statement is, in part

"The member insurance companies of the Health Insurance Council, mindful of their obligation to assure the American people that the highest possible quality of medical care is being provided, support the concept that the providers of health care should base such care on scientifically-established methods of diagnosis and treatment. These companies also realize how vital it is for practitioners who hold themselves out as qualified individuals to treat human illness and disease to have adequate initial and continuing education and training. Further, such education and training, at a minimum, should be conducted in institutions that are accredited by recognized educational accrediting agencies "

AMERICAN COLLEGE OF RADIOLOGY

Board of Chancellors and Council of American College of Radiology approved a resolution in February 1969 advising the people of the United States that ACR member radiologists "regard the use of radiation by chiropractors as unwarranted and without likelihood of significant medical gain "

AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

The AAOS adopted a resolution pointing out that "Orthopaedic surgeons with particular knowledge of the musculoskeletal system have greater insight into the hoax of chiropractic " The AAOS resolution also affirmed the American Medical Association's Statement of Policy on Chiropractic, and requested that the Academy "establish appropriate activities to alert the professional and lay public of the hazards of such unscientific practice..."

AMERICAN CANCER SOCIETY, INC.

The Executive Committee of the American Cancer Society approved the following official statement in July 1967:

"Chiropractic is not based on a sound scientific medical approach to cancer and has no place in the diagnosis or treat-

ment of cancer. Because early diagnosis and proper treatment of cancer are vital in the saving of lives and the diminution of suffering from cancer, the use of chiropractic in the diagnosis or treatment of persons afflicted with cancer represents a health hazard."

NATIONAL ASSOCIATION FOR RETARDED CHILDREN

The Board of Directors of the National Association for Retarded Children, upon the recommendation of the NARC Public Health Services Committee, unanimously endorsed the following statement in 1968

"Because of the increased national interest in helping the mentally retarded, it is vitally important that the NARC goes on record as stating that the Association knows of no established scientific evidence that supports the value of any current practices of chiropractors in diagnostic, therapeutic or education activities in mental retardation."

AMERICAN COLLEGE OF SPORTS MEDICINE

A statement adopted by the American College of Sports Medicine in 1968 emphasizes

"The American College of Sports Medicine does not recognize practitioners of chiropractic, naprapathy, and naturopathy as appropriate for membership in the College because the College considers the principles underlying their alleged healing practices are not founded on scientific grounds."

AMERICAN MEDICAL ASSOCIATION

(Statement on Chiropractic adopted by AMA House of Delegates, Novermber 1966)

It is the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease. Chiropractic constitutes a hazard to rational health care in the United States because of the substandard and unscientific education of its practitioners and their rigid adherence to an irrational, unscientific approach to disease causation.

In 1965 a United States District Court, in upholding a state's constitutional right to refuse to license chiropractic, said that "since chiropractic claims to be a complete and independent healing art capable of curing almost all kinds of disease, the state legislature may have felt that the requirement of a foundation in materia medica and surgery. . .would be a protection to the public." Without dissent, the United States Supreme Court affirmed the decision.

The wisdom of these decisions by the nation's highest courts justifies the medical profession's education program of alerting the nation to the public health threat posed by the cult of chiropractic.

Patients should entrust their health care only to those who have a broad scientific knowledge of diseases and ailments of all kinds, and who are capable of diagnosing and treating them with all the resources of modern medicine. The delay of proper medical care caused by chiropractors and their opposition to the many scientific advances in modern medicine, such as life-saving vaccines, often ends with tragic results.

(Other organizations have endorsed the AMA Statement of Policy on Chiropractic. See back page.)

The AMA Statement on Chiropractic also has been endorsed by:

Interspecialty Committee of the American Medical Association (representing 19 national medical specialty groups)

The American Academy of General Practice

The American Academy of Pediatrics

American Congress of Rehabilitation Medicine

The American Surgical Association

American Academy of Physical Medicine and Rehabilitation

The American Broncho-Esophagological Association

The Central Association of Obstetricians and Gynecologists

National Tuberculosis and Respiratory Disease Association

American Thoracic Society

American Psychiatric Association

American Medical Association
Department of Investigation
535 North Dearborn Street
Chicago, Illinois 60610

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., December 8, 1971.

HON. WILBUR D. MILLS,
Chairman, Committee on Ways and Means, U.S. House of Representatives, Longworth House Office Building, Washington, D.C.

DEAR CONGRESSMAN MILLS: The purpose of this letter is two-fold: (1) to correct certain statements appearing in the transcript of the record and (2) to state our support for an extension of the expiring maternal and child care provisions of Title V of the Social Security Act.

It has come to our attention that during colloquy between Doctor Robert Cooke, Chairman, Department of Pediatrices, Johns Hopkins University Hospital, and Congressman Carey, certain statements were made which might indicate that the American Medical Association does not support the maternal and child care provisions under Title V.

As a matter of fact, we strongly support Title V programs. Moreover, during appropriations hearings, both before the House and Senate Committees, we advocated full funding. The following excerpt is taken from our testimony presented June 17, 1971, before the House Subcommittee on Labor and Health, Education, and Welfare as follows:

"Mr. Chairman, our Association urges that this Committee provide full funding for the Maternal and Child Health Care programs under Title V. The formula and project grants should be supported in full. Formula grant programs are the major sources of care for mothers and children who do not have access to private care for preventive services and treatment of sickness. The maternal and infant care projects now in operation have substantially reduced infant mortality rates in areas where they have traditionally been highest by providing early and comprehensive medical care to high risk women and follow-up treatment for mothers and infants. More importantly, these projects, in reducing the number of neurologically damaged children, have improved the quality of life for many. In addition, the children and youth programs have provided preventive health services, diagnosis, treatment, and after-care, as well as early identification of defects which are correctable.

"Notwithstanding the progress being made, the magnitude of the unmet health needs of infants, children and youth is staggering. Existing programs must be continued. Failure to do this would be a giant step backward. Many communities endeavoring to create new maternal and child health programs or to expand present services are unable to do so because sufficient funds are not available. The Title V legislation provides the means for financial assistance. The American Medical Association recommends strong support of the programs for maternal and child health and crippled children's services under Title V, including both formula and project grants, and recommends that full authorization of $325 million be appropriated for fiscal 1972, instead of the projected $235 million."

In addition to full funding, we strongly support an extension of the Title V maternal and infant, as well as the children and youth, programs which will expire next June.

The colloquy referred to occurred at page 2869 of the draft transcript of the Committee hearings on November 16. We would appreciate if this letter could be inserted at the appropriate place in the hearings so that our position may be appropriately presented.

Thank you for this courtesy.

Sincerely,

ERNEST B. HOWARD, M.D.

Mr. CORMAN. Our next witness is Dr. Wallace D. Buchanan, past president, Dr. Robert W. McConnell, president, and Otha W. Linton, director, Washington Office, American College of Radiology.

We are pleased to welcome you to the committee, gentlemen.

Dr. Buchanan, if you would identify the gentlemen with you we would be pleased to hear from you.

STATEMENT OF DR. WALLACE D. BUCHANAN, PAST PRESIDENT, AMERICAN COLLEGE OF RADIOLOGY; ACCOMPANIED BY DR. ROBERT W. McCONNELL, PRESIDENT; AND OTHA W. LINTON, DIRECTOR, WASHINGTON OFFICE

Dr. BUCHANAN. Mr. Chairman and members of the committee: On behalf of the 8,000 physicians who are members of the American

College of Radiology I want to express appreciation to the Committee on Ways and Means for hearing our comments and concerns about pending national health insurance legislation.

I am Dr. Wallace D. Buchanan, a practicing radiologist in South Bend, Ind. I am a past president of the college. Here with me today is the current president, Dr. Robert W. McConnell of Dallas, and Mr. Otha W. Linton, director of the Washington office of the college.

Radiologists are physicians. As such, they belong to the American Medical Association and to State and local medical societies. Many of these groups have presented views about the philosophies and economics of the proposals before you. The American College of Radiology has a policy statement of principles we regard as essential to delivery of good health care. A copy is appended to this testimony. With your permission, I would speak to the pragmatic problem of providing good radiologic services within any pattern of health care.

A radiologist specializes in the use of X-rays and other forms of radiation for the diagnosis and treatment of disease. In 1970, according to a Public Health Service study, Americans received some 137 million radiologic examinations. About two-thirds of that total were performed by specialists in radiology working in their own offices and in hospital X-ray departments. In addition, radiologists were involved in the performance of an estimated six to eight million diagnostic radioisotope procedures. Those of us who perform radiation therapy have a hand in the care of almost two-thirds of all cancer patients treated during any year. A radiologist is personally involved in each one of these procedures.

With this kind of responsibility and direct involvement in the medical care of millions of Americans each year, it is particularly vexing to have our services described as they were on October 19 by Secretary Richardson in the phrase, "laboratory, X-ray and other ancillary medical services." This differentiation from other medical specialities is not justified by the facts or by our licensure. It is an artificial distinction.

In addressing ourselves to the legislation before you, we feel it necessary to point out that some of the issues represent differences of opinion within the health community which did not originate with medicare. The advent of medicare required us to make some tough decisions. It also required the Congress to make some decisions about the relationships among health providers. Many of us hope these decisions will now be affirmed in the broader legislation.

Some members of this committee will remember that proponents of some versions of medicare in 1965 sought to limit coverage of X-ray services under the program to those provided in hospital X-ray departments and billed by hospitals. Fortunately, the committee rejected this expensive and prejudicial policy. Some 40 percent of the diagnostic X-ray procedures in the country are performed in the private offices of radiologists and other physicians. The expense of expanding hospital facilities to absorb these millions of examinations would have been substantial and utterly wasteful.

Since 1965, the Social Security Administration has confirmed that hospitals are the most expensive location for health care services. Most doctors understood this long before the actuaries confirmed it. But, somehow the unfortunate idea was put forth that the doctor in

a hospital or clinic is a better practitioner than the same doctor in his own office.

If I seem to belabor this point, it is because radiologists have worked for years to eliminate discrimination in insurance coverage by site of service. Many private insurance plans still decline to pay for diagnostic X-ray services performed in the offices of radiologists. A few carriers still wish to pay only for examinations which produce a positive diagnosis of disease and not for the majority of those which rule out disease. This kind of thinking is doubly absurd if the emphasis is to be placed on preventive health and keeping people out of hospitals.

The argument is made that radiology should be treated differently than other medical practice because it is different. This is valid only in the sense that the diagnostic radiologist is a consultant, not a primary physician. But so are most of the other 22 groups of medical specialists. In 1965, I told this committee that the nation's radiologsts wanted to be treated in the Medicare legislation exactly the same way as other physicians were to be covered. The committee granted that request and upheld it in the eventual language of the law.

In the fall of 1965, the American College of Radiology adopted as policy the position that its members practicing in voluntary hospitals should separate their professional fees from hospital charges where the two elements previously had been mixed and should submit their own bills to patients for professional services. We also pledged that independent practice in hospitals would not result in higher costs to patients.

This change in practice arrangements has been made by more than half of the radiologists practicing in voluntary hospitals. The college also stated as policy that where other physicians in an institution or group are not on a fee for service basis the radiologists should conform to the practice of other physicians. This is to cover situations where patients are not billed for services or where the entire medical staff works on salary.

We have surveyed our members each year since 1965 to determine the status of their practice. Our survey for 1971 shows that 54 percent of the radiologists on the staffs of voluntary hospitals conduct their practice independently of the institution. This figure is based upon a response of 3,575 from a mailing of 7,400 to college members practicing in the United States in 1971. In addition to those whose practice is entirely independent, we are advised that another 14 percent do their own billing for some portion of their practice in one or more hospitals, but not all of their hospitals.

These changes to independent practice were made in the face of strong opposition from some hospital groups, from some insurance carriers including many Blue Cross plans and from the Social Security Administration. In our opinion, the separate regulations promulgated by SSA for what they styled "hospital based physicians" were discriminatory and a violation of the express intent of this committee and the Congress.

I have recited this recent history for two purposes: One is to emphasize to the committee that we accepted its mandate to the best of our ability and have tried to make medicare work as written for radiology. The second is to view with alarm continuing efforts to

separate us from the rest of medicine, both in hospital practice and in our offices as well.

Of the bills before you, this is most emphatically spelled out in H.R. 22. Indpendent radiology services are identified in section 27, in section 50(a) and again in section 65(b) as a different type and category from the services of other physician specialists. Section 88(b) directs a different basis of payment for radiology. In their explanatory remarks, the sponsors of H.R. 22 state their intention of reversing the parity of radiology granted by the medicare legislation.

In H.R. 48, Representative Dingell refers to diagnostic X-ray as auxiliary services and leaves their coverage to the discretion of the administrative bodies to be created by this bill.

In our opinion, the proposals to cover radiology in H.R. 22 and H.R. 48 would be detrimental to the ability of radiologists to furnish the X-ray services which will be required in the future by the American people. It is significant that since 1965, with radiology reestablishing its independent practice status, our residency training programs have filled up. They were 82 percent filled in 1965 and more than 95 percent filled this fall. This was accompanied by an increase of more than 400 additional positions in the nearly 300 approved programs. Apparently, our successors share our feelings about the importance of having the same right to choose one's terms of practice as do other groups of practitioners.

We recognize that radiology services and radiology facilities are expensive and should be handled efficiently. Long before medicare, we had devised a relative value scale to aid patients and insurance carriers in evaluating charges. We have worked with the insurance industry to devise ways to cover radiology in offices without allowing excessive usage or excessive charges. We have worked with our hospitals to provide coverage for swelling emergency room loads. In that regard, we recognize the needs of our colleagues to request X-ray studies for their own protection against claims of negligence of malpractice. We are beginning now on an extensive project to determine the usefulness and efficacy of basic X-ray examinations which are over used in the opinions of many of us.

We think that there are adequate and effective ways of measuring and controlling the medical uses of X-rays by physicians without discriminatory treatment under the law.

Our plea to this committee, if you please, is for equal treatment with other physicians. We wish to be subjected to the same obligations, the same standards, the same reviews, and the same penalties, if such be needed, as are imposed upon other physicians. We expect to perform our services within the same framework and to be compensated under the same arrangements as other physicians.

I would repeat my gratitude and that of my colleagues for this opportunity to speak to the committee.

(Attachment to Dr. Buchanan's statement follows:)

[From the Bulletin, American College of Radiology]

DELIVERY AND FINANCING OF MEDICAL CARE

The American College of Radiology believes that:

1. Every person should have access to an adequate level of quality medical services; no person should be made destitute by catastrophic illness.

2. Improved access to needed medical services can best be achieved by strengthening our present pluralistic medical care structure. No single system can embrace the flexibility required to meet the present spectrum of medical care needs.

3. Sound use and development of resources for medical care are the shared responsibility of the public, physicians, patients, administrators and third parties who pay for medical services.

4. Public educational programs to promote more intelligent use of critical skills and limited facilities are urgently needed.

5. Decisions regarding the immediate medical care needs of an individual patient must remain the prerogative and responsibility of that patient's physician. Determination of the quality of care and assessment of the medical necessity for use of professional and institutional services are, primarily, the responsibility of the medical profession.

6. The goal of community and regional planning for health care is a high level of personal health maintenance for individuals and environmental health protection for the community. Cooperation and coordination among the many interested segments of the community is essential.

7. Provision of medical services in an ambulatory setting must be more strongly emphasized and encouraged. Methods of financing should not limit the site of service to an institutional environment. Financing of medical care should not enforce or exclude a specific mode of medical service.

8. Mechanisms developed to finance medical care must be adaptable, varied and innovative. The goal is utilization of the most medically productive and economically sound method of delivery of medical services in a specific circumstance. Insurance programs which over the costs of an adequate level of medical services and catastrophic illness must be made available to everyone. To achieve this, assistance from government will be necessary for some. Nevertheless, the broad base for financing the cost of medical care for the entire population should be evolved within the framework of a viable voluntary insurance system. Government should create an environment to stimulate, not stifle, this evolution.

9. Research to advance medical knowledge, improve and develop resources for the delivery of health care, and establish new ways in which allied health professional personnel might be used to amplify the physician's effectiveness should be supported by both the private and public sectors.

Mrs. GRIFFITHS. I would like to say of all the people sitting up here, I feel your position most strongly. I am part of a little group which is referred to generally as children, lunatics, and women.

Dr. BUCHANAN. I might respond to Mrs. Griffiths' remark by saying those of us in medicine, in spite of our differences of opinion, strongly respect your opinions.

Mrs. GRIFFITHS. Thank you.

Dr. BUCHANAN. I might also throw in an additional aside here, to say that I would like you to know, Mrs. Griffiths, that you are looking at what is generally considered to be an eminently successful specialist who has never come close to earning $90,000 a year.

Mr. CORMAN. Mr. Burleson?

Mr. BURLESON. No questions.

Mr. CORMAN. Gentlemen, thank you for your testimony.

Dr. BUCHANAN. Thank you.

Mr. CORMAN. Our next witness is Dr. Charles E. Jaeckle, president-elect, American Association of Ophthalmology.

Doctor, we are pleased to have you before the committee. Would you identify the gentleman with you?

STATEMENT OF DR. CHARLES E. JAECKLE, PRESIDENT-ELECT, AMERICAN ASSOCIATION OF OPHTHALMOLOGY; ACCOMPANIED BY WARREN MAGEE, GENERAL COUNSEL

Dr. JAECKLE. The gentleman is Mr. Warren Magee, general counsel of the association.

Mr. Chairman and members of the committee, my name is Charles E. Jaeckle. I am appearing here today on behalf of the American Association of Ophthalmology to comment on proposals for national health insurance. I am a doctor of medicine, practicing in Defiance, Ohio, specialing in diseases and abnormalities of the visual system, an ophthalmologist.

The term "eye patient" as used here means any patient with an ocular or visual complaint or whose attending physician finds indication for specialist consultation or treatment with reference to the visual system.

The visual system includes the eyes and related structures, including pathways of the brain.

No different principle applies to the care of the patient with ocular symptoms than to the care of any other patient. Eye care is an integral part of medical care. Patients with ocular or visual complaints need the services of physicians in ophthalmology, internal medicine, neurosurgery, family practice, and other branches of medicine.

"Eye care" is the medical care provided by all these physicians to eye patients.

Because diseases of the visual system, however, by the nature of their symptoms, are identified by the patient as eye problems, a large percentage of eye patients go directly to the ophthalmologist.

Seventy-nine percent of eye patients are thus self-referred.

In-hospital specialist care for the eye patient is primarily surgical—an estimated 95 percent.

Ninety-three percent of ophthalmologists' patients contacts are in the office.

These office services are about 95 percent medical, as distinguished from surgical services.

Medical specialist care for eye patients is delivered chiefly (72 percent) by ophthalmologists in solo practice, but ophthalmologists have traditionally made extensive use of medical assistants. Thus, the ophthalmologist provides the patient with the services not of a physician alone, but of a team of a physician and physician-directed medical supportive personnel.

The American Medical Association has held officially that:

> All professional medical services relating to the care and treatment of the eye patient are properly included in the regular benefit structure for physician services in health insurance and health services programs.

The American Association of Ophthalmology concurs in this position.

We are concerned when programs which are apparently intended to provide services for eye patients are proposed as so-called "vision services" or "vision care", segregated from medical services in general. Such terms are misnomers.

In some bills before the Congress, services of physicians and services of nonphysician limited practitioners are offered as alternative benefits, and in some instances with a unit-per-calendar period utilization limit, which could inadvertently lead a beneficiary to sacrifice his entitlement to medical care by the prior use of limited nonmedical services.

We wish to direct attention to certain features of specific bills.

The basic coverage of H.R. 4960 embraces all medical services, except cosmetic surgery, provided by or under the direction of a doctor

of medicine or a doctor of osteopathy, wherever rendered. It provides all services required by the eye patient. All beneficiaries would be covered for eye services by a physician as needed.

H.R. 7741, in the Basic Health Insurance Plan, covers the services, "if needed," of all physicians except psychiatrists, hence all the services of physicians required by eye patients are covered in section 603 (a) (2) and (4).

Section 603(a)(5) provides coverage, "if needed," in a calendar year for "one routine eye examination, in the case of a child under the age of 12 years." Since subparagraphs (2) and (4) cover all examinations by a physician, subparagraph (5) serves no useful purpose, whatever may be intended by the term "routine eye examination." This benefit is listed here separated from the physicians' services benefits, but there can be no true "eye examination" without the services of a physician.

The term "routine eye examination" does not describe and identify a medical service. Physician examinations (subparagraphs (2) and (4)) and screening procedures performed by medical assistants, including the pediatric nurse associate mentioned (subparagraph (4)), identify children needing eye care. Such screening is an established procedure in physicians' offices.

What if this explicit limited authorization for "one routine eye examination" in a calendar year is construed to supersede the preceding general provision for physicians' services, and a child who has had service under this clause then develops a complaint meriting diagnostic ophthalmological examination? Might subparagraph (5) operate to impair or prevent delivery of needed medical care, which otherwise would have been available under subparagraph (4)?

"Physicians' services" covers all eye examinations which may be medically necessary. No other provision is called for.

Mr. CORMAN. Doctor, we are going to have to recess to vote. The committee will recess, and we will be back in 10 minutes.

(Brief recess.)

Mr. CORMAN. The committee will come to order.

Dr. Jaeckle, I understand that you have been summarizing your statement, and perhaps for the record, would you like for it to appear in full?

Dr. JAECKLE. I would. I would appreciate that.

Mr. CORMAN. All right, sir. You may proceed.

We appreciate your summarizing.

Because of the problem of votes, we are going to be interrupted again.

Your full statement will appear at this point in the record, without objection.

(The full statement follows:)

STATEMENT OF CHARLES E. JAECKLE, M.D., AMERICAN ASSOCIATION OF OPHTHALMOLOGY

Mr. Chairman and Members of the Committee, my name is Charles E. Jaeckle, I am appearing here today on behalf of the American Association of Ophthalmology to comment on proposals for national health insurance. I am a Doctor of Medicine, practicing in Defiance, Ohio, specializing in diseases and abnormalities of the visual system, an ophthalmologist. I am President-Elect of the American Association of Ophthalmology.

1. MEDICAL CARE NEEDS OF EYE PATIENTS

(a) *Definition of Eye Patient*

The term, "eye patient," as used here means any patient with an ocular or visual complaint or whose attending physician finds indication for specialist consultation or treatment with reference to the visual system.

The visual system includes the eyes and related structure, including pathways of the brain.

(b) *Eye Care is Medical Care*

No different principle applies to the care of the patient with ocular symptoms than to the care of any other patient. Eye care is an integral part of medical care. Ocular manifestations cannot be evaluated as isolated disorders of a particular organ. The patient with an eye problem, whether of functional, organic or psychiatric origin, requires medical examination and diagnosis. Patients with ocular or visual complaints need the services of physicians in ophthmalogy, internal medicine, neurosurgery, family practice and other branches of medicine.

"Eye care" is the medical care provided by all these physicians to eye patients. Physicians provide all "eye care."

Any proposal that would deal with the provision of physicians' services, general and specialist medical care, will automatically include the services of physicians in ophthalmology. A patient with an eye or visual system problem may consult his family physician or his ophthalmologist. Many eye problems properly are brought to the primary, family physician, who treats them or refers the patient to the ophthalmologist, as may be indicated. Because diseases of the visual system, however, by the nature of their symptoms, are identified by the patient as eye problems, a large percentage of eye patients go directly to the ophthalmologist.

2. SPECIAL CONSIDERATION PERTAINING TO OPHTHALMOLOGICAL MEDICAL SERVICES

(a) 79% of eye patients are *self-referred* as noted above.

(b) *In-hospital specialist care* for the eye patient is *primarily surgical*—an estimated 95%. Some patients are admitted for medical ophthalmological management, e.g., for glaucoma. Serious injuries may require operative surgery or medical management (as for intraocular injury), or both.

(c) 93% of ophthalmologists' patient contracts are in the *office*.

(d) *Ambulatory* patient care services are about 95% *medical*, as distinguished from surgical services. They consist of medical diagnosis and treatment.

(e) *A recurrent need* for ophthalmological services in common in early childhood and young adults, and is virtually universal after the age of 45.

(f) *Medical specialist care for eye patients* is delivered chiefly (72%) by ophthalmologists in solo practice but ophthalmologists have traditionally made extensive use of medical assistants. Thus the ophthalmologist provides the patient with the services not of a physician alone, but of a *team of a physician and physician-directed medical supportive personnel.* Many opthalmologists practice in communities too small for large multispecialty groups; increasingly opthalmologists are forming ophthalmology groups.

3. MEDICAL POSITION ON EYE SERVICES

(a) *Eye Services Integral to Medical Care*

The American Medical Association has held officially that—

"All professional medical services relating to the care and treatment of the eye patient are properly *included in the regular benefit structure for physician services* in health insurance and health services programs." (Italic added).

The American Association of Ophthalmology concurs in this position.

(b) *"Vision Care" a Misnomer*

We are concerned when programs which are apparently intended to provide services for eye patients are proposed as so-called "vision services" or "vision care", segregated from medical services in general. Such terms are misnomers. As had been noted, the preservation of the patient's vision requires the joint efforts of physicians in almost all branches of medicine; these terms have no medical application. Furthermore, segregation of medical services for eye patients is not consistent with sound medical practice.

(c) *Alternative but Unequal*

In some bills before the Congress services of physicians and services of nonphysician limited practitioners are offered as alternative benefits, and in some instances with a unit-per-calendar period utilization limit, which could inadvertently lead a beneficiary to sacrifice his entitlement to medical care by the prior use of limited nonmedical services.

(d) *Precise Terminology*

Identification of the services to which beneficiaries shall be entitled in precise terminology that actually describes the services physicians render is conductive to clearer understanding of benefits by all parties and so contributes to the efficient delivery of medical care. It will facilitate communication between physician and administrator and so reduce costs by enabling carriers correctly to recognize physicians' services.

The American Association of Ophthalmology has been collaborating with the American Medical Association on a continuing basis in the development of precise descriptive *Current Procedural Terminology*. On invitation in 1965 and again in 1969 we conferred with the Bureau of Insurance of the Social Security Administration regarding identification of certain Medicare benefits.

4. COMMENT ON SPECIFIC LEGISLATIVE BILLS AS THEY AFFECT THE EYE PATIENT

(a) *H.R. 4960 (Medicredit)*

The *basic coverage* of H.R. 4960 embraces *all* medical services provided by or under the direction of a doctor of medicine or a doctor of osteopathy wherever rendered. It provides all the services required by the eye patient. His needs are met, beginning with well-baby care, and including physical examination, consultation, diagnosis, treatment, x-ray, laboratory and anesthesiology services, eye surgery, and office care for eye patients. All beneficiaries would be covered for eye services by a physician as needed.

The *catastrophic expense coverage* would protect the patient with respect to his visual system problem as it does all other systems.

(b) *H.R. 7741 (National Health Insurance Partnership)*

In the Basic Health Insurance Plan, H.R. 7741 covers the services, "if needed", of all physicians except psychiatrists, hence all the services of physicians required by eye patients are covered in Sec. 603(a) (2) and (4) (page 7, line 1–2 and 8–12).

Sec. 603(a)(5) provides coverage, "if needed", in a calendar year or "one routine eye examination, in the case of a child under the age of 12 years." Since subparagraphs (2) and (4) *already* cover *all* examinations by a physician of *all* persons, subparagraph (5) serves no useful purpose, whatever may be intended by the term "routine eye examination". This benefit is listed here separated from the physicians' service benefit, but there can be no true "eye examination" without the services of a physician. We do not know what is meant by "routine eye examination. The term does not describe and identify a medical service. The presence of such a provision, if there were such a service, at best would be redundant. If it were intended to be a procedure to identify children needing ophthalmological examination, we would point out that the procedures to accomplish such identification of physician examinations (subparagraphs (2) and (4)) and screening procedures performed by medical assistants, including the pediatric nurse associate mentioned (subparagraph (4)). Such screening is an established procedure in the office of every family practitioner and pediatrician. This express stipulation of "one routine eye examination" in a calendar year is actually in conflict with the provision stipulating coverage for physicians' services. What if this explicit limited authorization is construed to supersede the preceding general provision for physicians' services in a child who has had service under this clause then develops a complaint meriting diagnostic ophthalmological examination? Might subparagraph (5) operate to impair or prevent delivery of needed medical care under the insurance program? "Physicians' services" covers all eye examinations which may be medically necessary; no other provision is called for.

The same comment is applicable to Sec. 626(a) (2), (4) and (6) (pages 37–38) in the Family Health Insurance Plan.

(c) *H.R. 4349 (National Health Care Act)*.

Physicians' services, including periodic health examinations, are covered in the Table of Minimum Standards of H.R. 4349. Hence the services of ophthalmologists

are covered in Item I subparagraph (a) (i) (ii) (vii). The provision in subparagraph "(x) for eye examination—see Item 5 below" is redundant. It constitutes the identification of certain physician services, then isolates them from all other physicians services and couples them with services of nonphysicians. The term "eye examination" as used in Item (5) (a) becomes meaningless when it is used to refer to both the diagnostic service rendered by a physician and the limited services of a nonphysician. These are dissimilar services and the representation that they constitute a common benefit item is erorneous and misleading. To offer these unequal services as alternatives is to do the public a grave disservice. Public confusion about the distinction between these unequivalent services can lead and has led to delay in medical care and to blindness. It should be recognized, as legal authorities have, that the services of physicians and the services of independent nonphysician practitioners are never comparable; independent nonphysician services should therefore not be offered to the public as an equivalent alternative to medical care.

The injury to the beneficiary is further compounded if, as in Item 5 (a), medical care may be denied by the prior use within a calendar period of a limited nonphysician service. The provision cited places a unit per calendar period utilization limit on the services of physicians to eye patients, and specifically applies this limit to the services of physicians who are qualified specialists in the eye and the related part of the brain which constitute the visual system. All other physician services are covered on an "if needed" basis.

The isolation of Item 1 (a) (x) and transfer of this physician service to Item 5 (a), apparently denies the beneficiary the services of a physician for diagnostic examination for eye disease if he is 19 years of age or older and has had within the preceding 3 years, either a diagnostic ophthalmological examination by a physician or a determination of the refractive state by an independent nonphysician practitioner. We do not believe the sponsors intended such denial.

(*d*) *H.R. 48 (National Health Insurance Act).*

H.R. 48 provides proper coverage for physician services, "as necessary", including those required by the eye patient. The bill also provides, under the "auxiliary services" section, coverage for eyeglasses and related nonphysician services. Some "auxiliary services" are absolutely essential to the health of the beneficiaries.

(*e*) *H.R. 22 (National Health Security Act).*

H.R. 22 would provide the beneficiary could consult a physician specialist only on referral by the family physician. This will, in many situations, be unnecessarily cumbersome. It is suggested provision be made for the Secretary to waive this requirement to those classes of physicians' services the Secretary may designate. If nonphysician services are to be supplied under the program, this should be available only after diagnostic examination by a physician. Failure so to provide will have an adverse effect on patient welfare.

5. PRIORITIES IN HEALTH SERVICES INSURANCE FOR EYE PATIENTS

(*a*) *Comprehensive Medical Care*

The eye is in the body. There is an erroneous conception that "eye care" is something separate from or other than medical care. The first need of the eye patient is the same as that of every patient:

Medical Service Benefits—services of Doctors of Medicine and Doctors of Osteopathy, family physicians and specialists, provided in the office, the hospital, the home.

(1) These benefits cover the *specific diagnostic and treatment procedures required by the eye patient*, whether rendered by the family physician or specialist, whether the treatment is medical or surgical. They are covered under Medicare.

(2) *Consultative services* are essential in all areas of medicine. The eye is no exception. In turn, other physicians look to the ophthalmologist for examination to shed light on conditions elsewhere in the body.

(3) *Preventive services.* If preventive services such as periodic health examinations are contemplated, it should be recognized that they fall within the area of concern of the family or general (or "primary") physician. Identifying problems requiring specialist care is a function of this primary physician. The eyes and vision are no exception. Periodic *specialist* examination of all persons who are symptom-free should not be built into the system.

(4) All the essential specialist services described below are included in "services of Doctors of Medicine and Doctors of Osteopathy" as stated in the "Medical Services Benefits" described above.

(*b*) *Specialist Services*

(1) Diagnostic ophthalmological examination and initiation of treatment plan. Examination will be comprehensive or limited or intermediate in character depending on the nature of the problem and usually requires the use of medication in the eye.

(2) Special opthalmological diagnostic procedures. These may require medication to the eye, or by mouth or by injection, or may require general anesthesia. They are concerned with, among others, organic disease limited to the eye, the ocular manifestation of diseases of other systems, the ocular evidences of diseases of the brain, intraocular pressure and its functional aspects.

(3) Treatment, either therapeutic or for management.

(4) Ophthalmic surgery.

The foregoing services are basic. If prosthetic services are offered to be included, additional eye services might be covered.

(5) Artificial eye prosthetics—fitting and supply of the artificial eye, done in the physician's office or on a physician's order by an independent allied medical supportive worker. This is presently covered under Medicare. It could appropriately be covered in a national health insurance program when found necessary by a Doctor of Medicine or Doctor of Osteopathy.

(6) Contact lens prosthetics on the order of a physician might be a covered benefit, but limited strictly to those conditions where because of disease or the sequelae of disease, a Doctor of Medicine or Doctor of Osteopathy finds contact lenses medically necessary. Such medical necessity should be determined by need for contact lenses for therapeutic treatment of the disease or for removal of a severe visual disability due to disease, and contact lens services should be a covered benefit only when the physician has determined other medical and surgical treatment is not first indicated. Cosmetic contact lenses should be excluded. If any contact lens benefit were contemplated, a prior study of the use of contact lenses under Medicare, by government and the private sector, might prove valuable.

(*c*) *Eyeglasses*

We do not suggest coverage for eyeglasses and related services. These are optical services and should be so identified if at some time the Congress were to include such a benefit.

6. REQUIREMENT FOR ADEQUATE MEDICAL CARE FOR EYE PATIENTS UNDER HEALTH INSURANCE

The provisions necessary for adequate medical care for eye patients are:

(*a*) That the professional services of Doctors of Medicine and Doctors of Osteopathy be a covered benefit.

(*b*) That professional medical services relating to the eye and the visual system be recognized in the regular benefit structure for physician services.

(*c*) That patients not have any limitations placed on benefits for medical services by the concurrent availability or prior utilization of coverage, if any, for nonmedical services.

Mr. Chairman, on behalf of the American Association of Opthalmology allow me to thank you for this opportunity to present the views of the Association on this important subject. I will be pleased to attempt to answer any questions which you and the members may have.

SUMMARY OF THE AMERICAN ASSOCIATION OF OPHTHALMOLOGY STATEMENT ON NATIONAL HEALTH INSURANCE PRESENTED BY CHARLES E. JAECKLE, M.D.

1. Eye care is medical care for patients with an ocular or visual complaint or whose attending physician finds indication for specialist consultation or treatment with reference to the visual system.

2. Most of the opthalmologist's patient contracts are outside the hospital and are diagnostic and therapeutic, rather than surgical.

3. Services required by eye patients lie within the regular benefit structure for services of Doctors of Medicine and Doctors of Osteopathy.

4. The specific provisions of certain bills as they affect the eye patient are discussed.

5. Separate benefits for eye services are not consistent with sound medical care.

6. Unequal services, e.g., physician's services and the limited services of independent nonphysician practitioners, if covered, should not be presented as equivalent alternatives.

7. Patients must not have any limitations placed on benefits for medical services by the concurrent availability or prior utilization of coverage, if any, for nonmedical services.

The American Association of Ophthalmology will be pleased to be of any assistance we can to the Committee in the development of a national health insurance plan.

Dr. JAECKLE. The same comment is applicable to section 626 in the Family Health Insurance plan.

Physicians' services, including periodic health examinations, are covered in the Table of Minimum Standards of H.R. 4349. Hence the services of opthalmologists are covered in item 1, subparagraphs (a) (i), (ii), and (vii).

The provision in subparagraph "(x) for eye examination— see item 5 below" is redundant. It constitutes the identification of certain physician services, then isolates them from all other physician services and couples them with services of nonphysicians.

The term "eye examination" as used in item 5(a) becomes meaningless when it is used to refer to both the diagnostic service rendered by a physician and the limited services of a nonphysician. These are dissimilar services, and the implication that they constitute a common benefit item is erroneous and misleading.

To offer these unequal services as alternatives is to do the public a grave disservice. Public confusion about the distinction between these unequivalent services can lead and has led to delay in medical care and to blindness.

The provisions of item 5(a) place a unit-per-calendar period utilization limit on the diagnostic services of physicians to eye patients, and would deny physician services by prior use of nonmedical services.

The isolation of item 1(a)(x) "for eye examinations" and transfer of this physician service to item 5(a) denies the beneficiary the services of a physician for diagnostic examination for eye disease if he is 19 years of age or older and has had, within the preceding 3 years, either a diagnostic opthalmological examination by a physician for any condition, or has had a determination of the refractive state by an independent nonphysician practitioner.

We presume the sponsors did not intend such denial.

H.R. 48 provides coverage "as necessary" for physicians' services, automatically including those required by the eye patient. The bill also provides, under the "auxiliary services" section, coverage for eyeglasses and related nonphysician services.

H.R. 22 would provide that beneficiaries could consult a physician specialist only on referral by the family physician. This will, in many situations, be unnecessarily cumbersome. It is suggested provision be made for the Secretary to waive this requirement for those classes of physicians' services the Secretary may designate.

If nonphysician services are to be supplied under the program, they should be available only after diagnostic examination by a physician.

The eye is in the body. It is an erroneous conception that "eye care" is something separate from or other than medical care. The first need of the eye patient is the same as that of every patient: Medical services

benefits—services of doctors of medicine and doctors of osteopathy, general practitioners and specialists, provided in the office, the hospital, the home.

These benefits cover the specific diagnostic and treatment procedures required by the eye patient.

Consultative services are essential in all areas of medicine. The eye is no exception. In turn, other physicians look to the ophthalmologist for examination to shed light on conditions elsewhere in the body.

If preventive services such as periodic health examinations are contemplated, it should be recognized that they fall within the area of concern of the family or general (or "primary") physician. Identifying problems requiring specialist care is a function of this primary physician. Periodic specialist examination of all persons who are symptom-free should not be built into the system.

All of the essential specialist services listed below are included in "services of doctors of medicine and doctors of osteopathy" as stated in the "medical services benefits" described above.

Four basic categories of specialist services are essential:

1. Diagnostic ophthalmological examination and initiation of treatment plan. Examination will be comprehensive or limited or intermediate in character, depending on the nature of the problem.

2. Special ophthalmological diagnostic procedures. These are concerned with, among others, organic disease of the eye, intraocular pressure and its functional aspects, ocular manifestation of disease of other systems, ocular evidence of disease of the brain.

3. Treatment, either therapeutic or for management.

4. Ophthalmic surgery.

If prosthetic services are also to be included, there might be covered:

5. Fitting and supply of the artificial eye on the physician's order.

6. Contact lens prosthetics on the order of a physician might be a covered benefit, but limited strictly to those conditions where, because of disease or the sequelae of disease, a doctor of medicine or doctor of osteopathy finds contact lenses medically necessary. Such medical necessity should be determined by need for contact lenses for therapeutic treatment of disease or for removal of a severe visual disability due to disease. Cosmetic contact lenses should be excluded.

We do not suggest coverage for eyeglasses and related services. These are optical services and should be so identified if at some time the Congress were to include such a benefit.

The provisions necessary for adequate medical care of eye patients are:

1. That the professional services of doctors of medicine and doctors of osteopathy be a covered benefit.

2. That professional medical services relating to the eye or the visual system be recognized in the regular benefit structure for physicians' services.

3. That patients not have only limitations placed on benefits for medical services by the concurrent availability or prior utilization of coverage, if any, for nonmedical services.

We thank you for the opportunity of presenting this statement. The American Association of Ophthalmology will be pleased to be of any assistance we can to the committee in the development of a national health insurance plan.

We would appreciate it if we may supply information supplementing the statement that we have already submitted.

Mr. CORMAN. Thank you, Doctor. We would be pleased to have those supplemental statements.

I will ask the indulgence of the committee and the witness. We have two more panels, both of whom must be out of here by 4 o'clock, and I would hope we could accommodate each panel in that time, and so, Dr. Judith Ladinsky, and David Blumenthal, Health Professionals for Political Action.

If you have prepared statements, they may appear in the record at this point as if you had given them. It might be good if you would summarize the statements, so we can use some of the about 15 minutes we have together to respond to questions the committee may have.

I regret that the time pressures that we are all under are so severe.

Proceed however you wish. Perhaps, Dr. Ladinsky, you would identify the others with you for the record.

STATEMENT OF DR. JUDITH L. LADINSKY, HEALTH PROFESSIONALS FOR POLITICAL ACTION; ACCOMPANIED BY DAVID BLUMENTHAL AND FRANK EISENBERG

Dr. LADINSKY. On my left is David Blumenthal, a medical student at Harvard, and Frank Eisenberg, also a medical student from the Harvard College of Medicine.

Mr. BLUMENTHAL. Our statements come out to be about 15 minutes together, so I think we will read them to you. Is that all right with the committee?

Mr. CORMAN. All right.

Mr. BLUMENTHAL. I would like to thank the committee and the chairman for having us here today to give our views on national health insurance.

We come here today as representatives of Health Professionals for Political Action, a newly formed group of young health professionals who support the concept of national health insurance.

Though we are obviously concerned about specific features of the plans now before Congress, we do not intend to instruct you on the fine print of the legislation you are considering. We are not experts in economics. We have no special knowledge of tax laws and their consequences. We are not facile with all the statistics which competing sponsors marshal to support their programs.

We do have some special knowledge, however, of one subject which is crucial to the debate over national health insurance, and which, as far as we can tell, has not received extensive treatment before this committee. We refer to the opinions of young health professionals about national health insurance in particular and the present health of the American medical care system in general.

A few figures will convey the thrust of our message far more succinctly and forcefully than we can in words. For the last 13 years, Dr. Daniel Funkenstein of the Harvard medical faculty has done extensive surveys on the attitudes and backgrounds of students at the medical school I attend, Harvard Medical School. He has made some remarkable findings which document the conclusions which many members of HPPA have derived from conversations with their friends.

In 1958, Dr. Funkenstein reports, 9 percent of the graduating class at Harvard Medical School supported the creation of a system of national health insurance. In 1971, that same figure stood at 81 percent.

These findings are limited, we admit, to students at a single medical school, but members of our organization at other schools believe Dr. Funkenstein's data to be typical of other institutions as well.

The last 10 years have seen a revolutionary change in the opinions of young professionals on the question of how the American medical care system should be constituted. The Nation's next generation of physicians and health workers will not only accept national health insurance. It will actively seek such a system, and more.

As young health professionals, we support major changes in this Nation's health care system for the simple reason that millions of Americans now go without adequate medical care either because they cannot afford to purchase medical help or because that help is not available when they need it.

Our profession teaches us that it is our job to preserve life and to improve its quality. At the same time, the way in which medical care is financed and organized in this society sets intolerable roadblocks between us and the fulfillment of our duties.

We find that all too often the financial sacrifice involved in securing medical care deters people from seeking help until they are dangerously ill. We find also that all too often the fears of our patients and future patients are justified: that they regain their health, but only at the cost of their life savings—gone to pay for their hospital bed, their lab tests, their medications, and their doctors' fees.

Right now, the Congress is considering proposals that would buffer the costs of medical care for consumers. We think that measures aimed at removing financial obstacles to medical care are important, but removing those obstacles will not finish the job of rehabilitating our health care system. Any national health insurance system must contain creative provisions aimed at discouraging the inefficiencies that plague the existing delivery mechanism.

For many years, the American Medical Association has maintained that any Government involvement in health affairs will lead inevitably to the creation of a monolithic and unresponsive medical care system. At one time, the AMA warned that national health insurance was equivalent to "socialized medicine."

Now, it argues that if the Congress takes forceful and imaginative action to remedy the deficiencies of the existing health care delivery system, then it will crush the "pluralism" of that system.

We suspect that what organized medicine means by the word "pluralism" is the freedom of the provider to deliver medical care when, where, and at whatever cost he chooses.

This raises two critical points. The first is that the AMA no longer speaks for health professionals in this country. Young physicians are deserting that organization in droves. Of the 51,228 house officers now working in U.S. hospitals, only 459 are dues-paying members of the AMA. That is less than 1 percent.

The second point is that we believe this country's new generation of physicians will accept and welcome dramatic changes in structure of the health care delivery system.

To return to Dr. Funkenstein's figures: In 1959, only 9 percent of the graduating class at Harvard Medical School was dissatisfied with

the mode of delivery of health care in this country. In 1971, 86 percent was unhappy with the way care was being delivered.

In 1959, 9 percent of Harvard Medical seniors thought group practice was the best way to deliver health care. In 1971, that figure stood at a remarkable 98 percent.

Thirteen years ago, 4 percent of Harvard's graduating class believed in doing away with fee-for-service as a method of physician payment. By 1971, that figure had risen to include over half the class—61 percent.

These statistics give some indication, we feel, of the direction in which young health professionals feel our medical system must move to overcome its present failings.

A restructured health care system, we believe, must include, as a minimum, the following key features:

First of all, prepaid group practices, adapted to local conditions, must replace the fragmented, fee-for-service system which is the basis of the present delivery system.

These new vehicles for health care delivery must work out of clinics located in communities where they are readily accessible to local populations and responsive to community needs.

The extension of prepaid group will have several beneficial effects. Prepayment combined with an incentive system will encourage health care workers to emphasize preventive medicine for patients, and to think carefully before prescribing costly tests and treatments which may not be necessary. The Kaiser-Permanente system has demonstrated the efficiency of this financing mechanism.

A reconstituted health care system must also make extensive use of health professionals other than physicians. Primary health care workers are often more sensitive to the health needs of local communities than physicians, and should have authority proportionate to their knowledge and experience.

In a reordered medical care system, communities should also be able to design health facilities which match their special needs, and consumers at the grassroots should have a substantial voice in the administration of the health care institutions which serve them. Clinics which involve their communities as active decisionmakers encourage an awareness of health care problems and a commitment to the prevention of disease.

The active participation of consumers in the administration of their health care institutions assumes even greater importance in light of the dismal failure of the medical profession to clean its own house. For the last 40 years, physicians have proved beyond any doubt that they either will not or cannot take the lead in reforming our health care system.

The time has come for the Federal Government, working with consumers at the grassroots, to design a creative and progressive program for restructuring our medical care system. We believe that this Congress and the people of this country can count on the cooperation and support of a new generation of health professionals.

I would now like to let Dr. Ladinsky complete our testimony.

Mr. CORMAN. Thank you, Doctor.

I hope you will bear with me for keeping my eye on the clock.

Dr. LADINSKY. I understand.

I wish to focus my remarks today on private health insurance, because the private health insurance companies cover 80 percent of the Nation's population under age 65.

The public outcry for national health insurance is evidence that people are not satisfied with the present private health insurance system. But three of the proposals for national health insuurance, (1) the Nixon administration's National Health Insurance Standards Act, (2) the American Medical Association's Medicredit plan, and (3) the Health Insurance Association of America's health care plan, use the private health insurance system as their foundation. Therefore, an essential question in the debate over ntional health insurance is: How has the private health insurance system failed, and are the flaws irreparable?

There are several flaws which I wish to discuss quickly. The first flaw of the private health insurance system is the fine print of the policy which limits the coverage of services and requires the patient to pay coinsurance charges and deductibles.

Private health insurance pays only about one-third of consumers' expenditures for personal health care. The other two-thirds is paid by the patients, because the services which they needed were excluded from their policy's coverage of deductibles and coinsurance charges were imposed.

Theoretically, coinsurance and deductibles are intended to limit the unnecessary use of medical care by discouraging the patient from seeking help when he does not really need it. But in practice, once the patient has contacted a physician, he has very little to do with choosing how much and what kind of medical care he will receive. Those decisions are made by the physicians, who often have no knowledge of the terms of the patient's insurance policy. Moreover, the system encourages patients to delay seeking medical care until they are very ill—when their treatment becomes much more expensive—and penalizes patients who genuinely need treatment but seek it early in the course of disease.

As evidence to support the other flaws of the private health insurance system, I want to report to you the findings of a study I did of private group health insurance. With a research team at the University of Wisconsin Medical School, I have surveyed the 35 major employers of Madison, Wis., about their group health insurance policies.

Madison is a good city to use for a study of private group health insurance because if there are any biases, they would be in favor of better than average insurance coverage. The employees of Madison include several national manufacturing firms and large service industries. There are both public and private employers. The list of underwriters of the group health insurance policies include many of the major health insurance companies. Considering these facts, our results are important to the debate over national health insurance. The findings of our study are startling.

The first finding of the study is that less than 60 percent of the employees in the 35 firms are eligible for the group health insurance policies. All but five employers require that an employee work full time to be eligible. Perhaps some of the 40 percent who are not eligible do have health insurance from other sources. But this raises doubts about the common assumption that the 20 percent reported as not

covered by insurance in national figures are those who are unemployed. The 20 percent must include many who are employed.

The second finding of our study is that benefits covered by private group health insurance policies vary greatly among policies, but none of the policies are as comprehensive as the benefits of the major prepaid group practice plans: Kaiser-Permanente. None of the policies offer preventive medical services, dental services, or prescription drugs. All the policies have very restricted coverage of physicians' fees, both for outpatient and inpatient care. Coverage of other outpatient services is also very limited. Psychiatric care is another area with inadequate coverage.

Finally, two loopholes in typical maternity benefits illustrate the subtle, but grave, flaws in private health insurance. First, if a man changes his job while his wife is pregnant, they lose their insurance coverage for maternity care. Second, the coverage of the newborn child frequently does not begin until he has been discharged from the hospital or until 14 days after birth. Medical problems at birth or the first few days of life, the ones which are the most critical and expensive to treat, are not covered. These loopholes are subtle, but they point out the important shortcomings in the coverage of private health insurance.

An additional finding of the study is that size of the premium and the comprehensiveness of the benefits are not correlated. To compare the benefits covered by various plans, we randomly selected four patients' bills from one of the Madison hospitals. Let us look at an actual bill for medical care and compare how much of the bill would have been covered by the insurance policies of four Madison employers, and by the prepaid group practice plan, which is hypothetical, because there is none available in Madison. You have a copy on page 15, I assume, which has a summary table on that.

(The table referred to follows:)

	Company FF	Company W	Company YY	Company CC	Prepaid group practice plan
Monthly family premium for major medical	$41.10	$39.46	$62.70	$31.66	$35.05
Medical bill, total bill	1,533.55	1,533.55	1,533.55	1,533.55	1,533.55
Covered by insurance	1,533.55	1,488.55	1,221.79	1,186.96	1,533.55
Out-of-pocket expense	0	45.00	311.76	346.59	0
Surgical bill, total bill	4,432.35	4,432.35	4,432.35	4,432.35	4,432.35
Covered by insurance	4,397.70	4,313.70	1,820.00	3,498.63	4,432.35
Out of pocket	34.65	118.65	1,157.08	933.72	0
Outpatient, total bill	72.00	72.00	72.00	72.00	72.00
Covered by insurance	32.00	22.00	0	36.00	72.00
Out of pocket	40.00	50.00	72.00	36.00	0
Maternity, total bill	864.25	864.25	864.25	864.25	864.25
Covered by insurance	864.25	699.25	395.00	457.35	689.25
Out of pocket	0	165.00	469.25	406.90	175.00

Dr. LADINSKY. The total bill was $1,533.55, a common hospital bill. The policy with the highest monthly family premium, $62.70, is that of company YY. But the policy leaves the patient with the second highest out-of-pocket expense, $311.76.

On the other hand, the prepaid group practice plan has the second lowest premium, but completely covers the total bill of $1,533.55. The lack of correlation between premiums and coverage is shown further by the surgical bill. The total bill was $4,432.35. Company YY's

policy, the one with the highest premium, has the largest out-of-pocket expense, $1,157.08.

The same is true for the maternity and out-patient bills. Finally, compare the coverage of Company FF's and Company W's policies. The difference in premiums is less than $2, but look at the difference in out-of-pocket expenses: $45 for the medical bill, $10 for the out-patient bill, $169.08 for the surgical bill, and $165 for the maternity bill.

Why is there no relation between the premium and the coverage of the policy? The most frequent comment which we had from the personnel directors and union leaders surveyed was that they were completely baffled by the endless fine print of the policies.

They knew of no way to compare the coverage offered by different policies. How can one judge whether a $500 maximum on the coverage of a service is better coverage than 50 percent coinsurance on the use of the service? The buyer has very little basis on which to choose intelligently among policies.

In conclusion, let me summarize the points I have made.

First, coinsurance and deductibles do not achieve the purpose they are intended to achieve.

Second, many employed people are not covered by insurance.

Third, private group insurance policies do not cover many essential medical services.

Fourth, the premiums charged for private group insurance policies are not correlated with the benefits covered.

Gentlemen, the private insurance system is too shaky a foundation on which to build a national health insurance program.

Mr. CORMAN. Thank you very much.

If time permitted, I would have liked to ask some questions, but we have other witnesses who must leave at 4 o'clock, too, and I regret that our time is so limited.

Thank you very much for your presentation.

Dr. Jokichi Takamine, president, Los Angeles County Medical Association.

Dr. Takamine, we are sorry to be so short of time. There is a 6:40 plane to San Diego.

STATEMENT OF DR. JOKICHI TAKAMINE, PRESIDENT, LOS ANGELES COUNTY MEDICAL ASSOCIATION; ACCOMPANIED BY DR. WILLIAM P. FRANK, CHAIRMAN, COMMITTEE ON NATIONAL HEALTH INSURANCE; AND DR. RUBEN M. DALBEK

Dr. TAKAMINE. I am Dr. Jokichi Takamine, president of the Los Angeles County Medical Association. I am in private practice, specializing in internal medicine.

With me is Dr. William P. Frank, also an internist, who practices in Alhambra, Calif. Dr. Frank is the chairman of our committee on national health insurance, and Dr. Ruben Dalbek.

We appreciate the opportunity to present to you the statement of the Los Angeles County Medical Association in regard to national health insurance.

Our association represents almost 10,000 physicians, the majority of whom are in the private practice of medicine. We have a long history

of involvement with the day-by-day administration of various Government medical programs in the Los Angeles area.

Since the inception of the medicare program, we have provided committees of physicians to work with the intermediaries in an effort to make the programs more efficient and more productive for the patients, the physicians, and for the taxpayers.

Our committees throughout the county regularly assist the intermediaries for the Federal medicare program and the title XIX program by reviewing problem claims, by advising the intermediaries and governmental agencies on new regulations and new directives which pertain to the medical care of the beneficiaries of these programs.

We are actively engaged in the utilization review of medicare patients in nursing homes in Los Angeles County. Also, we have developed and are now offering to the intermediaries of both medicare and medicaid in Los Angeles County a hospital review program in which our physicians would assist in the determination of the proper length-of-stay for hospitalized patients under these two programs.

We believe we have gained valuable insight and comprehension of Government-sponsored plans through these activities. We feel that our observations may be useful to your committee in its deliberations concerning national health insurance.

Our association has developed a set of principles which we consider essential to any future programs sponsored by Government at either the State or Federal level. These principles are based upon our experiences in dealing with all parties concerned with the present Government medical programs. We believe that these principles should be clearly expressed in any program of national health insurance, thereby obviating the problems and inequities which have been present throughout the medicare and medicaid programs.

Los Angeles County has been called a microcosm of the State of California. Our doctors have participated in the formation and delivery of medical care to widely diverse areas—Metropolitan Los Angeles, Beverly Hills—poverty areas of Watts and East Los Angeles—industrial areas of eastern Los Angeles County, and the rural areas of Antelope Valley. Our experience thereby traverses the entire social, economic, cultural, and ethnic spectrum. From this it has become apparent beyond question that no single system could adequately serve the needs of the entire population. A pluralistic approach to medical care in this country is not only desirable, it is a necessity. A single monolith of health care delivery, from every point of view, would be nothing but a disaster.

We are alarmed at certain practices being carried out in Los Angeles County by some of the new State and Federal health programs. To be specific, we deplore the active solicitation of patients by Government-financed capitation and closed panel groups, by reports of kickbacks and special favors to social workers who refer patients to specific closed panel groups. We are alarmed at the seeming readiness with which governmental agencies sign contracts with health care providers, apparently using the dollar amount as the sole criterion in the awarding of such contracts.

Equally disturbing is the fact that no prior consultation with the county medical organization was obtained with regard to the quality of care offered by such providers.

Daily, the public is being told in the press and over the air that closed panels, prepaid groups, HMO's, capitation programs, et cetera, will be the salvation of health care in the United States. Who is saying this? Based on what? Who is championing such delivery systems? Clear-cut criteria had not yet been established for HMO's, and yet millions are being allocated for the development of such groups.

We believe that in all future programs, the patient, the physician—in fact, all providers of health care—must have the option to join the program which each believes will best meet his requirements. In our opinion, all programs must be flexible enough to allow easy access to or withdrawal from a program by any patient or physician, should he so desire.

We consider it essential that the method of delivery of services, the extent of the services to be provided, and the reimbursement procedures for these services be clearly understood and accepted by all parties concerned. We believe many of the current problems in the Government medical programs have arisen because the patient and/or the provider has not understood the limitation of benefits, the methods of delivery, or the procedures for reimbursement.

All programs should be subject to the same standards and the same mechanism of peer review which apply throughout any given community.

We are concerned with the current proposals and the current regulations which would establish health maintenance organizations, and which would leave the review of the quality of care provided by these organizations to the organizations themselves.

We believe that the provisions of medical services in future programs should be in conformance with the highest moral, ethical, and professional standards. We are firmly convinced that the peer review mechanism must be under the control and under the direction of the local practicing physicians through their local medical society. If the decisions of the peer review organizations are questioned or challenged by the fiscal intermediary, there should be prompt consultation between the intermediary and the review committee to resolve any difference. The final decision, however, must rest with the peer review organization.

Practicing physicians must be fairly represented at all decision-making levels which affect, in any way, the delivery of medical care.

In addition to these essential principles, we have also developed principles which we believe are desirable, and which can more directly be applied to the evaluation of a national health insurance program.

We believe that catastrophic health insurance coverage should be given careful consideration. We believe that Government assistance for the purchase of such insurance should be directly related to the individual's ability to pay. In other words, the Government should assume the major cost for those at the lower income levels, with the Government's portion decreasing as the individual's income increases.

We believe there should be co-payment by the individual for some part of his health care. This co-payment should be stated in a percentage rather than in a fixed dollar amount, so that those with lower incomes would pay a smaller amount of their health bill than those at the higher levels of income.

We have used our set of principles to evaluate most of the legislation pending before your committee. It is our opinion that S. 3 by Senator

Edward Kennedy and H.R. 22 by Representative Martha Griffiths would not be acceptable to most physicians, nor to the public. The bills would place undue strain on the resources of this Nation. They would offer the same relief from financial obligation to the wealthy who do not need to be subsidized as to those who are in need of financial assistance. These bills would provide the opening wedge for the Federal Government to assume the State's rights and privileges in medical licensing. These proposals could usurp the physicians' right to prescribe the most efficacious treatment for his patients by setting up restrictive drug and therapeutic devices lists.

We are confident that your committee will give every consideration to H.R. 4960, the bill developed by the American Medical Association—and to H.R. 11351, the proposals from the California Medical Association. We believe these bills do provide catastrophic illness protection as well as financial assistance determined by the person's needs.

In closing, may I note that it is obvious we have not touched upon many matters of concern, such as consumerism, cost considerations, medical education, the so-called health manpower shortage, and others. Of greater importance, though, is the fact that in all the diverse discussion about health care, nowhere have we heard any discussion or consideration of the patient as a human being—a human being not only entitled to, but his well-being dependent upon, the 1-to-1 relationship between himself and his doctor.

I firmly believe if, in the pursuit of actuarial soundness and in the name of efficiency, we lose sight of the patient as a person, more problems will be created than will be solved.

Again, thank you for the time you have given us to present our views. May we assure you of our sincere desire to work with you.

I will add to the prepared testimony and touch on a few of the issues which are contained therein, and which have arisen within the last 2 days of testimony, if I may have your permission.

Mr. CORMAN. We would be pleased to have your comments on that.

Dr. TAKAMINE. Yesterday, the president of the California Medical Association wisely and cogently made a differentiation between health care and medical care, but that differentiation in a sense has posed many problems for a practicing physician, many of which I am sure you are aware of.

We seem to be blamed for many of the ills besetting society, and, as I say, this creates a problem in that a physician today is supposed to wear many hats. We are supposed to be knowledgeable in air pollution, transportation, nutrition, housing, inner-city problems, rat infestation. We are supposed to keep up in our particular field with continuing education.

And at the same time, we are supposed to be always in our office when our patients want us, which poses for the practicing physician a real ordering of priorities, if you will.

Also, this leads to a problem when we discuss the coming education of future medical school students, because in the years ahead it is going to pose the questions of: What is a doctor, what is his primary role supposed to be, how is he supposed to allocate his time, how is he supposed to be out in the community, knowledgeable in the subjects I previously mentioned, and yet be in his office when his patients become ill and need his attention?

I am sure over the last several weeks you have heard many people testify as to the great need for accelerating medical school education, for cutting down the number of years in school, skipping internships, if you will, decreasing the period of residency, but for myself, Dr. Frank, Dr. Finland, and many others, we see pitfalls in this, I think, in this acceleration of education, Mr. Chairman, and it is not the fault of the students.

Really, it is not anybody's fault—that is a bad term—because with the changing structure of society, and thereby, the changing structure of medical care, the student thereby, and the resident, become confronted with a whole series of problems, as does the faculty.

How is their attention to be directed? On what subjects are they to lay main priorities? With important issues now coming to the fore, issues with which you gentlemen, I am sure, are well acquainted, such as the matter of genetic engineering, chemical manipulation in drugs, is it fair to our students, and society, to thrust younger people out into society, as I say, with these complex problems?

I wish I had an answer, but I don't think any answer is very simplistic, or easily forthcoming, and as I say, the entire medical school curricula and the faculty are now wrestling with these problems, how best to train young physicians to equip them, as I say, with these extremely difficult, at time very vague and imprecise problems which will confront these young people as they go out into practice.

Along with this comes the question of health manpower, which ties directly into this. As you heard today—and we support the bill which has been passed as a matter of health manpower—there has been a great hue and a cry for a rapidly increasing number of physicians and paramedical personnel.

How real this need is, I don't know if anybody can say, really, Mr. Chairman, whether it is real, or rather than an actual shortage of doctors, that this is a maldistribution, if there is in reality more demographic gaps with regard to medical care than there is a national shortage of doctors.

This, again, poses questions: what kind of personnel are you going to train to go where?

In one attempt to seemingly alleviate this problem, one dean of a very well known medical school made the suggestion that the Government pick up all the tabs for the medical students and/or interns or residents, but at the same time becoming entitled to tell them where they should go practice, and in what field they should practice.

Although, as I say, I cannot answer the question as to the actual manpower shortage, so to speak, I do think such an approach is contrary to everything upon which this country has been built, because I don't think any other particular professional would take to this suggestion very kindly, and I don't think the medical profession has.

Mr. CORMAN. At that point, Doctor, we do that with military officers, and though I would not think anyone would consider doing it—just putting all medical schools out of business—might there be some justification for creating an academy similar to the military academies, and the beneficiaries of that education would then obligate themselves to move in the areas——

Dr. TAKAMINE. That has been suggested.

Mr. CORMAN. What would be your evaluation of that, to create this as an adjunct to the existing schools?

Dr. TAKAMINE. I think it would have merit, yes.

To go from this into a question about which all of you have heard a good deal, and agreeing with Dr. Finland yesterday and with the AMA today, the Los Angeles County Medical Association supports the position that there should be HMO's, there should be foundations. As you well know, they are in California now. This is probably the father State for them.

But we are not able to grant this sense of urgency with respect to HMOs. We have four in our State now, and other grants are pending.

When the status has not been clarified, and the bill has not been enacted by both Houses of Congress, why is there this great need, when the criteria have not been set?

We have talked with many Congressmen about this matter, and members of HEW, and we hear over and over again, "Well, the criteria are not clear, it will depend on this situation."

They were going to be created to take care of the poor in areas where there was a shortage of doctors. One time it was said that perhaps 90 percent of the country could have them available by 1980 as an option for medical care.

But we have had some unfortunate happenings in Los Angeles County, where money has been given to start up so-called HMO's, and the county has not been consulted at all.

This is not to say that we are on an ego trip, that our knowledge is expertise—don't misunderstand—but we feel we are better acquainted with the problems in our county, and we would enjoy the Congress, HEW, Congress, or the people allocating these funds to consult us as to the qualifications and necessity as to the personnel and the groups arising.

To deal very briefly with the matter of cost, because this—I am sure you are all a little tired of discussing this matter—as practicing physicians on the coast, all of us become rather concerned with the great emphasis that was being placed on the words "cost" and "efficiency" and "organizations."

Not to say, Mr. Chairman, that we are in any sense opposed to these concepts. We are not. But it seemed that one factor was being omitted in the great impetus to arrive at cost-cutting mechanisms, to get smoothly functioning organization, and we talk about health care being delivered.

One object that seems to be omitted in all these discussions was the recipient of the new innovations in health care, and that is the patient.

We talk about delivering health care to the patient. We talk about taking care of the patient. But it would be our hope, as physicians, and I am sure, taking you away from your role for a minute as legislators to those roles as husbands and fathers and patients, if you will, that a climate would be created in which a doctor would be allowed to have the time and the milieu for the patient, because, as you know, the diseases which are coming more and more to the fore as the matrix of our society comes along, are different.

Now, cancer and stroke all have a psychological component, and if these factors are overlooked in our haste to achieve some other objec-

tive, and the patient is in a sense bypassed or put down the list of priorities, I think in a sense we will create as many problems as we try to solve, and maybe, speaking unilaterally, I have overlooked something, but in all this conversation about prepaid groups and certain new innovative structures, I as a physician fail completely to see how groups such as these, no matter what they may be. capitation or fee-for-service or otherwise, will help to solve these problems that I previously alluded to, drug abuse, accidents, alcoholism.

One person said several months ago that each one of us bears a major responsibility for our own health, and that we all work too hard, they say, drink to hard, drink to much, and don't have enough of a balanced life, and, as I say, I make this plea with regard to these new groups, in that these diseases have to be viewed very carefully, and the patient put in the center of them, because they are not unilateral, simplistic disease entities we treated 30 or 40 years ago, that your parents were treated for.

If medicine, or a bill is created, let us say, which creates a structure or a climate in which the patient in any way is going to feel as if he is going to be treated as an object, a set of symptoms, signs and symptoms, a thing, a disease entity, if in any way he is to be depersonalized further in this changing society, dehumanized, I think a great disservice will have been done to the patients and the people of this country, and, as I say, a whole rash of new problems will be created for those ostensibly we are trying to eradicate.

I know there are many issues that we would like to discuss, that we would like to call to your attention, that concern us greatly—those of community health centers, neighborhood health centers, the matter of consumers, which is a tremendous problem in the ghetto areas such as Watts and east Los Angeles. Time does not permit these.

I would like to say, Mr. Chairman, that Los Angeles County is now in the processes of finalizing a set of principles that have been submitted to every member of our 10,000-member organization for their, not approval, but for their working over, and that, hopefully, this spring we will be able to mail these to your committee for your consideration.

In conclusion, I would like to say two things: One, speaking not only for the two men here, Dr. Finland and others who testified yesterday, but all the members, we would hope that any bill which would be forthcoming, no matter when it comes out to the public, will be one which will not only maintain the health but in a sense elevate or better the health of the total individual, and the word that I probably heard used most frequently in the last few days here is that of "pluralism," and this is a concept that I can say all the members of my county heartily endorse, because it seems through the centuries that the strength of America has been by virtue of its heterogeneity, its diversity, and therefore, its pluralistic approach to problems.

We hope, as I say, that a bill which will be forthcoming will take this fact into consideration.

Some people consider heterogeneity a weakness, in a sense, the democratic processes. This is one of the cases, I suppose, that a weakness is a strength, and a strength is a weakness. I am sure the members of this committee are fully cognizant of this fact, and will act accordingly.

And now, if I may have the permission of the chair for just 1 minute, and again I am speaking personally, Congressman Corman, I would like Dr. Frank, who is the chairman of our committee and who has worked many months and hundreds of hours, if he may have a closing statement.

May I have the permission?

Thank you.

Dr. FRANK. Gentlemen, as my president has alluded to, in Los Angeles County we are preparing a list, a group of essential principles which we feel can be applied to any government program and will make it workable, acceptable, and in the best interest of the Nation. We have these principles in the process of preparation.

And I want to close with one statement. Physicians of this country number among the best that the Nation has. Let them practice as free men, and do nothing to degrade the profession in a manner that would deter the young people, the bright young people who will carry on the traditions of our noble profession from entering this field.

I thank you.

Mr. CORMAN. Did you have anything further?

Dr. TAKAMINE. Yes, sir, we have a couple of minutes. You have been so kind. We would be happy to answer any questions.

Mr. CORMAN. We missed the vote. I hope you don't miss the plane.

I may be misinformed, but it was my information that some years ago, when group practice first started in Los Angeles County, that the Los Angeles County Medical Association did not admit into its membership those who practiced in group practice. Is that accurate or inaccurate?

Dr. DALBEK. Initially, that was true. The Los Angeles County Medical Association did take a position against group practice. However, that matter was straightened out and they were accepted.

Mr. CORMAN. I wonder what the original reason for it was, and then what the reason was for the change.

Dr. DALBEK. I don't recall. I was not in Los Angeles at that time. I would be very happy to check on it and let you know.

Mr. CORMAN. I am wondering if it was that you were apprehensive about group practice, and your apprehensions were not realized, and therefore, you changed your position.

Dr. FRANK. Mr. Chairman, we recognize there must be a pluralistic approach to the practice of medicine, but it must be provided with the highest standards of ethics, morality, and responsibility by the physician.

The method of delivery of health care should be determined, and which method of delivery of health care should be determined by the patient himself. He should have a choice of which system he likes to participate in, and also have the right, if subsequently disenchanted, to withdraw from that system, and similarly, the physician have the right to adopt any form of delivery of medical care, and withdraw if he finds that this is not his way of practicing medicine.

Dr. TAKAMINE. If you would like, Mr. Chairman, as Mr. Dalbek said, we would find that out. I cannot give you that answer.

Mr. CORMAN. We have another witness who wants to respond to that question.

Dr. CRUM. Because it was felt that the patient retains the freedom of choice of his position, and in a closed panel group practice there was no assurance that the patient would have a choice of his physician—he may return at one time to see one physician and get whoever might be on call—we felt this was not in keeping with what we felt to be the tenets of quality medical care.

There have been alterations in these programs so that the patient has a freedom of choice, and therefore, this restriction has been withdrawn and this has been rethought, and we now have a different approach to the matter.

Mr. CORMAN. Thank you very much.

I believe you can catch your plane.

We will resume at 10 o'clock tomorrow morning.

(Whereupon, at 4:10 p.m., the committee adjourned, to reconvene at 10 a.m., Thursday, November 11, 1971.)