The original documents are located in Box D8, folder "Ford Press Releases - Medicare, 1965-1966" of the Ford Congressional Papers: Press Secretary and Speech File at the Gerald R. Ford Presidential Library.

Memo:

REP. JOHN W. BYRNES
6TH DISTRICT, WISCONSIN
HOUSE OF REPRESENTATIVES
WASHINGTON 25, D.C.

February 2, 1965

HEALTH CARE FOR AGED ... I outlined, at a press conference in the Capitol last week, a proposal for a national health insurance plan for persons aged 65 and over. Legislation embodying the plan is now being drafted and I will introduce the bill on my own behalf and on behalf of the majority of the Republican members of the Ways and Means Committee and with the support of the House Republican leadership. The plan is the result of long study and consideration of the problems our elder citizens encounter in financing comprehensive medical care. It is advanced as an alternative to the Administration's Medicare proposal under Social Security, a plan I consider inequitable, inadequate and a danger to the future of the Social Security System.

HOW IT WOULD WORK ... Under my proposal, all persons over 65 would be eligible for health insurance which would provide comprehensive medical, hospital, surgical and nursing home benefits comparable to those now provided for federal employees. Enrollment would be voluntary. Part of the cost of the plan would be borne by the beneficiaries through payment of contributions based upon ability to pay (with Social Security benefits used as a guide). The remainder would be paid by the federal government out of general revenues. States could contribute by insuring as groups the medically indigent who are now receiving public assistance funds for medical care. The health insurance fund would be administered by the Treasury; payment of benefits from the fund would be the responsibility of the Surgeon General who would contract with service agencies (such as Blue Cross) to handle this administrative chore. (I will be glad to send complete details to those who are interested.)

CONTRAST ... The plan is vastly different - in philosophy, in impact and in principle - from the Administration's Medicare plan. It overcomes the deep-seated, basic objections which many of us have had to that proposal:

COVERAGE ... The Administration's plan is compulsory; this plan is voluntary; it preserves the right of choice ... Medicare restricts coverage; some groups are not eligible; this plan is open to everyone.

BENEFITS ... In order to hold down the payroll tax it requires, Medicare provides inadequate benefits generally limited to hospital and nursing home care. This plan provides the kind of comprehensive benefits which the Administration program would eventually have to provide if it is to truly meet the medical needs of our elder citizens. Included are hospital and nursing home care, medical services, surgery and physician's fees, patterned after the federal employee program.

FINANCING ... Medicare's financing is inequitable and dangerous. It would be paid for by a payroll tax upon the lowest wage levels - with the income being used to pay for benefits of another group. This is tax regression with a vengeance. The plan I propose would be financed by the contributions of those who participate and by federal funds derived from taxes based upon ability to pay ... Medicare, moreover, would push the payroll tax up to the limits of acceptability. Since Social Security is also financed by payroll taxes, future adjustments in benefit levels for retirement, death and disability would be endangered....Finally, Medicare would establish a bureaucracy under Social Security with the dangers of government control over Medicare. This plan minimizes government administration.

John W. Byrnes

(Not printed at Government expense)

United States *of* America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 89th CONGRESS, FIRST SESSION

COMPREHENSIVE HEALTH CARE PLAN

REMARKS
OF

HON. JOHN W. BYRNES

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Thursday, February 4, 1965

Mr. BYRNES of Wisconsin. Mr. Speaker, I am today introducing a bill to provide for comprehensive health insurance for all persons aged 65 and over on a uniform basis throughout the United States. The cost of the program will be shared by the individual participants and the Federal Government. The program will be entirely voluntary.

I am happy to state that joining me today in the introduction of identical bills are Hon. JAMES B. UTT, of California; Hon. JACKSON E. BETTS, of Ohio; Hon. HERMAN T. SCHNEEBELI, of Pennsylvania; Hon. HAROLD R. COLLIER, of Illinois; Hon. MELVIN R. LAIRD, of Wisconsin; Hon. BEN REIFEL, of South Dakota; Hon. WILLIAM L. DICKINSON, of Alabama.

The plan will more adequately meet the medical needs of the aged than the administration's medicare proposal. It will be more equitable. It will not endanger the soundness of the social security system. It will be voluntary instead of compulsory.

The administration plan is generally limited to hospital and nursing home expenses. This plan will cover both hospital and nursing home care and surgical and medical expenses. It is both comprehensive in scope and comprehensive in effect. It will cover up to $40,000 of expenses.

The administration plan is compulsory. This plan is voluntary and every citizen over 65, without a means test, will be eligible for coverage under it.

The administration plan is inequitable. It requires wage earners to pay a regressive payroll tax chargeable to the lowest levels of income to provide medical benefits for others—a tax misleadingly justified on the basis that workers are prepaying for their own care. This plan will mainly be financed from two sources—the beneficiaries themselves based upon their ability to pay, and by the Federal Government through general revenues derived from taxes collected on the same principle. In addition, provision will be made for the States to share in financing full participation for the medically indigent.

The administration plan endangers the adequacy of retirement, death, and disability benefits under the social security system by pushing the regressive payroll tax to the limits of acceptability. The insurance concept of this plan, its method of financing, and its administration are completely independent of the social security system. Social security benefits are used merely as a test of ability to pay the individual contribution. The social security system's only involvement is the assignment of a specified percentage of an individual's social security benefits to a health insurance fund administered by the Secretary of the Treasury.

In summary, the administration's medicare proposal is unsound and dangerous. Its enactment would start us down a path from which there is no returning—the path toward regimented and deteriorating medical care. We propose a solution which we believe is typically American—comprehensive, fair, voluntary, and oriented to individual freedom and initiative. This is the way to meet the urgent needs of our elder citizens in the financing of medical care.

In brief outline, the plan would work as follows:

All persons aged 65 or over would be eligible, on a uniform basis, for insurance protection equivalent to the Government-wide indemnity benefit plan. Their participation would be voluntary; there would be no means test. Enrollment would be during an initial enrollment period, followed by periodic enrollment periods.

For those under social security—or railroad retirement—enrollment would be exercised by an assignment of a premium contribution to be taken out of, or checked off, the individual's current social security benefit. Those not under social security would execute an application accompanying it with their initial premium contribution. State agencies would be granted an option to purchase the insurance for their old-age assistance and medical assistance for the aged recipients at a group rate.

Premium contributions by individuals would be based upon the cash benefits which they would either receive, or be entitled to receive, upon reaching age 65. The premium would be 10 percent of the minimum social security benefit and 5 percent of the balance. Those receiving the lowest social security benefits would pay the least. The average premium contribution on the basis of today's benefit levels would be $6 per month per person. Persons not under social security would pay a premium equivalent to the maximum contribution of an individual under social security. The remainder of the cost of the insurance would be paid by the Federal Government out of general revenues.

Benefits would be paid out of a national health insurance fund. The fund would receive as deposits the contributions of individuals, contributions from the social security system and Railroad Retirement Board on behalf of individuals covered under those systems, State contributions for OAA and MAA recipients, and annual appropriations from the Federal Treasury. The Secretary of the Treasury would administer the fund. The insurance program would be administered by the Department of Health, Education, and Welfare, which would be charged with general administration, recordkeeping, and so forth, but would not process the claims or bills of hospitals, physicians, and the like. The Surgeon General would contract with private agencies—Blue Cross-Blue Shield, for example—which would process and pay the claims of those furnishing services and would then be reimbursed from the national health insurance fund.

DESCRIPTION OF COMPREHENSIVE HEALTH INSURANCE BILL

SUMMARY OF BENEFITS

The program will provide for comprehensive health insurance equivalent to the medical services available to Government employees under the high option of the Governmentwide indemnity plan, modified in order to meet the special needs of the aged.

The benefits under the program will greatly exceed the benefits provided for in the King-Anderson bill (H.R. 1). The program provides for full coverage of the first $1,000 of hospital—or nursing home—room and board plus 80 percent of any balance. This is the equivalent to 50 days in the hospital or 100 days of a qualified nursing home without a deductible.

In addition, the program provides for 80 percent of all other hospital, surgical, and medical expenses, after a deductible of $50, of which only $25 will apply to other hospital charges. This includes professional services of doctors, such as surgery, consultations, and home, office, and hospital calls, professional services of registered nurses, diagnostic services, rental of medical equipment, ambulance service, and prescribed drugs and medicines.

The program covers the catastrophic illness, with up to $40,000 in benefits. No longer will the life savings of an elderly person be wiped out because of a major illness.

The program will pay the actual charges for the service, subject to the reasonable and customary test used by private insurers.

Except for the liberalization of the coverage of hospital room and board to include nursing homes, the program is in all respects identical to the high option of the governmentwide indemnity plan offered to Federal employees. This means that an individual can undergo major surgery and have paid in full the first $1,000 of hospital room and board plus 80 percent of all other hospital and medical expense incident to that operation after a deductible of not more than $50. In addition, the program will cover 80 percent of all posthospital medical expense after the deductible of $50 has been exceeded by prior expense, including the $25 deductible applicable to the hospital charges.

METHOD OF FINANCING

The program would be financed by a graduated premium contribution by the individual participants based on ability to pay, supplemented by an annual appropriation from the general revenues.

By including a contribution or premium charge, the cost of the program is shared by those who receive the benefits and by the Government.

Unlike the King-Anderson bill, the program does not rely upon a regressive payroll tax for financing. The program thus avoids the dangerous fiction inherent in the King-Anderson bill that, through the use of a payroll tax, today's workers and their employers are prepaying the cost of health protection for their later years. The fact is that the regres-

sive payroll tax will be financing the cost of medicare for those currently over 65. Under our program, the Government's share of this cost will be paid from the general funds of the Government.

ELIGIBILITY FOR COVERAGE

All persons upon attaining age 65 will be eligible for coverage on a voluntary basis. Following enactment of the program, there will be a 6-month enrollment period during which all persons 65 years of age and over will be eligible to elect to participate. Thereafter, there will be periodic enrollment periods. All persons upon reaching age 65 will have 7 months within which to elect to participate.

Under the King-Anderson bill, all persons aged 65 and over—except Federal employees—are automatically covered regardless of their wishes in the matter. This results in the inclusion of persons opposed to such coverage, for example, the Amish, Christian Scientists, as well as those already covered by group insurance programs.

The voluntary concept avoids excess coverage. Since there is a cost to the insured, those who already have adequate programs paid for by their former employers or through associations and the like, may decide not to participate in the Government-sponsored program. The automotive workers, the chemical workers, and other large industrial groups, have fully paid comprehensive health plans for retired workers. To the extent that these do not participate, the cost to the Government is reduced.

MANNER OF ELECTION

For those under social security—or railroad retirement—the election will be exercised by authorizing a "check-off" or assignment of the prescribed premium contribution out of the individual's current monthly social security benefit. An election by those not under social security—or railroad retirement—will be evidenced by execution of an application for participation in the program and the payment of premium contributions.

BASIS FOR PREMIUM CONTRIBUTIONS

The premium contributions by the participants are graduated according to ability to pay as evidenced by their old-age insurance benefit. The premium is an amount equal to 10 percent of the minimum cash benefit of a primary beneficiary—currently $40 per month—plus 5 percent of the additional cash benefit payable to the primary beneficiary and his spouse—if over age 65. This will result in an average premium contribution of $6 per month per person.

If an individual otherwise entitled to receive cash benefits under social security is ineligible for such benefits—or such benefits are reduced—on account of the earnings test, this will not affect the individual's contribution. The amount of the individual's contribution will be paid by the Social Security Administrator to the insurance program irrespective of earnings. To this extent, there is an automatic liberalization of the earnings test.

At the existing level of social security cash benefits, the premium contributions required for select benefit levels would be as follows:

Monthly benefit of aged family unit and monthly health contribution

$40 (single worker)	$4.00
$60 [1]	5.00
$75	5.75
$105	7.25
$150	9.50
$190 [2]	11.50

[1] Present monthly minimum of $40 for worker and $20 for wife.

[2] Present monthly maximum of $127 for worker and $63 for wife.

Railroad retirement contributions would be based upon the same formula as the social security contributions, up to the maximum payable by social security participants.

For a couple receiving the maximum social security benefit—currently $190—the cost of the insurance will be $11.50 per month. A couple receiving the minimum social security benefit—currently $60—will be able to buy the same health insurance at a cost of $5 per month. The amount of the Government subsidy thus varies with the economic status of the individual, as measured by social security benefits.

At the conference on the social security amendments bill of 1964, it was virtually agreed that OASI cash benefits should be increased by 7 percent with a minimum increase of $5 per month. We can assume that an increase will be enacted this year at least equal in amount. This will provide the OASI beneficiaries with additional funds required to participate in the insurance program.

Persons who are not under social security may participate by a premium contribution equal in amount to the maximum contribution of those eligible under social security. Where payment of the premium would represent an undue hardship, such as in the case of a person under old-age assistance, the individual could be included under the group buy-in option extended to the States.

The insurance concept is completely independent of the social security system. Social security benefits are used merely as a test of ability to pay in determining the amount of the individual contribution. The assignment of a predetermined percentage of these benefits to the health insurance fund is the only relationship of the program to the OASDI system.

PARTICIPATION BY STATE AGENCIES—GROUP BUY-IN OPTION

State agencies will have the option to purchase the plan benefits for their old-age assistance—OAA—and medical assistance for the aged—MAA—recipients at a group rate equivalent to the weighted average rate applicable to the social security beneficiaries, which is presently about $6 per month.

The program preserves fully the role of the States in providing for those who are in need. The State agency will have considerable flexibility in meeting the requirements of these groups. If the individual is a social security beneficiary, presumably the State would require the individual to elect the benefits through the assignment of social security benefits and increase the individual's old-age assistance cash allowance to make up the difference. Other recipients of State aid could be blanketed in at the group rate.

Thus, while the individual contributions will vary, all persons over 65 will be eligible for the identical comprehensive protection. No distinction is made between the person covered on an individual basis, the recipient of OAA or the recipient of MAA.

ADMINISTRATION OF PROGRAM

There will be established a national health insurance fund. The fund will be administered by the Secretary of the Treasury. Premium contributions of the individual participants will be deposited directly to the credit of the fund. An appropriation will be made annually to provide for the additional amount required by the fund in order to finance benefits for the ensuing benefit period.

The general administration of the insurance program will be entrusted to the Department of Health, Education, and Welfare. That Department will be charged with the responsibility of making known the program to those presently over age 65; notifying those reaching age 65 in the future of their rights to participate; maintaining records; preparing actuarial studies; and presenting the appropriation requests for the program to the committees of the Congress, and so forth.

The Office of the Surgeon General will be charged with the administration of the benefit provisions of the program. The Surgeon General will utilize established health insurance organizations to process the claims—bills—of the hospitals, physicians, and other organizations rendering the service. Payment for health service will be processed in the same manner as a charge presently covered by Blue Cross-Blue Shield or a private insurer. The hospital, physician, and the like will send their bills to the accredited health organization designated to process claims. After the customary verification, such organization will pay the charge. The paying organization will then be reimbursed by the Treasury for the charges paid together with an agreed upon fee or handling charge.

Examples showing comparable benefits under King-Anderson bill (H.R. 1) and under this program

CASE A—HOSPITAL

	Amount
Hospital room and board	$441
Hospital ancillary charges	353
Surgeon and anesthetist	260
Other physicians	200
Private duty nurse	85
Out-of-hospital drugs	75
Other expense	15
Total medical expense	1,429
Recovery under King-Anderson bill	−754
Cost to insured under King-Anderson bill	675
Additional recovery under this program	−438
Cost to insured under this program	237

CASE B—NONHOSPITAL

Surgery	10
Nonhospital physician visits	120
Nonhospital nurse visits	8
Prescribed drugs	94
Other nonhospital care	18
Total medical expense	250
Recovery under King-Anderson bill	0
Cost to insured under King-Anderson bill	250
Additional recovery under this program	−160
Cost to insured under this program	90

PUBLIC BILLS AND RESOLUTIONS

Under clause 4 of rule XXII, public bills and resolutions were introduced and severally referred as follows:

By Mr. BYRNES of Wisconsin:

H.R. 4351. A bill to establish a program of voluntary comprehensive health insurance for all persons aged 65 or over; to the Committee on Ways and Means.

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The administration plan is inequitable. It requires wage earners to pay a regressive payroll tax chargeable to the lowest levels of income to provide medical benefits for others—a tax misleadingly justified on the basis that workers are prepaying for their own care. This plan will mainly be financed from two sources—the beneficiaries themselves based upon their ability to pay, and by the Federal Government through general revenues derived from taxes collected on the same principle. In addition, provision will be made for the States to share in financing full participation for the medically indigent.

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In brief outline, the plan would work as follows:

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DESCRIPTION OF COMPREHENSIVE HEALTH INSURANCE BILL

SUMMARY OF BENEFITS

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Excerpts from the remarks by Rep. Gerald R. Ford

HOUSE OF REPRESENTATIVES

April 8, 1965

Mr. Chairman,

I conclude with these observations. The House Republican Policy Committee and the House Republican Conference have endorsed H.R. 7057, the Byrnes bill, as the motion to recommit. H.R. 7057 was unanimously endorsed by all of the Republican members of the Committee on Ways and Means. I commend the Republicans on the Committee for their hard and constructive work. I especially commend Congressman John Byrnes for his leadership in drafting H.R. 7057 which is constructive legislation, far preferable to the Committee proposal.

As far as final passage is concerned, if the motion to recommit fails, neither the House Republican Policy Committee nor the House Republican Conference have recommended any guidelines. This is quite understandable. The Committee bill, H.R. 6675, is to a substantial degree Republican legislation, except that part which incorporates the Administration's King-Anderson proposal for hospital care financed by a payroll tax.

Many of my Republican colleagues, in weighing the Republican portions of H.R. 6675 against the Administration's part of the same bill, with understandable logic will vote for the bill on final passage. On the other hand some of us, including myself, have strongly and consistently opposed the regressive payroll tax method of financing hospital care for the aged.

In my judgment that portion of H.R. 6675 which is unsound, outweighs the good. In the final analysis it is one's own conscience, not a Republican policy position, that will determine how Republicans will vote on final passage.

I conclude, however, by re-emphasizing that the Republican motion to recommit is sound. It is our policy as a party. I urge that my colleagues support the Byrnes substitute, H.R. 7057.

Excerpts from the remarks by Rep. Gerald R. Ford

HOUSE OF REPRESENTATIVES

April 8, 1965

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THE JOINT SENATE-HOUSE REPUBLICAN LEADERSHIP

Press Release

IMMEDIATE RELEASE
March 29, 1966

STATEMENT BY THE

JOINT SENATE-HOUSE REPUBLICAN LEADERSHIP

The Republican Congressional Leadership today introduced Medicare legislation to extend through August 31, 1966 the initial enrollment period for coverage under the program of supplementary medical insurance benefits for the aged.

Senator Everett McKinley Dirksen and Representative Gerald R. Ford announced the filing of identical bills for this purpose in the Senate and House of Representatives in fulfillment of the Republican Co-ordinating Committee pledge to do so.

The law presently requires registration for these benefits by March 31st but once it became clear that over 5 million older persons would be unable to register by that date, the Republican Congressional Leadership took action to prevent the denial of such benefits to these millions of citizens.

The supplemental benefits portion of the law was added to Medicare on the insistence of Republican Congressmen John W. Byrnes of Wisconsin. Republican congressional agreement and insistence upon extension of the enrollment period is unanimous.

Room S-124 U.S. Capitol—CApitol 4-3121 - Ex 3700
Staff Consultant – John B. Fisher

REPUBLICAN NATIONAL COMMITTEE
1625 EYE STREET, NORTHWEST, WASHINGTON, D. C. 20006 NATIONAL 8-6800

NEWS

FOR RELEASE

Tuesday, A.M.'s
March 29, 1966

STATEMENT ON MEDICARE ISSUED BY THE REPUBLICAN COORDINATING COMMITTEE AT ITS MEETING IN WASHINGTON, D. C., MARCH 28, 1966

We must warn Americans of an acute crisis developing under the Medicare and Supplemental Medical Insurance Program which were passed more than a year ago. The law requires registration for certain benefits by March 31st.

The supplemental medical benefits portion of the law was added to medicare on the insistence of Republican Congressman John W. Byrnes. It becomes effective July 1.

It now appears that some 5 million older persons may be unable to register by the required date. They will be denied these benefits.

The inability of these older persons to qualify has been caused by a clumsy and obstructive bureaucracy. The aged have been bewildered and harassed by cumbersome technical requirements. They have been victimized by endless red tape.

We insist that these 5 million people not be denied these benefits because of the inexcusable administrative failures of the Johnson-Humphrey Administration.

The Republican Congressional Leadership will introduce legislation to change the registration date to September 1. We call upon the Administration to give full support to this legislation so it can be enacted at once.

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