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OFFICE OF THE VICE PRESIDENT

WASHINGTON, D.C.

February 6, 1976

TO: SPENCER C. JOHNSON

FROM: GRADY E. MEANS

For your information.

Medicine proposal

Washington Report on MEDICINE & HEALTH

A McGRAW-HILL PUBLICATION

Dale R. Bauer, *Publisher*
Jerome F. Brazda, *Editor*

February 2, 1976 - Vol. 30, No. 5

**By the comfortable margins of 310-113 in the House and 70-24 in the Senate, Congress last week overrode President Ford's veto of the fiscal 1976 appropriations bill for the Departments of Labor and HEW. After several failures during the Nixon and Ford Administrations, it was the first time Congress has overridden an HEW appropriations veto. The vote clears up some of the confusion over the amount of money available during the current fiscal year, which ends June 30, and the subsequent transition quarter. But even before the vote last week, the Office of Management and Budget muddied up the waters anew by sending Congress more requests to rescind or defer spending of HEW health monies (see p.3). Congress is not likely to go along with the requests, but the Administration is expected to continue efforts to delay spending the funds. (For details on the funds now available, see the special insert in this week's WRMH).

**Determined to meet the April 14 deadline set by Senate Appropriations Committee Chairman John McClellan (D-Ark.), the subcommittee of Warren Magnuson (D-Wash.) last week opened hearings on the HEW budget request. Secretary David Mathews presented the initial testimony but, because of the veto override only the day before, didn't have updated comparative figures to present. Although the reception for Mathews' first appearance before the subcommittee was cordial enough, Magnuson wondered aloud why the Administration continues to send proposed rescissions and deferrals when it has "lost 35 cases in a row."

**In view of the lack of post-override cost figures, Magnuson cancelled scheduled appearances of HEW's Office of the Assistant Secretary for Health, NIH, the Center for Disease Control and the Health Services Administration. Other health agencies may meet the same fate this week. Magnuson instructed the health leaders to send him written budget presentations and said he planned to proceed without verbal testimony in order to meet the April 14 deadline. The House HEW subcommittee of Rep. Daniel Flood (D-Pa.) meanwhile opens this week with Labor Department witnesses and has scheduled HEW to begin in two weeks.

CATASTROPHIC INSURANCE PLAN CHANGING AS EXPERTS WORK OUT THE FINE PRINT

It is becoming increasingly clear that President Ford's plan for "catastrophic" health insurance coverage under Medicare was not one of the better thought-out proposals in his State of the Union message. With only a week left to get a draft bill on paper before the beginning of Ways & Means Health Subcommittee hearings, Administration legislative technicians still have some big loopholes to close.

The idea of putting a catastrophic "cap" on Medicare beneficiary cost-sharing has been kicking around the Executive Branch think tanks for some time. But it was dusted off rather hurriedly by Office of Management and Budget officials for inclusion in the State of the Union and the fiscal 1977 budget request. The first sign that the plan was less than complete came several days after the State of the Union when HEW officials called a hasty press briefing to emphasize that Mr. Ford had meant to include elimination of Medicare spell of illness limitations. That required revision of original cost estimates.

Now being examined are such problems as whether physicians will accept assignment of Medicare fees (meaning payment in full by the insurance program) under a proposed 4 percent limitation on increases, as the President said he thought they would. Signals from organized medicine indicate that they will not. If physicians refuse to accept assignment then only the part of their fees paid by Medicare Part B would qualify for the $250 cap on doctor bills; charges over and above that would not, meaning some beneficiaries could have to incur liabilities well over $250 before becoming eligible for catastrophic coverage. Also giving HEW experts pause is the realization that the catastrophic plan could act to bring heavy emphasis on the more expensive acute care end of the health industry.

HIBAC MEMBERS ARE CONFUSED OVER WORDING OF RESOLUTION

When the Health Insurance Benefits Advisory Council (HIBAC), charged with advising the Secretary of HEW on Medicare and Medicaid policy, resolved 15-2 at its Jan. 23 meeting in favor of trading patient cost-sharing for increased protection against catastrophic expenses, it appeared the group had endorsed President Ford's new budget plan. But a spot poll of some HIBAC members by MEDICINE & HEALTH indicates some confusion over what the resolution meant and what those who voted for it intended it to mean.

In a letter to HEW Secretary David Mathews, dispatched shortly after the meeting, HIBAC Chairman Stanley A. Miller, a Harrisburg, Pa., businessman, said the resolution states that HIBAC "supports legislative efforts to re-orient the financial liability and protection included in the Medicare program achieved by trading off increased initial patient cost-sharing for increased protection against catastrophic expenses." But one HIBAC member said he meant only to say "if you're going to charge them more, give them something in return." Another said he agreed with the principle of last-dollar coverage but found the resolution poorly worded and did not intend it to specifically endorse the President's proposal. One member didn't think the wording put down on paper by Miller was what had been voted on. The resolution was offered by Paul Ginsburg of the Michigan State University

PRESIDENT FORD SENDS CONGRESS SECOND REQUEST FOR RESCISSION AND DEFERRAL OF HEALTH FUNDS

Only days before Congress voted to override his veto of the fiscal 1976 HEW appropriations bill, President Ford sent (on Jan. 23) a proposed rescission of $266.3 million in HEW health funds and a request to defer spending of $13.9 million. The proposal followed another request to defer spending of $82 million in health program funds (WRMH 1-26-76). In both cases, Congress is expected to reject the requests that were made under the new budget control law enacted to prevent impoundment of appropriated funds.

In the new proposed rescission, President Ford is asking that much of the funds provided in a second supplemental appropriation bill last December be returned to the Treasury. Included is $103.2 million of $437 million appropriated for health services plus $24.7 million appropriated for services for the transition quarter from June 30 until Oct. 1 when fiscal 1977 begins under a new arrangement whereby fiscal years begin Oct. 1 and end Sept. 30. Amounts the President wants rescinded for fiscal 1976 include $41.5 million for Community Health Centers, $22.5 million for grants to states, $3.8 million for hypertension projects, $21.8 million for family planning, $5.8 million for migrant health services, $2.5 million for the National Health Service Corps, $3 million for home health services and $3 million for a new hemophilia program.

Other proposed rescissions include $5.3 million for the Indian Health Service, $7.7 million for rat control project grants, $56.5 million for Community Mental Health Centers and $67 million for nurse training. The $13.9 million spending deferral requested by the President is earmarked for Indian Health Service facilities.

MATHEWS AND MOSS TANGLE IN FIRST ROUND OF HEARINGS

HEW Secretary David Mathews made his first appearance before a hostile Congressional committee last week when he and department aides testified before the House Commerce Subcommittee on Oversight and Investigations chaired by Rep. John Moss (D-Calif.). Despite several hours of subcommittee attempts to nail the voluble Secretary with subcommittee pique over his refusal to implement Medicaid penalties against states for failure to institute utilization review, Mathews was not noticeably bruised. In his opening statement, the Secretary said he feels the penalty statute is unjust but said he has invoked a $1.1 million legal penalty against the State of Pennsylvania "for shortcomings in its early screening program under Medicaid."

Because of errors in the survey of state performance during fiscal 1974, Mathews said he will impose no penalties for that year. He added, however, that a new survey is underway "to determine state compliance with selected aspects of utilization control during FY 1975." Much of Mathews' time before the subcommittee was spent hassling over the meaning of the law, part of the 1972 Social Security Amendments. A return bout is expected on the subjects of unnecessary surgery, childhood screening, hospital accreditation and health planning. Among other things, Moss said the subcommittee wants to know if Professional Standards Review Organizations are an appropriate alternative to Utilization Review.

BRIEFLY THIS WEEK:

--More detailed material on the Ford Administration's fiscal 1977 budget request is found in a 233-page book, "Seventy Issues, Fiscal Year 1977 Budget," published by the Office of Management and Budget. The book contains sections on Health Income Security and other HEW budget categories. The book essentially is a compilation of budget briefing documents issued by various departments. For a copy send $5.20 to the Government Printing Office, Washington, D.C. 20402.

--AMA officials met with President Ford for nearly an hour last week in what was described as a cordial discussion of issues of mutual concern.

--The National Association of Counties has advised members to sit tight on President Ford's block grant proposals until draft legislation is completed. "Discussions with Administration officials raise several preliminary questions" about the block grant plan, NACO's newspaper "County News," reported. Administration experts say they believe more counties will find the plan favorable than will find it unfavorable.

--Hearings on a Federal Trade Commission complaint against AMA that is aimed at opening the AMA code of ethics to permit physician advertising have been delayed. Originally scheduled for Feb. 9, the hearings now are set for Feb. 25.

--The Public Service Administration is the new name of HEW's Community Services Administration that administers programs of social services under Title 20 of the Social Security Act. The name change avoids confusion with the Community Services Administration that is the successor agency to the Office of Economic Opportunity.

--President Ford has promoted James H. Cavanaugh, PhD, former HEW health official, to Deputy Assistant to the President for Domestic Affairs. Cavanaugh continues as deputy director of the Domestic Council, which he has been for more than a year. In both positions he is deputy to James Cannon. Although also involved in other domestic policy areas, Cavanaugh is the Ford Administration's top-ranking health official. Newly appointed to the Domestic Council as assistant director for health, Social Security and welfare is Spencer Johnson, until recently administrative assistant to Rep. James Hastings (R-N.Y.), who resigned from Congress effective with the start of the second session.

--Two contracts for biomedical studies related to possible health hazards of energy have been awarded by the Energy Research and Development Administration (ERDA) to Cornell University's New York State Veterinary College. The contracts total $117,337.

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WASHINGTON REPORT ON MEDICINE & HEALTH

Special Budget Report

2-2-76

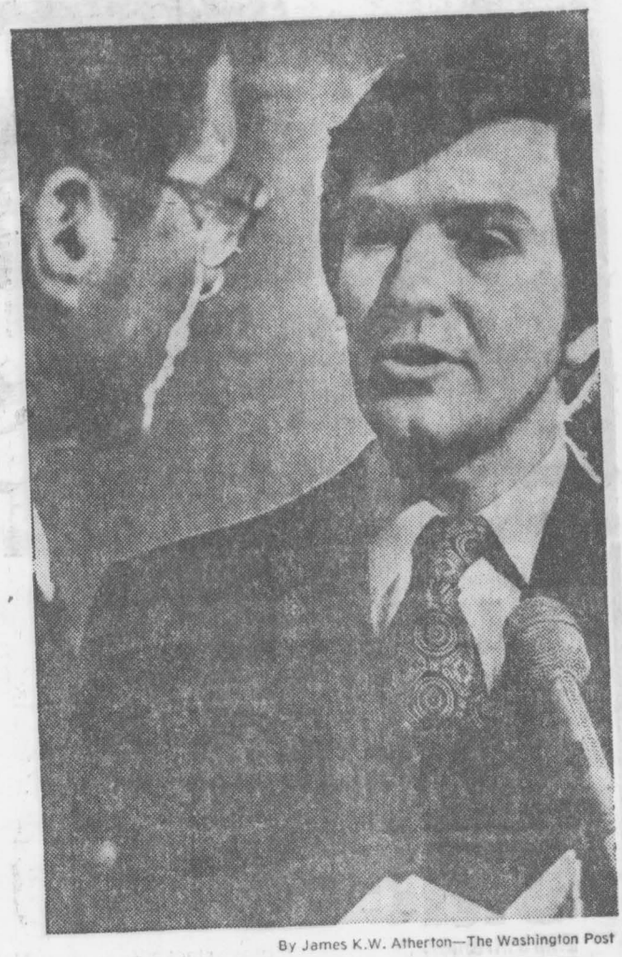
Following is a chart comparing the amounts provided for selected health programs during the fiscal year ended last June 30 with the amounts provided for in the fiscal 1976 appropriations bill passed by Congress over the veto of President Ford and with the Ford Administration requests for comparable programs for fiscal 1977.

(Figures in Millions)	1975 Actual	1976 Appropn.	1977 Budget
HEALTH SERVICES ADMINISTRATION			
Community Health Centers	$196.6	$196.6	$155.2
Health Grants to States	90.0	90.0	--
Maternal and Child Health:			
--Grants to States	267.0	295.7	193.9
--Sudden Infant Death Syndrome	2.0	2.5	--
--Research and Training	25.9	23.7	17.5
Family Planning	100.6	100.6	79.4
Migrant Health	23.8	25.0	19.2
Health Maintenance Organizations	7.2	18.6	18.6
National Health Service Corps	17.1	15.0	24.5
Hemophilia Treatment Centers	--	3.0	--
Hypertension	--	3.7	--
Home Health Services	--	3.0	--
Medical Care Standards	4.7	5.2	4.2
Professional Standards Review	36.1	47.6	62.0
Patient Care & Special Services	108.3	118.0	107.0
Emergency Medical Services	37.0	33.6	25.1
CENTER FOR DISEASE CONTROL			
VD Control	28.0	--	19.8
Immunization	6.2	--	5.0
Rat Control	13.1	13.1	5.4
Lead-based Paint Poisoning	9.0	--	3.5
Disease Surveillance	42.2	43.4	43.4
Laboratory Improvement	9.6	10.6	15.0
Health Education	3.0	3.5	3.0
Occupational Health	32.0	39.5	37.1
HEALTH RESOURCES ADMINISTRATION			
National Health Statistics	22.0	25.6	24.0
Planning & Resources Development	98.2	90.0	90.0
Health Services Research	27.9	26.0	24.0
Health Manpower:			
Institutional Assistance	159.7	--	124.0
Student Assistance	68.4	33.5	35.0
Special Educational Assistance	155.2	17.5	124.0
Nurse Institutional Assistance	59.3	64.0	26.0
Nurse Student Assistance	41.9	42.5	10.0
Health Facilities Construction	138.0	84.8	--

(Over, please)

(Figures in Millions)	1975 Actual	1976 Appropn.	1977 Budget
ALCOHOL, DRUG ABUSE, & MENTAL HEALTH			
General Mental Health Total	$420.5	$404.2	$264.2
Research	93.2	92.9	83.0
Training	94.2	70.3	30.0
Community Center Construction	14.3	--	--
Community Center Staffing	170.8	135.4	110.5
Mental Health of Children	28.1	26.8	20.3
Mental Health Center Operation	--	53.5	--
Rape Prevention Program	--	3.0	--
Management & Information	19.9	22.3	20.4
Drug Abuse Total	220.2	71.0	247.8
Research	34.1	34.0	34.0
Training	14.0	9.8	4.0
Project Grants and Contracts	122.0	12.9	160.0
Grants to States	35.0	--	35.0
Management & Information	15.0	14.3	14.8
Alcoholism Total	134.0	138.4	98.0
Research	11.0	11.8	10.0
Training	7.8	6.6	2.0
Project Grants & Contracts	52.9	56.4	33.5
Grants to States	52.0	55.5	45.6
Management & Information	10.3	8.1	7.0
NATIONAL INSTITUTES OF HEALTH *			
National Cancer Institute	691.4	744.5	687.7
Heart and Lung Institute	324.4	349.4	342.9
Dental Research	50.0	45.9	52.2
Arthritis, Metabolism, Digestive	173.4	175.5	180.8
Neurological Diseases & Stroke	142.0	136.8	146.5
Allergy & Infectious Diseases	119.4	119.2	135.6
General Medical Sciences	187.3	146.5	193.4
Child Health & Human Development	126.5	127.0	129.9
Institute on Aging	15.7	17.6	26.2
Eye Institute	44.0	45.6	47.0
Environmental Health Sciences	35.2	36.0	46.1
Research Resources	128.3	130.0	92.3
Fogarty International Center	5.4	5.7	7.5
Library of Medicine	28.8	29.2	35.2
Office of the Director	18.0	14.9	16.2
Total, Biomedical Research	2,089.8	2,123.9	2,139.6

* 1976 appropriation column excludes estimates for training, not considered in Labor-HEW bill due to lack of authorizing legislation --training funds are included in all other columns ($154 million in 1975 and $105 million 1977 request).



By James K.W. Atherton—The Washington Post

HEW's Mathews talks with reporters after hearing.

Ford Proposals On Medicare Hit

By Stuart Auerbach
Washington Post Staff Writer

President Ford's budget-cutting Medicare changes — under attack for different reasons from doctors, hospitals and the elderly — took a beating on Capitol Hill yesterday.

After hearing administration officials defend the proposals, Chairman Dan Rostenkowski (D-Ill.) of the House Ways and Means Committee's health subcommittee said, "There's no enthusiasm for the President's program at all."

He said there is a good possibility that Congress will approve President Ford's plan to put a ceiling on out-of-pocket medical bills the elderly would have to pay under Medicare. But the accompanying cost-sharing proposals and limits on the increases that Medicare would cover in doctor and hospital bills "are in dire trouble," Rostenkowski added.

The addition of coverage for catastrophic medical bills was a key feature of President Ford's State-of-the-Union message a month ago. But it was not until his budget message a few days later that the details of the cost-sharing proposals — which would have recipients pay a greater share of their medical bills — became known.

Secretary of Health, Education and Welfare David Mathews decried Rostenkowski's idea of accepting part of the President's proposal while rejecting the rest.

He acknowledged that Congress has the right to pick and choose, but said it should "attack on all fronts and look at the proposals as a whole."

Mathews testified at the end of three days of hearings at which the President's proposals evoked almost unified opposition. "When you do what the President did, which is to make a hard choice to reduce things . . . I don't think it should be surprising that you find a lot of opposition," Mathews said.

The reductions would hit Medicare recipients, doctors and hospitals.

For the first time, under the President's proposals, the elderly and disabled would have to pay 10 per cent of hospital bills after paying, as they do now, $104 for the first day's care.

They would also have to pay a greater share of the supplemental program covering out-of-hospital doctor bills — $77 instead of the present $60.

After $500 in hospital bills and $250 in doctor bills was paid, however, the catastrophic coverage would take over. Presently, Medicare patients pay $26 a day for the 61st to the 90th day and $52 a day for the next 60 days of coverage.

If the President's entire Medicare package was passed, Mathews said, 1 million of the 25 million Americans covered by Medicare would benefit from the lid on hospital payments and 2 million would benefit from the lid on doctor bills. The rest would pay more.

Under present law no more than 150,000 would benefit from the catastrophic provisions, Social Security Administration Commissioner James B. Cardwell said.

Rep. William R. Cotter (D-Conn.) called the Ford proposals "a cruel hoax . . . on those people who could least afford it" and accused the President of making budget cuts by taking benefits away.

The American Medical and American Hospital associations objected to the President's ceiling on the amount Medicare would pay as hospital and doctor bills go up. These are expected to rise next year by 14.5 per cent for hospitals and 10 per cent for doctors, compared to an expected 7 per cent general cost-of-living increase.

Under the administration plan, hospitals would be held to a 7 per cent increase and doctors a 4 per cent increase.

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Office of the White House Press Secretary

THE WHITE HOUSE

FACT SHEET

THE PRESIDENT'S MESSAGE ON OLDER AMERICANS

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THE PRESIDENT's MESSAGE ON OLDER AMERICANS

The President's message to Congress today referred to two proposals dealing with income and health security for the aged and stated his continuing support for programs delivering services to the elderly under the Older Americans Act.

I. SOCIAL SECURITY AMENDMENTS OF 1976

To assist in protecting the financial integrity of the Social Security system, the President is proposing to increase the Social Security Old Age, Survivors and Disability Insurance (OASDI) tax rate by 0.3 percent each for employers and employees, and by 0.9 percent for the self-employed, beginning January 1, 1977. This increase would be divided between the OASI trust fund, which would receive 0.175 percent, and the DI trust fund, which would receive 0.125 percent.

In addition, provisions are included to phase out benefits for 18-22 year old full-time students, to change the Social Security retirement test from a limit on monthly earnings to a limit on annual earnings with no change in the amounts involved, and to eliminate the payment of monthly Social Security benefits for the months before a person files a claim if future monthly benefits would be permanently reduced as a result.

BACKGROUND

The Old Age, Survivors and Disability Insurance (OASDI) trust funds are paying out more in benefits than their current payroll tax receipts. This is largely due to increased benefits in the past few years and payroll tax receipts, which have lagged because of unemployment and slowed wage growth.

In 1975, the expenditures of the OASDI program exceeded income to the program by $1.8 billion. Outgo is expected to exceed income by more than $4 billion in 1976. Under present tax rates, the OASDI funds will continue to pay out more than they take in in all subsequent years until they are exhausted in the 1980's.

At present, it is possible to make up the shortfall in income by spending assets of the trust funds. Additional income is needed within the next few years, however, to prevent the trust fund assets from falling below an acceptable level -- and ultimately being exhausted.

The following table illustrates the projected status of the combined OASDI trust funds under two different sets of economic assumptions if no additional revenue is provided to the funds:

more

Status of OASDI Trust Funds--Present Law
(Dollars in billions)

Calendar Year	1977 Budget Assumptions: Income Minus Outgo	1977 Budget Assumptions: Assets beginning of year as % of outgo during year	1975 Social Security Trustees Report Assumptions: Income Minus Outgo	1975 Social Security Trustees Report Assumptions: Assets beginning of year as % of outgo during year
1977	$-4.1	46%	$-5.0	44%
1978	-4.3	37	-5.8	33
1979	-3.4	29	-6.2	25
1980	-2.6	24	-7.0	18
1981	-2.0	20	-9.0	11

To prevent the rapid decline of the Social Security trust funds over the next few years, the choices are either to restrain increases in retirement and disability benefits or to increase revenues.

DESCRIPTION OF PROGRAM

The President has included a full cost of living increase in Social Security benefits in his FY 1977 budget. To improve the future financial stability of the Social Security system, the President proposed, effective January 1, 1977, a payroll tax increase of 0.3 percent each for employees and employers of covered wages. Also, the OASDI tax rate for the self-employed would be restored to a level equal to 1-1/2 times the employee rate.

The current Social Security tax rate is 5.85% for each employee and employer of covered wages. Under this proposal, the tax rate in 1977 would be 6.15% on a maximum wage base of $16,500. This increase will cost workers with the maximum taxable income less than $1 a week and will help stabilize the trust funds so that current and future recipients can be assured of the benefits that they have earned.

The following table shows the Social Security tax rates for employees and employers each under present law and under the proposal. It includes the Medicare Hospital Insurance (HI) tax in order to show the effect of the proposal on total Social Security tax rates.

Social Security Tax Rates

Calendar Year	Present Law: OASDI	Present Law: HI	Present Law: Total	Proposal: OASDI	Proposal: HI	Proposal: Total
1976	4.95%	.9 %	5.85%	4.95%	.9 %	5.85%
1977	4.95	.9	5.85	5.25	.9	6.15
1978-80	4.95	1.1	6.05	5.25	1.1	6.35
1981-85	4.95	1.35	6.30	5.25	1.35	6.60
1986-2010	4.95	1.50	6.45	5.25	1.50	6.75
2011+	5.95	1.50	7.45	6.25	1.50	7.75

more

The following table shows the additional income, over what would be produced by present law tax rates, and the ratios of trust fund assets to outgo that would result from the proposed 0.3% rate increase. For purposes of comparison, the information is shown on the basis of the economic assumptions used in the 1977 budget and also on the basis of the earlier assumptions used in the 1975 Social Security Board of Trustees' Report.

Cost Effect of 0.3% Increase
(Dollars in billions)

Calendar Year	1977 Budget Assumptions: Additional Income	1977 Budget Assumptions: Assets beginning of year as % of outgo during year	1975 Trustees Assumptions: Additional Income	1975 Trustees Assumptions: Assets beginning of year as % of outgo during year
1977	$ 4.4	46%	$ 4.4	44%
1978	5.2	41	5.2	39
1979	5.9	39	5.7	36
1980	6.5	38	6.3	34
1981	7.1	40	6.9	32

The effect of the proposal on taxes paid by employers and employees is at maximum an increase of less than $1.00 per week. The following table shows the taxes paid by employees at various earnings levels in 1976 and the amounts they would pay in 1977 under present law and under the proposal.

Social Security Taxes for Employers and Employees, Each, under Present Law and under the Proposal

Earnings Level	1976	1977		Year's Increase over
		Present Law	Proposal	Present Law
$ 5,000	$292.50	$292.50	$ 307.50	$15.00
7,500	438.75	438.75	461.25	22.50
10,000	585.00	585.00	615.00	30.00
Maximum 1/	895.05	965.25	1,014.75	49.50

The following table shows the Social Security tax rates for OASDI for employees and employers, each, and for the self-employed under the present law and under the proposal.

Calendar Year	Employees and Employers (Each): Present Law	Employees and Employers (Each): Proposal	Self-Employed: Present Law	Self-Employed: Proposal
1976	4.95%	4.95%	7.0%	7.9%
1977	4.95	5.25	7.0	7.9
1978-80	4.95	5.25	7.0	7.9
1981-85	4.95	5.25	7.0	7.9
1986-2010	4.95	5.25	7.0	7.9
2011 +	5.95	6.25	7.0	9.4

1/ $15,300 for 1976; projected to increase automatically under present law to $16,500 for 1977 under 1977 budget assumptions.

more

The following table shows present and proposed allocation to the DI trust fund for employees and employers combined and for the self-employed.

Calendar Year	Employees and Employers, Combined		Self-Employed	
	Present Law	Proposal	Present Law	Proposal
1977	1.15%	1.40%	0.815%	1.055%
1978-80	1.20	1.45	0.850	1.090
1981-85	1.30	1.55	0.920	1.165
1986-2010	1.40	1.65	0.990	1.240
2011+	1.70	1.95	1.000	1.465

COST EFFECT

The following table shows the additional income, over what would be produced by present law tax rates, that would result from the proposed 0.3% rate increase, on the basis of the economic assumptions used in the 1977 budget.

Calendar Year	Additional Income as a Result of 0.3% Increase (billions)
1977	$ 4.5
1978	5.7
1979	6.3
1980	7.0
1981	7.7
1977-81	31.2

The following table shows the yearly increase under the proposed 0.9 percent rate increase for the self-employed on the basis of the economic assumptions used in the FY 1977 budget.

OASDHI Taxes for the Self-Employed
under Present Law and under a Proposal
to Increase the Rate to 1.5 Times the Employee Rate

Earnings Level	1976	1977		
		Present Law	Proposal	Increase Over Present Law
$ 5,000	$ 395.00	$ 395.00	$ 440.00	$ 45.00
7,500	592.50	592.50	660.00	67.50
10,000	790.00	790.00	880.00	90.00
Maximum 2/	1,208.70	1,303.50	1,452.00	148.50

OTHER PROVISIONS INCLUDE:

--- Phasing out Social Security benefits for students aged 18-22 who are in school full time. The phase out would occur over 4 years so that no student now receiving benefits would be eliminated. Federal student grant and loan programs and other student assistance programs enacted since the student benefit was included in the Social Security Act provide and

2/ $15,300 for 1976; projected to increase automatically to $16,500 for 1977 under 1977 Budget assumptions.

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make available a wide range of funds for educational support. Savings to the Social Security system from this phase out are approximately $300 million in FY 1977.

-- Changing the Social Security retirement test from a limit on monthly earnings to a limit on annual earnings with no change in the amounts involved. This change would eliminate current inequitable treatment for those who receive earnings in some months but not in others, as opposed to those who receive comparable earnings spread equally in each month.

-- Eliminating the payment of monthly Social Security benefits for the months before a person files a claim if future monthly benefits would be permanently reduced as a result. Faced with a choice between a large lump-sum payment and a reduction of future benefits, beneficiaries in many cases prejudice their longer run income. This result is considered inconsistent with the purposes of the Social Security Act.

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II. MEDICARE IMPROVEMENTS OF 1976

The President is proposing significant modifications in the Federal Medicare program to provide catastrophic health cost protection to Medicare beneficiaries, changes in cost sharing requirements, and limits on the annual cost increases which will be reimbursed by Medicare.

BACKGROUND

The Nation's health care system continues to be one of the most inflationary sectors of the economy. Hospital costs have risen by more than 200 percent since 1965 (from $40/day to $128/day), and physicians' fees have risen more than 85% in the same period. Both rates of increase are significantly higher than the corresponding increases in the consumer price index.

Medicare is a major component of Federal health spending. It provides protection to more than 24 million aged and disabled Americans, and is expected to pay out more than $17 billion for health care in 1976. However, Medicare has several failings -- it does not provide protection against the catastrophic financial burden of extended illness, and it does not include adequate restraints on the increases in the costs of health care.

For hospital care, Medicare currently pays nothing for the first day, 100% of costs from the 2nd through the 60th day, a reduced percentage through the 150th day, and nothing at all after that. This pattern serves to lengthen short-term hospital stays, but can lead to financial ruin for persons suffering serious, extended illness. Medicare also requires a $60 deductible and co-payments of 20% for physicians' services. Since there is no annual maximum, this provision contributes to the financial burden of catastrophic health costs.

An additional problem with Medicare is that it contains inadequate mechanisms to control health inflation. Like most health insurance plans, it reimburses largely on the basis of actual costs or customary charges giving providers insufficient cause to seek to limit cost increases.

DESCRIPTION OF PROGRAM

The major elements of the proposed "Medicare Improvements of 1976" are the following:

A. Catastrophic Cost Protection for Health Care

For the first time, Medicare beneficiaries would be provided protection against catastrophic health costs by limiting the amounts an individual must pay annually to $500 for covered hospital and nursing home care and $250 for covered physicians' services. These limits will be allowed to increase in future years in proportion to increases in cash benefits.

B. Cost Sharing Modifications

-- Hospital Costs (Part A). Part A benefits would be expanded to provide unlimited hospital and skilled nursing facility (SNF) days. Under this proposal, beneficiaries would be required to pay a deductible for the first day of a hospital stay (as under current law), and 10% of additional charges up to an annual maximum of $500 for all covered Part A services.

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-- Physicians' Services (Part B). This proposal would increase the current annual deductible of $60 to $77 and maintain the existing co-payment of 20% for physicians' services. However, it would institute a maximum of $250 a year. The deductible would increase with Social Security benefit increases. It would also establish a coinsurance of 10% of all charges above the deductible for all hospital-based physician and Part B home health charges.

C. Reimbursement Limits

Annual Medicare reimbursement increases would be limited to 7% for Part A provided per diem or per visit costs and 4% for physicians' service charges in 1977 and 1978.

Detailed Explanation

A. CATASTROPHIC PROTECTION

Service	Current Law	President's Proposal
Part A	No maximum liability limit on out-of-pocket expenses for covered services.	$500 annual maximum liability limit for all covered services in 1976 and 1977, increased in future years in proportion to increases in cash benefits. All out-of-pocket expenses incurred in the last month of calendar year can be carried forward to next year.
Part B	No maximum liability limit on out-of-pocket expenses for covered services.	$250 annual maximum liability limit for all covered services in 1977, increased in future years in proportion to increases in cash benefits. Same one month carry-over as Part A. Out-of-pocket expenses for charges in excess of reasonable charges do not count toward the maximum liability limit.

B. BENEFIT PACKAGE

1. Medicare Part A

Service	Current Law	President's Proposal
a. Hospital days (except in psychiatric hospitals)	90 days per benefit period plus 60 days of life-time reserve.	Unlimited days.

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b. Psychiatric hospital days.	190 lifetime days.	Same as current law.
c. Skilled nursing facility (SNF) days.	100 days per benefit period.	Unlimited days.
d. Post-hospital home health visits.	100 visits per benefit period following hospital or SNF discharge.	100 visits in year following hospital or SNF discharge.

2. Medicare Part B

No change in current coverage which has no upper limits on most covered services.

Home health services would continue to be limited to 100 visits per year and outpatient psychiatric services to no more than $500 of reasonable charges per year and out-patient physical therapy services provided by a self-employed therapist to no more than $100 in reasonable charges per year.

C. COST SHARING

1. Medicare Part A

Service	Current Law	President's Proposal
a. Hospital Services		
Deductible	$104 for initial hospitalization in each benefit period beginning in 1976 (based on average daily hospital costs in 1974) and rising annually to reflect increases in hospital costs.	$104 per admission, and allowed to rise annually. Deductible waived if Medicare covered inpatient services were received within 60 days prior to admission.
Coinsurance	An amount equal to 1/4 of the deductible for days 61-90 in a benefit period and 1/2 of the deductible for the 60 lifetime reserve days.	10% of hospital charges above the deductible.
b. SNF Services		
Deductible	None	None
Coinsurance	None for the first 20 days. An amount equal to 1/8 of the hospital deductible for days 21-100.	10% of charges.

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Service	Current Law	President's Proposal
c. Home Health Services		
Deductible	None.	None.
Coinsurance	None.	10% of charges.
d. Blood		
Deductible	3 pints per benefit period.	3 pints per year.

2. Medicare Part B

Service	Current Law	President's Proposal
a. Physician, outpatient hospital care, outpatient physical therapy and speech pathology, laboratory services, medical supplies and most other covered services.		
Deductible	$60 per calendar year.	$77 in 1977, and increased in future years in proportion to increases in cash benefits.
Coinsurance	20% of reasonable charges above the deductible.	Same.
b. Hospital-based physicians (inpatient pathology and radiology)		
Deductible	None.	None.
Coinsurance	None.	10% of charges.
c. Home Health Services		
Deductible	Included among services subject to $60 per calendar year deductible.	Included among services subject to $77 deductible in 1977.
Coinsurance	None.	10% of charges.

more

Service	Current Law	President's Proposal
d. Outpatient psychiatric services.	50% of reasonable charges (up to maximum reimbursement of $250).	Same as current law.

D. PROVIDER REIMBURSEMENT

Provider	Current Law	President's Proposal
Hospitals, SNF's and home health agencies.	Reimbursed on the basis of reasonable costs. (Level of reimbursement for hospital per diem routine costs is limited to the 80th percentile of the per diem routine costs of similar hospitals.)	Places a 7% reimbursement limitation on the annual rates of increases in per diem hospital and SNF costs and home health visit costs.*
Physicians and other medical services.	Reimbursed on the basis of customary and prevailing charges. (Rates of increase in prevailing charges are limited by an economic index reflecting practice costs and earnings levels in the economy.)	Limits reimbursable increases in reasonable charges (the lesser of the customary and prevailing charges) to 4 percent per year.*

* Both the 7% cost and 4% charge increase limitations are proposed for two years pending the development of a longer run cost containment policy.

E. COST ESTIMATES

The following are the estimated cost increases attributable to the new catastrophic protection and the cost savings attributable to reforms in cost sharing and limits in reimbursement. The additional costs are estimated to range between $1.1 billion and $1.4 billion. The cost sharing reform is estimated to save about $1.8 billion and the reimbursement limits to save about $900 million. The savings from placing a limit on increases in medicare repayment rates and some of the revenues from increased cost sharing will be used to finance the catastrophic program.

Costs	FY 77 (in millions of dollars)
1. Catastrophic protection	
a. Hospital Insurance	
--- Initial estimate of cost of $500 limit in FY 77 budget.	* +330

more

Costs	FY 77 (in millions of dollars)
-- Additions based on refinement of cost of $500 limit.	+590 to 890
b. Supplementary Medical Insurance	
-- $250 limit	+208*
Total Cost	+$1,128 to $1,428

* Shown in President's budget request.

Savings	FY 77 (in millions of dollars)
1. Cost Sharing Reforms	
a. Hospital Insurance	
-- 10% coinsurance	(-)1,730*
b. Supplementary Medical Insurance	
-- Dynamic deductible ($77)	(-) 111*
-- Coinsurance on hospital based physicians and Part B home health services	(-) 19*
Subtotal	(-)1,860*
2. Reimbursement limits	
a. Hospital Insurance	
-- limited to 7% per diem increase	(-)730*
b. Supplementary Medical Insurance	
-- limited to 4% charge increase	(-)179*
Subtotal	(-)909*
Total Savings	(-)$1,641 to (-)$1,341

*Shown in President's budget request.

F. NUMBER OF PERSONS COVERED, FY 77

Service	Current Law	President's Proposal
Part A		
Enrollees	24,900,000	Same
Users	5,900,000	Same
Users Assisted by $500 limit	NA	1,200,000
Part B		
Enrollees	24,600,000	Same
Users meeting the deductible	14,200,000	12,200,000
Users Assisted by $250 limit	NA	2,000,000

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III. OLDER AMERICANS ACT

The Older Americans Act was initially enacted in 1965 and has been subsequently amended in 1967, 1969, 1972, 1973, 1974, and the most recent amendments were signed into law by the President in November, 1975.

BACKGROUND

The major objective of the Older Americans Act is to bring into being a system of coordinated comprehensive services at the community level designed to enable older persons to live independent lives in their own homes or other places of residence and to participate in the life of their community. To achieve this objective, the Older Americans Act provides authorization for a national network on aging. This national network is composed of a State Agency on Aging in each State and Territory and the District of Columbia, 489 Area Agencies on Aging, 700 nutrition projects and the advisory committees to the State and Area Agencies on Aging and the nutrition projects.

DESCRIPTION OF ACT

Major sections of the Act designed to achieve the Act's overall objective include:

Title III: Provides support to State Agencies on Aging and through them, Area Agencies on Aging for the development of coordinated comprehensive service systems designed to enable older persons to live in their own homes or other places of residence.

This Title provides funds (1) for the support of State Agencies on Aging and (2) for the support of Area Agencies on Aging and social services provided by those agencies.

States receive funds under Title III on a formula basis based upon approval by the Commissioner on Aging of an annual State Plan submitted by the Governor.

Primary emphasis is placed on meeting the needs of low income and minority older persons. Prior to submitting the annual State Plan, the State must hold a public hearing on it. The State Plan designates within the State planning and service areas and identifies those areas in which Area Agencies on Aging will be established. Currently, States have identified 585 such planning and service areas and indicated that 489 Area Agencies will be in operation.

The Area Agencies, which may be public or private organizations receive their funds from the State Agencies on Aging based on an annual area plan approved by the State Agency. A public hearing must be held on this plan before it can be submitted to the State.

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The States must utilize at least 20% of their Title III funds for four national priority services: transportation, home care, legal services, and home repair. In addition, as additional resources become available under Title III States must use 50% of the new funds for the priority services. This requirement will no longer be operative when the States reach the point where they are utilizing 33-1/3% of their funds for these four priority services.

Section 308 of Title III provides for a model projects program designed to demonstrate new or innovative means of meeting the needs of older persons. This section of the law is administered directly by the Administration on Aging.

Title VII: Provides funds to the States for the operation of nutrition programs designed to provide hot, nutritious meals in congregate settings to older persons.

States receive funds for this program on a formula basis after the Commissioner on Aging has approved their annual State Plan submitted by the Governor. Primary emphasis is placed on meeting the needs of low income and minority older persons. Currently this program provides support for 700 nutrition projects that serve approximately 300,000 means a day, five days a week, at over 4900 community sites located in churches, senior centers, and schools.

Eighty seven percent of these meals are provided in congregate settings; 13% are home delivered. More than 60,000 volunteers provide their assistance to this program.

Surplus commodities are contributed to the program at the rate of fifteen cents a meal during this Fiscal Year. This rate will increase to 25¢ a meal in Fiscal Year 1977.

An important provision in the 1975 amendments to the Act authorizes State or Area Agencies on Aging to enter into agreements for the purpose of meeting the common needs for transportation services of older persons and other segments of the population.

Several other recent actions have taken place designed to help meet these transportation needs.

-- The Administration on Aging and the Department of Transportation have entered into a working agreement which has resulted and will continue to result in improved coordination of transportation services for older persons.

-- $20.8 million of Fiscal Year 1975 Urban Mass Transportation Administration funds were allotted for capital assistance grants to nonprofit corporations and organizations to serve the transportation needs of older persons and the handicapped. The Department of Transportation will release $22 million for this purpose in Fiscal Year 1976.

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-- Approximately 45 projects in 31 States have been selected under the Rural Highway Public Transportation Demonstration Program in Fiscal Year 1975. A major criterion for project selection is that the projects be adaptable to the needs of older persons and the handicapped.

-- The first formula allotments have been made to the States under the Section 5 Capital Assistance Formula Grant Program of the National Mass Transportation Act of 1974. A section of the Act specifies that recipients of funds must provide for reduced fares for the elderly and the handicapped.

The Administration on Aging has made awards to 47 State Agencies on Aging for the purpose of promoting and developing ombudsman services for residents of nursing homes. The objective of these services is to establish a process at the community level which will be responsive to complaints from residents or relatives of older persons in Skilled Nursing Facilities and Intermediate Care Facilities. Activities are now underway at the State and local levels to achieve this purpose. The 1975 amendments to the Act authorize the Administration on Aging to continue such programs.

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Office of the White House Press Secretary

THE WHITE HOUSE

FACT SHEET

THE PRESIDENT'S MESSAGE ON OLDER AMERICANS

TABLE OF CONTENTS

THE PRESIDENT's MESSAGE ON OLDER AMERICANS

The President's message to Congress today referred to two proposals dealing with income and health security for the aged and stated his continuing support for programs delivering services to the elderly under the Older Americans Act.

I. SOCIAL SECURITY AMENDMENTS OF 1976

To assist in protecting the financial integrity of the Social Security system, the President is proposing to increase the Social Security Old Age, Survivors and Disability Insurance (OASDI) tax rate by 0.3 percent each for employers and employees, and by 0.9 percent for the self-employed, beginning January 1, 1977. This increase would be divided between the OASI trust fund, which would receive 0.175 percent, and the DI trust fund, which would receive 0.125 percent.

In addition, provisions are included to phase out benefits for 18-22 year old full-time students, to change the Social Security retirement test from a limit on monthly earnings to a limit on annual earnings with no change in the amounts involved, and to eliminate the payment of monthly Social Security benefits for the months before a person files a claim if future monthly benefits would be permanently reduced as a result.

BACKGROUND

The Old Age, Survivors and Disability Insurance (OASDI) trust funds are paying out more in benefits than their current payroll tax receipts. This is largely due to increased benefits in the past few years and payroll tax receipts, which have lagged because of unemployment and slowed wage growth.

In 1975, the expenditures of the OASDI program exceeded income to the program by $1.8 billion. Outgo is expected to exceed income by more than $4 billion in 1976. Under present tax rates, the OASDI funds will continue to pay out more than they take in in all subsequent years until they are exhausted in the 1980's.

At present, it is possible to make up the shortfall in income by spending assets of the trust funds. Additional income is needed within the next few years, however, to prevent the trust fund assets from falling below an acceptable level -- and ultimately being exhausted.

The following table illustrates the projected status of the combined OASDI trust funds under two different sets of economic assumptions if no additional revenue is provided to the funds:

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Status of OASDI Trust Funds--Present Law
(Dollars in billions)

Calendar Year	1977 Budget Assumptions: Income Minus Outgo	1977 Budget Assumptions: Assets beginning of year as % of outgo during year	1975 Social Security Trustees Report Assumptions: Income Minus Outgo	1975 Social Security Trustees Report Assumptions: Assets beginning of year as % of outgo during year
1977	$-4.1	46%	$-5.0	44%
1978	-4.3	37	-5.8	33
1979	-3.4	29	-6.2	25
1980	-2.6	24	-7.0	18
1981	-2.0	20	-9.0	11

To prevent the rapid decline of the Social Security trust funds over the next few years, the choices are either to restrain increases in retirement and disability benefits or to increase revenues.

DESCRIPTION OF PROGRAM

The President has included a full cost of living increase in Social Security benefits in his FY 1977 budget. To improve the future financial stability of the Social Security system, the President proposed, effective January 1, 1977, a payroll tax increase of 0.3 percent each for employees and employers of covered wages. Also, the OASDI tax rate for the self-employed would be restored to a level equal to 1-1/2 times the employee rate.

The current Social Security tax rate is 5.85% for each employee and employer of covered wages. Under this proposal, the tax rate in 1977 would be 6.15% on a maximum wage base of $16,500. This increase will cost workers with the maximum taxable income less than $1 a week and will help stabilize the trust funds so that current and future recipients can be assured of the benefits that they have earned.

The following table shows the Social Security tax rates for employees and employers each under present law and under the proposal. It includes the Medicare Hospital Insurance (HI) tax in order to show the effect of the proposal on total Social Security tax rates.

Social Security Tax Rates

Calendar Year	Present Law: OASDI	Present Law: HI	Present Law: Total	Proposal: OASDI	Proposal: HI	Proposal: Total
1976	4.95%	.9 %	5.85%	4.95%	.9 %	5.85%
1977	4.95	.9	5.85	5.25	.9	6.15
1978-80	4.95	1.1	6.05	5.25	1.1	6.35
1981-85	4.95	1.35	6.30	5.25	1.35	6.60
1986-2010	4.95	1.50	6.45	5.25	1.50	6.75
2011+	5.95	1.50	7.45	6.25	1.50	7.75

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The following table shows the additional income, over what would be produced by present law tax rates, and the ratios of trust fund assets to outgo that would result from the proposed 0.3% rate increase. For purposes of comparison, the information is shown on the basis of the economic assumptions used in the 1977 budget and also on the basis of the earlier assumptions used in the 1975 Social Security Board of Trustees' Report.

Cost Effect of 0.3% Increase
(Dollars in billions)

Calendar Year	1977 Budget Assumptions: Additional Income	1977 Budget Assumptions: Assets beginning of year as % of outgo during year	1975 Trustees Assumptions: Additional Income	1975 Trustees Assumptions: Assets beginning of year as % of outgo during year
1977	$ 4.4	46%	$ 4.4	44%
1978	5.2	41	5.2	39
1979	5.9	39	5.7	36
1980	6.5	38	6.3	34
1981	7.1	40	6.9	32

The effect of the proposal on taxes paid by employers and employees is at maximum an increase of less than $1.00 per week. The following table shows the taxes paid by employees at various earnings levels in 1976 and the amounts they would pay in 1977 under present law and under the proposal.

Social Security Taxes for Employers and Employees, Each, under Present Law and under the Proposal

Earnings Level	1976	1977		Year's Increase over Present Law
	Present Law	Present Law	Proposal	
$ 5,000	$292.50	$292.50	$ 307.50	$15.00
7,500	438.75	438.75	461.25	22.50
10,000	585.00	585.00	615.00	30.00
Maximum 1/	895.05	965.25	1,014.75	49.50

The following table shows the Social Security tax rates for OASDI for employees and employers, each, and for the self-employed under the present law and under the proposal.

Calendar Year	Employees and Employers (Each): Present Law	Employees and Employers (Each): Proposal	Self-Employed: Present Law	Self-Employed: Proposal
1976	4.95%	4.95%	7.0%	7.9%
1977	4.95	5.25	7.0	7.9
1978-80	4.95	5.25	7.0	7.9
1981-85	4.95	5.25	7.0	7.9
1986-2010	4.95	5.25	7.0	7.9
2011 +	5.95	6.25	7.0	9.4

1/ $15,300 for 1976; projected to increase automatically under present law to $16,500 for 1977 under 1977 budget assumptions.

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The following table shows present and proposed allocation to the DI trust fund for employees and employers combined and for the self-employed.

Calendar Year	Employees and Employers, Combined		Self-Employed	
	Present Law	Proposal	Present Law	Proposal
1977	1.15%	1.40%	0.815%	1.055%
1978-80	1.20	1.45	0.850	1.090
1981-85	1.30	1.55	0.920	1.165
1986-2010	1.40	1.65	0.990	1.240
2011+	1.70	1.95	1.000	1.465

COST EFFECT

The following table shows the additional income, over what would be produced by present law tax rates, that would result from the proposed 0.3% rate increase, on the basis of the economic assumptions used in the 1977 budget.

Calendar Year	Additional Income as a Result of 0.3% Increase (billions)
1977	$ 4.5
1978	5.7
1979	6.3
1980	7.0
1981	7.7
1977-81	31.2

The following table shows the yearly increase under the proposed 0.9 percent rate increase for the self-employed on the basis of the economic assumptions used in the FY 1977 budget.

OASDHI Taxes for the Self-Employed
under Present Law and under a Proposal
to Increase the Rate to 1.5 Times the Employee Rate

Earnings Level	1976	1977		
		Present Law	Proposal	Increase Over Present Law
$ 5,000	$ 395.00	$ 395.00	$ 440.00	$ 45.00
7,500	592.50	592.50	660.00	67.50
10,000	790.00	790.00	880.00	90.00
Maximum 2/	1,208.70	1,303.50	1,452.00	148.50

OTHER PROVISIONS INCLUDE:

-- Phasing out Social Security benefits for students aged 18-22 who are in school full time. The phase out would occur over 4 years so that no student now receiving benefits would be eliminated. Federal student grant and loan programs and other student assistance programs enacted since the student benefit was included in the Social Security Act provide and

2/ $15,300 for 1976; projected to increase automatically to $16,500 for 1977 under 1977 Budget assumptions.

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make available a wide range of funds for educational support. Savings to the Social Security system from this phase out are approximately $300 million in FY 1977.

-- Changing the Social Security retirement test from a limit on monthly earnings to a limit on annual earnings with no change in the amounts involved. This change would eliminate current inequitable treatment for those who receive earnings in some months but not in others, as opposed to those who receive comparable earnings spread equally in each month.

-- Eliminating the payment of monthly Social Security benefits for the months before a person files a claim if future monthly benefits would be permanently reduced as a result. Faced with a choice between a large lump-sum payment and a reduction of future benefits, beneficiaries in many cases prejudice their longer run income. This result is considered inconsistent with the purposes of the Social Security Act.

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II. MEDICARE IMPROVEMENTS OF 1976

The President is proposing significant modifications in the Federal Medicare program to provide catastrophic health cost protection to Medicare beneficiaries, changes in cost sharing requirements, and limits on the annual cost increases which will be reimbursed by Medicare.

BACKGROUND

The Nation's health care system continues to be one of the most inflationary sectors of the economy. Hospital costs have risen by more than 200 percent since 1965 (from $40/day to $128/day), and physicians' fees have risen more than 85% in the same period. Both rates of increase are significantly higher than the corresponding increases in the consumer price index.

Medicare is a major component of Federal health spending. It provides protection to more than 24 million aged and disabled Americans, and is expected to pay out more than $17 billion for health care in 1976. However, Medicare has several failings -- it does not provide protection against the catastrophic financial burden of extended illness, and it does not include adequate restraints on the increases in the costs of health care.

For hospital care, Medicare currently pays nothing for the first day, 100% of costs from the 2nd through the 60th day, a reduced percentage through the 150th day, and nothing at all after that. This pattern serves to lengthen short-term hospital stays, but can lead to financial ruin for persons suffering serious, extended illness. Medicare also requires a $60 deductible and co-payments of 20% for physicians' services. Since there is no annual maximum, this provision contributes to the financial burden of catastrophic health costs.

An additional problem with Medicare is that it contains inadequate mechanisms to control health inflation. Like most health insurance plans, it reimburses largely on the basis of actual costs or customary charges giving providers insufficient cause to seek to limit cost increases.

DESCRIPTION OF PROGRAM

The major elements of the proposed "Medicare Improvements of 1976" are the following:

A. Catastrophic Cost Protection for Health Care

For the first time, Medicare beneficiaries would be provided protection against catastrophic health costs by limiting the amounts an individual must pay annually to $500 for covered hospital and nursing home care and $250 for covered physicians' services. These limits will be allowed to increase in future years in proportion to increases in cash benefits.

B. Cost Sharing Modifications

-- Hospital Costs (Part A). Part A benefits would be expanded to provide unlimited hospital and skilled nursing facility (SNF) days. Under this proposal, beneficiaries would be required to pay a deductible for the first day of a hospital stay (as under current law), and 10% of additional charges up to an annual maximum of $500 for all covered Part A services.

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-- Physicians' Services (Part B). This proposal would increase the current annual deductible of $60 to $77 and maintain the existing co-payment of 20% for physicians' services. However, it would institute a maximum of $250 a year. The deductible would increase with Social Security benefit increases. It would also establish a coinsurance of 10% of all charges above the deductible for all hospital-based physician and Part B home health charges.

C. Reimbursement Limits

Annual Medicare reimbursement increases would be limited to 7% for Part A provided per diem or per visit costs and 4% for physicians' service charges in 1977 and 1978.

Detailed Explanation

A. CATASTROPHIC PROTECTION

Service	Current Law	President's Proposal
Part A	No maximum liability limit on out-of-pocket expenses for covered services.	$500 annual maximum liability limit for all covered services in 1976 and 1977, increased in future years in proportion to increases in cash benefits. All out-of-pocket expenses incurred in the last month of calendar year can be carried forward to next year.
Part B	No maximum liability limit on out-of-pocket expenses for covered services.	$250 annual maximum liability limit for all covered services in 1977, increased in future years in proportion to increases in cash benefits. Same one month carry-over as Part A. Out-of-pocket expenses for charges in excess of reasonable charges do not count toward the maximum liability limit.

B. BENEFIT PACKAGE

1. Medicare Part A

Service	Current Law	President's Proposal
a. Hospital days (except in psychiatric hospitals)	90 days per benefit period plus 60 days of life-time reserve.	Unlimited days.

more

b. Psychiatric hospital days.	190 lifetime days.	Same as current law.
c. Skilled nursing facility (SNF) days.	100 days per benefit period.	Unlimited days.
d. Post-hospital home health visits.	100 visits per benefit period following hospital or SNF discharge.	100 visits in year following hospital or SNF discharge.

2. Medicare Part B

No change in current coverage which has no upper limits on most covered services.

Home health services would continue to be limited to 100 visits per year and outpatient psychiatric services to no more than $500 of reasonable charges per year and out-patient physical therapy services provided by a self-employed therapist to no more than $100 in reasonable charges per year.

C. COST SHARING

1. Medicare Part A

Service	Current Law	President's Proposal
a. Hospital Services		
Deductible	$104 for initial hospitalization in each benefit period beginning in 1976 (based on average daily hospital costs in 1974) and rising annually to reflect increases in hospital costs.	$104 per admission, and allowed to rise annually. Deductible waived if Medicare covered inpatient services were received within 60 days prior to admission.
Coinsurance	An amount equal to 1/4 of the deductible for days 61-90 in a benefit period and 1/2 of the deductible for the 60 lifetime reserve days.	10% of hospital charges above the deductible.
b. SNF Services		
Deductible	None	None
Coinsurance	None for the first 20 days. An amount equal to 1/8 of the hospital deductible for days 21-100.	10% of charges.

more

Service	Current Law	President's Proposal
c. Home Health Services		
Deductible	None.	None.
Coinsurance	None.	10% of charges.
d. Blood		
Deductible	3 pints per benefit period.	3 pints per year.

2. Medicare Part B

Service	Current Law	President's Proposal
a. Physician, outpatient hospital care, outpatient physical therapy and speech pathology, laboratory services, medical supplies and most other covered services.		
Deductible	$60 per calendar year.	$77 in 1977, and increased in future years in proportion to increases in cash benefits.
Coinsurance	20% of reasonable charges above the deductible.	Same.
b. Hospital-based physicians (inpatient pathology and radiology)		
Deductible	None.	None.
Coinsurance	None.	10% of charges.
c. Home Health Services		
Deductible	Included among services subject to $60 per calendar year deductible.	Included among services subject to $77 deductible in 1977.
Coinsurance	None.	10% of charges.

more

Service	Current Law	President's Proposal
d. Outpatient psychiatric services.	50% of reasonable charges (up to maximum reimbursement of $250).	Same as current law.

D. PROVIDER REIMBURSEMENT

Provider	Current Law	President's Proposal
Hospitals, SNF's and home health agencies.	Reimbursed on the basis of reasonable costs. (Level of reimbursement for hospital per diem routine costs is limited to the 80th percentile of the per diem routine costs of similar hospitals.)	Places a 7% reimbursement limitation on the annual rates of increases in per diem hospital and SNF costs and home health visit costs.*
Physicians and other medical services.	Reimbursed on the basis of customary and prevailing charges. (Rates of increase in prevailing charges are limited by an economic index reflecting practice costs and earnings levels in the economy.)	Limits reimbursable increases in reasonable charges (the lesser of the customary and prevailing charges) to 4 percent per year.*

* Both the 7% cost and 4% charge increase limitations are proposed for two years pending the development of a longer run cost containment policy.

E. COST ESTIMATES

The following are the estimated cost increases attributable to the new catastrophic protection and the cost savings attributable to reforms in cost sharing and limits in reimbursement. The additional costs are estimated to range between $1.1 billion and $1.4 billion. The cost sharing reform is estimated to save about $1.8 billion and the reimbursement limits to save about $900 million. The savings from placing a limit on increases in medicare repayment rates and some of the revenues from increased cost sharing will be used to finance the catastrophic program.

Costs	FY 77 (in millions of dollars)
1. Catastrophic protection	
a. Hospital Insurance	
--- Initial estimate of cost of $500 limit in FY 77 budget.	* +330

more

Costs	FY 77 (in millions of dollars)
-- Additions based on refinement of cost of $500 limit.	+590 to 890
b. Supplementary Medical Insurance	
-- $250 limit	+208*
Total Cost	+$1,128 to $1,428

* Shown in President's budget request.

Savings	FY 77 (in millions of dollars)
1. Cost Sharing Reforms	
a. Hospital Insurance	
-- 10% coinsurance	(-)1,730*
b. Supplementary Medical Insurance	
-- Dynamic deductible ($77)	(-) 111*
-- Coinsurance on hospital based physicians and Part B home health services	(-) 19*
Subtotal	(-)1,860*
2. Reimbursement limits	
a. Hospital Insurance	
-- limited to 7% per diem increase	(-)730*
b. Supplementary Medical Insurance	
-- limited to 4% charge increase	(-)179*
Subtotal	(-)909*
Total Savings	(-)$1,641 to (-)$1,341

*Shown in President's budget request.

F. NUMBER OF PERSONS COVERED, FY 77

Service	Current Law	President's Proposal
Part A		
Enrollees	24,900,000	Same
Users	5,900,000	Same
Users Assisted by $500 limit	NA	1,200,000
Part B		
Enrollees	24,600,000	Same
Users meeting the deductible	14,200,000	12,200,000
Users Assisted by $250 limit	NA	2,000,000

III. OLDER AMERICANS ACT

The Older Americans Act was initially enacted in 1965 and has been subsequently amended in 1967, 1969, 1972, 1973, 1974, and the most recent amendments were signed into law by the President in November, 1975.

BACKGROUND

The major objective of the Older Americans Act is to bring into being a system of coordinated comprehensive services at the community level designed to enable older persons to live independent lives in their own homes or other places of residence and to participate in the life of their community. To achieve this objective, the Older Americans Act provides authorization for a national network on aging. This national network is composed of a State Agency on Aging in each State and Territory and the District of Columbia, 489 Area Agencies on Aging, 700 nutrition projects and the advisory committees to the State and Area Agencies on Aging and the nutrition projects.

DESCRIPTION OF ACT

Major sections of the Act designed to achieve the Act's overall objective include:

Title III: Provides support to State Agencies on Aging and through them, Area Agencies on Aging for the development of coordinated comprehensive service systems designed to enable older persons to live in their own homes or other places of residence.

This Title provides funds (1) for the support of State Agencies on Aging and (2) for the support of Area Agencies on Aging and social services provided by those agencies.

States receive funds under Title III on a formula basis based upon approval by the Commissioner on Aging of an annual State Plan submitted by the Governor.

Primary emphasis is placed on meeting the needs of low income and minority older persons. Prior to submitting the annual State Plan, the State must hold a public hearing on it. The State Plan designates within the State planning and service areas and identifies those areas in which Area Agencies on Aging will be established. Currently, States have identified 585 such planning and service areas and indicated that 489 Area Agencies will be in operation.

The Area Agencies, which may be public or private organizations receive their funds from the State Agencies on Aging based on an annual area plan approved by the State Agency. A public hearing must be held on this plan before it can be submitted to the State.

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The States must utilize at least 20% of their Title III funds for four national priority services: transportation, home care, legal services, and home repair. In addition, as additional resources become available under Title III States must use 50% of the new funds for the priority services. This requirement will no longer be operative when the States reach the point where they are utilizing 33-1/3% of their funds for these four priority services.

Section 308 of Title III provides for a model projects program designed to demonstrate new or innovative means of meeting the needs of older persons. This section of the law is administered directly by the Administration on Aging.

Title VII: Provides funds to the States for the operation of nutrition programs designed to provide hot, nutritious meals in congregate settings to older persons.

States receive funds for this program on a formula basis after the Commissioner on Aging has approved their annual State Plan submitted by the Governor. Primary emphasis is placed on meeting the needs of low income and minority older persons. Currently this program provides support for 700 nutrition projects that serve approximately 300,000 means a day, five days a week, at over 4900 community sites located in churches, senior centers, and schools.

Eighty seven percent of these meals are provided in congregate settings; 13% are home delivered. More than 60,000 volunteers provide their assistance to this program.

Surplus commodities are contributed to the program at the rate of fifteen cents a meal during this Fiscal Year. This rate will increase to 25¢ a meal in Fiscal Year 1977.

An important provision in the 1975 amendments to the Act authorizes State or Area Agencies on Aging to enter into agreements for the purpose of meeting the common needs for transportation services of older persons and other segments of the population.

Several other recent actions have taken place designed to help meet these transportation needs.

-- The Administration on Aging and the Department of Transportation have entered into a working agreement which has resulted and will continue to result in improved coordination of transportation services for older persons.

-- $20.8 million of Fiscal Year 1975 Urban Mass Transportation Administration funds were allotted for capital assistance grants to nonprofit corporations and organizations to serve the transportation needs of older persons and the handicapped. The Department of Transportation will release $22 million for this purpose in Fiscal Year 1976.

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-- Approximately 45 projects in 31 States have been selected under the Rural Highway Public Transportation Demonstration Program in Fiscal Year 1975. A major criterion for project selection is that the projects be adaptable to the needs of older persons and the handicapped.

-- The first formula allotments have been made to the States under the Section 5 Capital Assistance Formula Grant Program of the National Mass Transportation Act of 1974. A section of the Act specifies that recipients of funds must provide for reduced fares for the elderly and the handicapped.

The Administration on Aging has made awards to 47 State Agencies on Aging for the purpose of promoting and developing ombudsman services for residents of nursing homes. The objective of these services is to establish a process at the community level which will be responsive to complaints from residents or relatives of older persons in Skilled Nursing Facilities and Intermediate Care Facilities. Activities are now underway at the State and local levels to achieve this purpose. The 1975 amendments to the Act authorize the Administration on Aging to continue such programs.

# # # #

EMBARGOED FOR RELEASE UNTIL
12:00 NOON, FEBRUARY 9, 1976

FEBRUARY 9, 1976

OFFICE OF THE WHITE HOUSE PRESS SECRETARY

THE WHITE HOUSE

PRESS CONFERENCE
OF
DAVID MATHEWS
SECRETARY OF THE DEPARTMENT OF
HEALTH, EDUCATION AND WELFARE
STANLEY THOMAS, JR.
ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT
OF THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
ARTHUR FLEMMING
UNITED STATES COMMISSIONER ON AGING
AND
JAMES BRUCE CARDWELL
UNITED STATES COMMISSIONER OF SOCIAL SECURITY

THE BRIEFING ROOM

10:15 A.M. EST

MR. NESSEN: Let me just tell you that you have received a copy of the message, I believe. The fact sheets are being collated now and will be ready in 15 minutes, or at the end of the briefing.

The message and the fact sheets and the briefing are embargoed for noon, which is the time that the message goes to Congress.

The briefers for today are primarily HEW Secretary, David Mathews -- and he has brought along with him the U.S. Commissioner of Social Security, Bruce Cardwell; the Assistant Secretary for Human Development at HEW, Stan Thomas; and the U.S. Commissioner on Aging, Dr. Arthur Flemming, who many of you know. He has been in Washington and served under five Presidents and did a great deal of the work on this project.

So, Mr. Secretary, why don't you come and say whatever you want to at the beginning and then can take whatever questions there may be.

SECRETARY MATHEWS: I have no additional statement other than the statement that is here, and I think your time probably will be better used just to go right into the questions.

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MR. NESSEN: The Secretary has to catch a train to Philadelphia at 11 o'clock, so he is going to have to leave in about 15 minutes.

Q Mr. Secretary, how soon is this proposal on decoupling going to go up?

SECRETARY MATHEWS: We are in the process of drafting that legislation. As you might imagine, that is a most complicated piece of legislation. I talked to the man who has the responsibility for doing the drafting. He said at best it would take him about one month to get that completed.

We are hoping that we will have it ready sometime around the 1st of March.

Q Mr. Secretary, several people who represent groups for the elderly have said they don't like those Social Security proposals. Would you like to comment on that? They feel it is going to cost 99 percent of the elderly more in order to give catastrophic benefits to 1 percent of them. Would you comment on this?

SECRETARY MATHEWS: Yes, we keep in mind that this is an insurance program and that it properly has all of the features and characteristics that are axiomatic for an insurance program. The function of insurance is to protect people from the truly disabling, catastrophic, overwhelming kinds of disability, and insurance programs characteristically are those that accommodate individuals' payments for whatever the initial problem and reserve their strength for those major financial claims that would be truly disabling.

This particular program is -- in comparison with other kinds of insurance programs -- really backwards because it protects at the low end of the scale now and affords no protection at the high end. What this proposal would do would be to make the Medicare insurance program consistent with the basic principles of insurance generally, and it has its merits in that it deals with the bills that would be frightfully disabling which would come at the point in time when a person was least able to pay for them.

Q But wouldn't this stop the elderly from going to the doctor at the beginning of an illness because of the payments they would have to make?

SECRETARY MATHEWS: It is not anticipated that the rate of increase that is proposed here would have that effect at all.

MORE

Q Mr. Secretary, could you give me a dollar figure for the cost to employers of the increase of the three-tenths of 1 percent, and since this almost inevitably will be passed on in the way of higher prices, will not this have an inflationary impact on the economy?

SECRETARY MATHEWS: The dollar figures that we have used are for workers, I think.

Q For employers, I am speaking of.

SECRETARY MATHEWS: The $22 is for the $7,500 employee.

MR. CARDWELL: It would cost $2.2 billion.

Q To the employers?

MR. CARDWELL: Yes.

Q Could you also comment on the inflationary impact this would have on the economy?

MR. CARDWELL: It is a relative matter. It is no question that it will increase cost for employers. If anything, it would tend to have a depressing effect rather than stimulatory effect because it would be taking money out of circulation rather than adding money into circulation.

Q I am talking about prices, Mr. Cardwell. The producers will pass on the costs in the form of higher prices, won't they?

MR. CARDWELL: Some of the costs would be passed on in the form of higher prices. That is a correct assumption.

Q So it will have an inflationary impact on the economy?

MR. CARDWELL: That is not my expertise. I cannot speak to that question.

Q Can somebody, please?

SECRETARY MATHEWS: We will furnish you a resident economist. I don't think Mr. Cardwell was denying that to the extent it was passed on it would. That is saying the same thing. I think his quibble was over how much would be passed on.

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Q Can you tell us why it was decided to go to an increase in payroll tax rather than increasing the base?

SECRETARY MATHEWS: Yes, I can.

First, you need to remember that there already is in law provision for increasing the base.

Secondly, if you increase the wage base further rather than achieving what you want to achieve -- namely, the stability of the funds over the long term -- you achieve the opposite effect because you include more people at higher incomes and, therefore, you increase your payout over a longer period of time and you would not have the effect that you wanted to have by proposing the legislation in the first place, which was to correct the long-term deficit or medium range deficit.

MORE

Q Mr Secretary, how does it protect the middle income group which really seems to carry the burden for everything?

SECRETARY MATHEWS: As I look at this particular proposal in the breakdowns that I have seen by income groups, it seems to me rather favorable to the middle income group, by the figures that I have seen as it is broken out.

Q Mr. Secretary, have you balanced out the cost of the increases and the reductions in this program for the elderly and whether its overall effect will be to reduce the budget or to increase it?

SECRETARY MATHEWS: Let me comment on that. If you look at the overall figures, they are, as the President is recommending them for 1977, lower than the current figures, because there was a decision not to -- it does not affect the service program,but rather the training programs.

The training programs generally are reduced or, in fact, taken out. The service programs, however, propose to continue at the same level -- the nutritional programs, the programs of assistance to States for the operation of various service programs that they provide. So our concentration has been on service aspects. We intend to give priority to those.

Q Do you have a net figure of how much you are going to be saving?

SECRETARY MATHEWS: I do. What we really need to give you is the differential between the President's budget proposal and the total budget.

MR. THOMAS: I think in terms of the Older Americans Act which is the Act the Secretary is speaking to, I think the net reduction from our fiscal 1975 budget request is somewhere around -- it is about the same as the fiscal 1975 budget request. In terms of the overall budget, I expect Mr. Cardwell can speak to that in terms of Social Security.

MR. CARDWELL: I would guess the question is driven toward the matter of what happens under the catastrophic, the cost of that coverage as an offset to the additional cost to the consumer, to the beneficiary of the co-insurance. The current estimates -- the best estimates we have on the cost of catastrophic is, when it is all over, it will probably add up to between $1.1 billion and $1.4 billion.

Remember when the budget was filed several weeks ago,that estimate stood at $503 million and we,since then, have doubled the potential cost of that particular provision. Offset against that are gross additional costs to consumers of about $2 billion.

Could I come back to the question about the impact on the economy of the $2.2 billion?

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Q I wish you would.

MR. CARDWELL: I cannot answer the economic theory of it,but I would point out some facts that would let you draw your own conclusions. We are talking about $2.2 billion as against annual payroll in excess of $600 billion, so we are really talking about one-third of one percent impact. Although I am not an economist, my assumption is that could be absorbed by the economy without distorting it one way or the other, but that is a matter for economic judgment.

Q Would you clarify -- did you say the cost on catastrophic would be $1.1 to $1.4 billion?

MR. CARDWELL: Somewhere between $1.1 and $1.4 billion.

Q I still don't have a net figure. Were you able to arrive at one?

MR. CARDWELL: In the fact sheet, if you would turn to it --

MR. NESSEN: They don't have the fact sheet yet.

MR. CARDWELL: You can do your own arithmetic. It shows gross reductions of $1.860 billion for the cost sharing reforms. Another $909 million reduction on reimbursements. The $1.8 billion would represent additional cost to the consumen Offset against that $1.8 is a figure of somewhere between $1.1 and $1.4 billion in additional Medicare costs.

Q Mr. Secretary, would you talk about Page 2, Number 3, lack of incentives to encourage efficiency and economical use of hospital and medical services? Will you talk about this specifically in language that somebody like myself can understand? Did you promise the hospital people when they were in town recently you would give them any help? I believe some of them said they were waiting for 19 months and another six months to get the money back from the Government and there were oppressive regulations that added to their costs.

SECRETARY MATHEWS: I generally said some things about regulations, none of them favorable, that would apply in this situation. However, I did inquire about the differential, or the difference, rather, in time,and I understand that we are required by law to complete certain audits before we can make reimbursements,and I believe we have to allow a year to pass, as I remember that legislation, before we can reimburse.

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So part of the time involved in the 19 months is a requirement in the law that an audit must be completed before we can reimburse, but in general I have said to this group and to other groups that I think we should do everything we can to speed up time.

As to your first question about the initial cost, that is what I was talking about when I said that this program is really, as it now stands, the insurance program, is backwards when compared to all other insurance programs. That is if it affords protection for the initial cost, but no protection for the catastrophic costs at the far end or the truly problematic cost.

What this proposal would do would essentially turn that around and it would, by our candid admissions, cost more initially, but its virtue would be it would protect you against the cost -- not you but the persons in the program -- for costs over $500 for hospital care, $250 for covered services, physicians fees.

Q Are you going to recommend that Congress change the part in the law that requires a year for an audit?

SECRETARY MATHEWS: I have no plans to at the present time.

Bruce, do you want to talk to that?

MR. CARDWELL: I have nothing to add.

Q Is that a result of Congress' actions or a result of your past recommendations?

SECRETARY MATHEWS: Since I did not make the past recommendations, I don't know. Bruce will speak to that point and, as the line goes, I have to catch a train to Philadelphia.

Bruce, why don't you elaborate on that?

Q The hospital people, when they were in, complained that it would be unfair to hold their increases down if you are not holding their expenses down, if inflation drives up the cost of the things they have to purchase. Can you answer that?

MR. CARDWELL: The number one problem in medical care today is the rapid rise in prices, whether those prices be charged against Medicare or against the public at large.

The Congress itself decided several years ago they wanted to put pressure on the Medicare portion of the delivery system and they require the Secretary of HEW and the Commissioner of the Social Security to put limits on the rate at which Medicare reimbursements can increase in a given year, and that is designed to put pressure on the system.

True, it puts the manager, operator, of the hospital in between an inflationary spiral for labor and for material, but it also says to him, "You have to take some action of your own, improve your efficiency of your operations. You have to absorb some of the shock. You can't continue to pass it on to Medicare."

That concept would probably be more effective. It would affect the entire delivery system. But, as the law now stands, it affects Medicare only.

Q In other words, we are not going to get anywhere? We are not going to get any relief at all? We are just going to have continuation of this problem?

MR. CARDWELL: I think the entire system will continue to reflect higher inflationary rates than general consumer index cost. In other words, hospital and medical prices are going to go up faster than other prices. That has been the history of the entire American system now for several years.

Q Why don't you ask them to change the law to put the pressure on the entire system?

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MR. CARDWELL: That is entirely another matter. We are administering the Medicare program, and this provision deals with Medicare. We are going to try to take care of our own costs.

Q What portion of the hospitals and doctors refuse to take Medicare assignments, and won't this make it worse?

MR. CARDWELL: About 55 percent last year of the bills processed by Medicare were processed under assignment. Seven or eight years ago that figure was as high as 60 percent. It has been declining actually rather slowly.

There is an assumption that most people make that any pressures you put from the top will cause the physicians or the hospital to pass the cost on to the consumer. Under the Medicare law, anyone who takes assignment must settle for our reimbursement level.

Our estimate is, however, that this will not be a dramatic downward shift. We do think, though, there is a downward pressure in place, and it has been in place for several years, and it is the result of the Federal Government trying to resist prices more than the private sector generally.

Q Mr. Cardwell, in view of the stepped-up activity in the Congress, is there any possibility that you will change your strategy and send a national health insurance bill to the Hill this year?

MR. CARDWELL: I do not think so.

Could I go back to an earlier question I was asked about the impact of the Social Security tax rate on the middle income worker. The statement was made the middle income worker carries the brunt of the rising cost of the system.

Really, the policy-making here has to choose between the effect on increased cost on various classes of earners. Most of our experience so far in the last ten days in Congress has been that they seem more concerned about the impact of the tax rate on the lower wage earner and less concerned about the middle wage earner.

We think our proposal is an attempt to spread the cost between the two. For example, the person at the so-called wage base -- a person who will be making $16,500 in 1977 -- will be paying additional Social Security tax burden of about $119.

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His brethren at the low end of the scale, say working for the minimum wage, will be paying a net additional burden of about $15. Now, that $119 is split for the middle income worker into two parts.

The first part is the result of an increase in the wage base that is already in law and will take place automatically in 1977. That adds $70 to his bill. The three-tenths of 1 percent adds $49 to his bill, in round figures.

So, the wage base is already driving up the cost at a faster rate for the middle income worker than is the President's tax proposal. But, in sum, our attempt is to spread the load over the two extremes, the low wage earner and the middle wage earner.

The middle wage earner is suffering fairly big bites as the result of the automatic provisions already in law to increase the wage base and increase the tax rate applied to that wage base.

Q Mr. Cardwell, wouldn't your Social Security plan have an adverse impact on recovery from a recession inasmuch as you are increasing withholding so there would be less spending?

MR. CARDWELL: Yes, your question centers on impact on the economy. Economists have examined the question of Social Security impact on capital formation, on stimulation or depressing effects on the economy. We think at this stage that these figures, the three-tenths of 1 percent, is relatively modest when compared to the gross figures the system works against, and they should not be so significant as to distort the economy one way or the other. That is the only answer we have.

Q In expanding the tax rate -- you were talking about spreading it more equitably -- implicit in your remarks is the feeling that low income wage earners were not carrying enough of the burden. Is that correct?

MR. CARDWELL: No, it is not. One of the most controversial issues about Social Security throughout its 40-year history has been this issue of the tax rate and whether it should not be made more progressive, whether it should be graduated more so that everyone pays proportionate to his income.

It is true that on the tax side of the system the low wage earner does pay proportionately more than the higher income worker. On the other hand, the benefits structure of the system from its origin have been deliberately designed with a weighted benefit in favor of the low wage earner.

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One of the propositions to deal with this controversy, of course, is to put in general revenues. We opposed that for two reasons.

First, we believe that general revenues will eventually erode the basic concept that every worker, regardless of his earnings, participates in the system by reason of having paid in, and the only ones who can participate are those who paid in.

We think general revenues invite an erosion of that principle.

Secondly, it is our belief that general revenues invite the Congress, oftentime, to enlarge the system and to increase its long-term costs rather than stabilize them.

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Q Sir, I'm sorry. It seems to me you can't have it both ways. If you are saying you are trying to spread this tax rate -- instead of spreading the base and going to the rate instead -- you are trying to spread this more equitably -- it seems you must be saying the low income wage earner --

MR. CARDWELL: Let me try one more time. We are not dealing with the tax progressivity question which is a long-term question. We are saying for this one time increase, we tried to spread the load as it would land on different classes of workers at this point in time. We are not denying that the low wage earner is proportionately paying more than the high wage earner, but he always has been.

Q And?

MR. CARDWELL: We are not taking any steps at this time, in this one time short-term financing move to deal with that. The Congress in the past has not either.

Q Sir, how would you compare the commitment by the Federal Government to the elderly embodied in this program of the 1960's? Is there a retreat in the Federal commitment to the elderly here?

MR. FLEMMING: Definitely there is not. I would like to respond in part to that question by coming back to the issue that has been under discussion. As all of us know, the Social Security system has been under attack over a period of the last few months in terms of its integrity, in terms of its stability. Older persons have been concerned about this attack. As I have gone out and met with them, they asked me many, many questions about it and I have assured them that this Government, the Executive Branch and the Legislative Branch, would see to it that the Social Security system was maintained on a sound basis.

The recommendations that the President is making to the Congress indicate very clearly his commitment to the Social Security system, to the maintenance and the soundness of the system,and because of developments, it is clear that in order to get additional revenue, in order to maintain the soundness of the system, it is going to be necessary for some people to carry a heavier load.

But I think the main thing about this is that it says to the older people of this Nation, the Executive Branch -- and I am sure in one way or another the Legislative Branch will respond also -- is going to see to it that the soundness of this system is maintained.

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Personally, to take the second part of your question, in the sixties, we did not have any such thing as the Older Americans Act. We now have got in place a new national network on aging that involves 50 States' agencies on aging, close to 500 areas' agencies on aging, 700 nutrition projects, and all of that has been put in place in the last year and one-half or two years. Whereas in the sixties we were talking about a few million dollars we made available to States and communities to help them on the delivery of services to older persons, we are now up over the $250 million mark.

In other words, the Government is really implementing the objective of the Older Ameircans Act; namely, to step up services for older persons to be given or to be made available to them, oftentimes in their own homes, but to step up the kind of service that will enable older persons to continue to live in their own homes rather than going into institutions.

The President's Message gives strong backing to that network and to the development and evolution of the network. We did not have anything like that in the sixties. This represents substantial progress in responding to the needs of older persons.

Q What is the maximum that a single person and a couple can get under Social Security now?

MR. CARDWELL: For a couple, it would be something slightlyunder $400 a month,and for a single person, something under $250 a month.

Q Does this affect just the people in hospitals or would it also help people who go to nursing homes or stay at home?

MR. CARDWELL: It would help people in hospitals, the catastrophic coverage. It would benefit people who go to hospitals, people who obtain services from physicians without hospitalization. It would also affect long-term care,including nursing homes and home health care.

I would point out, however, that Medicare is not a heavy financer of extended health care -- Medicaid is.

Q So what does a person do if they don't have Medicaid?

MR. CARDWELL: He would be eligible for Medicare and the Medicare, now under these provisions, would have an open-ended catastrophic coverage.

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Q Would that apply to nursing homes?

MR. CARDWELL: Nursing homes and home health.

Q I had a question for Dr. Flemming. You mentioned going around the country talking to older people. Did you see any signs of increased political activity on the part of older groups this year, say than four years ago?

MR. FLEMMING: Sure. I had the responsibility for the first White House Conference on Aging in 1961 when I was Secretary. At that time the number of older persons that belonged to organizations of older persons was about 250,000. Today it is about 11 million and they are organized at the local level, the State level,and they are in a position to put pressure on in order to achieve some of their objectives. So there is not any question at all but that they are playing a more significant role in the political system than they did a few years ago.

THE PRESS: Thank you.

END (AT 10:45 A.M. EST)

EMBARGOED FOR RELEASE
UNTIL 12 P.M. (EST)
MONDAY, FEBRUARY 9, 1976

February 9, 1976

Office of the White House Press Secretary

THE WHITE HOUSE

TO THE CONGRESS OF THE UNITED STATES:

I ask the Congress to join with me in making improvements in programs serving the elderly.

As President, I intend to do everything in my power to help our nation demonstrate by its deeds a deep concern for the dignity and worth of our older persons. By so doing, our nation will continue to benefit from the contributions that older persons can make to the strengthening of our nation.

The proposals being forwarded to Congress are directly related to the health and security of older Americans. Their prompt enactment will demonstrate our concern that lifetimes of sacrifice and hard work conclude in hope rather than despair.

The single greatest threat to the quality of life of older Americans is inflation. Our first priority continues to be the fight against inflation. We have been able to reduce by nearly half the double digit inflation experienced in 1974. But the retired, living on fixed incomes, have been particularly hard hit and the progress we have made in reducing inflation has not benefited them enough. We will continue our efforts to reduce federal spending, balance the budget, and reduce taxes. The particular vulnerability of the aged to the burdens of inflation, however, requires that specific improvements be made in two major Federal programs, Social Security and Medicare.

We must begin by insuring that the Social Security system is beyond challenge. Maintaining the integrity of the system is a vital obligation each generation has to those who have worked hard and contributed to it all their lives. I strongly reaffirm my commitment to a stable and financially sound Social Security system. My 1977 budget and legislative program include several elements which I believe are essential to protect the solvency and integrity of the system.

First, to help protect our retired and disabled citizens against the hardships of inflation, my budget request to the Congress includes a full cost of living increase in Social Security benefits, to be effective with checks received in July 1976. This will help maintain the purchasing power of 32 million Americans.

Second, to insure the financial integrity of the Social Security trust funds, I am proposing legislation to increase payroll taxes by three-tenths of one percent each for employees and employers. This increase will cost no worker

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more than $1 a week, and most will pay less. These additional revenues are needed to stabilize the trust funds so that current income will be certain to either equal or exceed current outgo.

Third, to avoid serious future financing problems I will submit later this year a change in the Social Security laws to correct a serious flaw in the current system. The current formula which determines benefits for workers who retire in the future does not properly reflect wage and price fluctuations. This is an inadvertent error which could lead to unnecessarily inflated benefits.

The change I am proposing will not affect cost of living increases in benefits after retirement, and will in no way alter the benefit levels of current recipients. On the other hand, it will protect future generations against unnecessary costs and excessive tax increases.

I believe that the prompt enactment of all of these proposals is necessary to maintain a sound Social Security system and to preserve its financial integrity.

Income security is not our only concern. We need to focus also on the special health care needs of our elder citizens. Medicare and other Federal health programs have been successful in improving access to quality medical care for the aged. Before the inception of Medicare and Medicaid in 1966, per capita health expenditures for our aged were $445 per year. Just eight years later, in FY 1974, per capita health expenditures for the elderly had increased to $1218, an increase of 174 percent. But despite the dramatic increase in medical services made possible by public programs, some problems remain.

There are weaknesses in the Medicare program which must be corrected. Three particular aspects of the current program concern me: 1) its failure to provide our elderly with protection against catastrophic illness costs, 2) the serious effects that health care cost inflation is having on the Medicare program, and 3) lack of incentives to encourage efficient and economical use of hospital and medical services. My proposal addresses each of these problems.

In my State of the Union Message I proposed protection against catastrophic health expenditures for Medicare beneficiaries. This will be accomplished in two ways. First, I propose extending Medicare benefits by providing coverage for unlimited days of hospital and skilled nursing facility care for beneficiaries. Second, I propose to limit the out-of-pocket expenses of beneficiaries, for covered services, to $500 per year for hospital and skilled nursing services and $250 per year for physician and other non-institutional medical services.

This will mean that each year over a billion dollars of benefit payments will be targeted for handling the financial burden of prolonged illness. Millions of older persons live in fear of being stricken by an illness that will call for expensive hospital and medical care over a long period of time. Most often they do not have the resources to pay the bills. The members of their families share their fears because they also do not have the resources to pay such

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large bills. We have been talking about this problem for many years. We have it within our power to act now so that today's older persons will not be forced to live under this kind of a shadow. I urge the Congress to act promptly.

Added steps are needed to slow down the inflation of health costs and to help in the financing of this catastrophic protection. Therefore, I am recommending that the Congress limit increases in medicare payment rates in 1977 and 1978 to 7% a day for hospitals and 4% for physician services.

Additional cost-sharing provisions are also needed to encourage economical use of the hospital and medical services included under Medicare. Therefore, I am recommending that patients pay 10% of hospital and nursing home charges after the first day and that the existing deductible for medical services be increased from $60 to $77 annually.

The savings from placing a limit on increases in medicare payment rates and some of the revenue from increased cost sharing will be used to finance the catastrophic illness program.

I feel that, on balance, these proposals will provide our elder citizens with protection against catastrophic illness costs, promote efficient utilization of services, and moderate the increases in health care costs.

The legislative proposals which I have described are only part of the over-all effort we are making on behalf of older Americans. Current conditions call for continued and intensified action on a broad front.

We have made progress in recent years. We have responded, for example, to recommendations made at the 1971 White House Conference on Aging. A Supplemental Security Income program was enacted. Social Security benefits have been increased in accord with increases in the cost of living. The Social Security retirement test was liberalized. Many inequities in payments to women have been eliminated. The 35 million workers who have earned rights in private pension plans now have increased protection.

In addition we have continued to strengthen the Older Americans Act. I have supported the concept of the Older Americans Act since its inception in 1965, and last November signed the most recent amendments into law.

A key component of the Older Americans Act is the national network on aging which provides a solid foundation on which action can be based. I am pleased that we have been able to assist in setting up this network of 56 State and 489 Area Agencies on Aging, and 700 local nutrition agencies. These local nutrition agencies for example provide 300,000 hot meals a day five days a week.

The network provides a structure which can be used to attack other important problems. A concern of mine is that the voice of the elderly, as consumers, be heard in the governmental decision-making process. The network on aging

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offers opportunities for this through membership on advisory councils related to State and Area Agencies on Aging, Nutrition Project Agencies and by participation in public hearings on the annual State and Area Plans. Such involvement can and will have a significant impact on determining what services for the aging are to be given the highest priorities at the local level.

The principal goal of this National Network on Aging is to bring into being coordinated comprehensive systems for the provision of service to the elderly at the community level. I join in the call for hard and creative work at all levels -- Federal, State and Area in order to achieve this objective. I am confident that progress can be made.

Toward this end, the Administration on Aging and a number of Federal Departments and agencies have signed agreements which will help to make available to older persons a fair share of the Federal funds available in such areas as housing, transportation, social services, law enforcement, adult education and manpower -- resources which can play a major role in enabling older persons to continue to live in their own homes.

Despite these efforts, however, five percent of our older men and women require the assistance provided by skilled nursing homes and other long term care facilities. To assist these citizens, an ombudsman process, related solely to the persons in these facilities, is being put into operation by the National Network on Aging. We believe that this program will help to resolve individual complaints, facilitate important citizen involvement in the vigorous enforcement of Federal, State and local laws designed to improve health and safety standards, and to improve the quality of care in these facilities.

Today's older persons have made invaluable contributions to the strengthening of our nation. They have provided the nation with a vision and strength that has resulted in unprecedented advancements in all of the areas of our life. Our national moral strength is due in no small part to the significance of their contributions. We must continue and strengthen both our commitment to doing everything we can to respond to the needs of the elderly and our determination to draw on their strengths.

Our entire history has been marked by a tradition of growth and progress. Each succeeding generation can measure its progress in part by its ability to recognize, respect and renew the contributions of earlier generations. I believe that the Social Security and Medicare improvements I am proposing, when combined with the action programs under the Older Americans Act, will insure a measure of progress for the elderly and thus provide real hope for us all.

GERALD R. FORD

THE WHITE HOUSE,

February 9, 1976.

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FOR IMMEDIATE RELEASE FEBRUARY 9, 1976

OFFICE OF THE WHITE HOUSE PRESS SECRETARY

THE WHITE HOUSE

REMARKS OF THE PRESIDENT
AT THE SIGNING CEREMONY
OF THE
OLDER AMERICANS MESSAGE

THE OVAL OFFICE

10:05 A.M. EST

Today I am sending a Message to the Congress that expressed my confidence and support of older Americans, my very deep concern about the problems of the aging and my proposals for dealing with the problems involving them. Society owes a very deep debt of gratitude to all older persons who have worked hard and contributed significantly to our Nation's progress.

Older Americans continue to enrich our lives with their vision, strength and experience. They have earned the right to live securely, comfortably and independently. The proposals that I am sending to the Congress offer significant improvements in the quality of life for all older Americans.

We all have a great stake in fighting inflation, but older Americans living on fixed incomes are especially hard hit. I pledge to continue the fight against inflation, to provide special relief to the elderly.

I am requesting in my budget for fiscal year 1977 that the full cost of living increase in Social Security benefits are paid during the coming year. The value of the Social Security system is beyond challenge. I am concerned, however, about the integrity of the Social Security Trust Fund that enables people to count on this source of retirement income. I am concerned because the system now pays out more in benefits than it receives in tax payments.

To prevent a rapid decline in the Trust Fund over the next few years I had to make a very difficult decision. I am proposing a small payroll tax increase of three-tenths of one percent each for employees as well as employers of covered wages. The alternative would have been to limit expected increases in retirement and disability payments. This proposed tax increase will help to stabilize the Trust Fund so that current and future recipients will be fully assured of receiving the benefits they are entitled to.

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I am also very concerned about the effect of catastrophic illnesses. I want to lighten the financial burden which now strikes after prolonged hospitalization -- When the elderly and their families can least afford it. Therefore, I am proposing catastrophic health insurance for the more than 24 million Americans and disabled Americans protected by Medicare.

No one who is covered by Medicare would have to pay more than $500 a year for covered hospitalization or nursing home care. No one who is covered by Medicare would have to pay more than $250 for one year's doctor bills. Beneficiaries and their physicials now have little incentive to limit the duration of hospitalization for less serious conditions.

To encourage economic use of covered health services I am also proposing changes in cost sharing arrangements. As under the current system, a beneficiary who is in the hospital will pay $104 a day for the first day of hospital services. In addition, he or she will pay ten percent of additional charges up to an annual maximum of $500. For covered services my proposal would increase the annual deductible from $60 to $77 and would continue the current 20 percent cost sharing.

To help finance the added protection, I am proposing to limit Medicare reimbursement rates to 7 percent for hospital services and 4 percent for physician services. These proposals are of particular importance in achieving my goal of helping all Americans live in dignity, security and good health.

I hope you will join me in efforts to secure Congressional passage of these important proposals.

We must show our commitment to a cause that is often too long neglected--the dignity and well-being of America's older generations.

I will now sign the Messages to the Congress -- one to the House and one to the Senate urging that they undertake the enactment of this necessary legislation.

Thank you very much.

END (AT 10:20 A.M. EST)

FOR IMMEDIATE RELEASE FEBRUARY 9, 1976

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FOR IMMEDIATE RELEASE March 23, 1976

Office of the White House Press Secretary

THE WHITE HOUSE

TO THE CONGRESS OF THE UNITED STATES:

Section 208 of the 1973 Amendments to the Older Americans Act (Public Law 89-73) provides that the Commissioner on Aging shall prepare and submit to the President for transmittal to the Congress a report on the activities carried out under this Act.

The Secretary of Health, Education, and Welfare has forwarded the Annual Report of the Administration on Aging for the fiscal year 1975 to me, and I am pleased to transmit this document to the Congress.

GERALD R. FORD

THE WHITE HOUSE,
March 23, 1976

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FOR IMMEDIATE RELEASE APRIL 5, 1976

OFFICE OF THE WHITE HOUSE PRESS SECRETARY

THE WHITE HOUSE

REMARKS OF THE PRESIDENT
UPON SIGNING THE PROCLAMATION FOR
OLDER AMERICANS MONTH - 1976

THE ROSE GARDEN

3:06 P.M. EST

Secretary Mathews and distinguished guests:

It is especially fitting this year that we set aside a period to honor our older citizens. Their insight and experience, their wisdom and their courage has contributed beyond measure to the developments of our 200-year-old Nation. We must make it possible for older Americans to continue their involvement in our national life.

One of the best ways we can draw upon their strengths and skills is in the job and volunteer markets. Too often older and even middle-aged Americans are the victims of myths and prejudices regarding their capabilities. Americans must repudiate these myths and prejudices, as we have repudiated others, and assure our older Americans the chance to prove that time has only enhanced their demonstrated abilities.

It is important that our Nation makes every effort to recognize the worth and the dignity of our older citizens. To this end, the Federal Council on Aging has prepared a Bicentennial charter for our older Americans. This charter sets forth principles to guide us in evaluating our Nation's response to the problems facing older persons and appreciating the response to the problems now confronting our Nation.

One of these principles is the right to an adequate standard of living in retirement. Let me reaffirm that older Americans have earned the right to live securely, comfortably and independently.

As I said before, the value of our Social Security system is beyond question. I will do all that I can to insure the integrity of the trust fund so that future generations of retirees may continue to rely on it.

With these thoughts and commitments in mind, I am happy today to join in this annual proclamation designating an Older Americans Month. I urge all organizations concerned with employment and volunteer services to observe this month with ceremonies, activities and programs designed to increase opportunities for older persons, and I urge that such programs include public forums for discussion of the Bicentennial charter for older Americans.

I ask all Americans to join me in reflecting upon the achievements and the needs of our older citizens.

END (AT 3:10 P.M. EST)

FOR IMMEDIATE RELEASE APRIL 5, 1976

Office of the White House Press Secretary

THE WHITE HOUSE

OLDER AMERICANS MONTH, 1976

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BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A PROCLAMATION

Among our Nation's most precious natural resources are the collective wisdom, experience and abilities of our older citizens.

In recent years we have become more aware of the important contributions older Americans have made in the past and in the tremendous potential they hold for the future. We are increasing our efforts to ensure that they have the opportunity for independent living through security of income, maintenance of health and continued useful involvement in the life of our Nation.

America's older citizens have earned the gratitude and respect of our society, as well as our recognition of their worth and dignity. In this spirit, the Federal Council on Aging has prepared the Bicentennial Charter for Older Americans expressing their rights and obligations.

The job market and the area of volunteer services provide some of the best opportunities to draw on the strengths and talents of older Americans. Unfortunately, older, and even middle-aged workers, are too often the victims of myth and prejudice regarding their capabilities. Our society needs the know-how, experience, judgment and eagerness to serve that these citizens bring to the job.

NOW, THEREFORE, I, GERALD R. FORD, President of the United States of America, do hereby designate the month of May, 1976, as Older Americans Month.

I urge all State and Area Agencies on Aging and other private and public organizations that are related to the field of aging to observe this month by arranging public forums where the Bicentennial Charter for Older Americans will be discussed and recommendations developed for implementation.

I urge all organizations concerned with employment to observe this month with ceremonies and programs designed to increase employment opportunities for older workers.

I urge all organizations engaged in the delivery of services to persons in need to observe this month by increased emphasis on efforts to recruit, train and place older volunteers.

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And I urge all Americans to observe this month by focusing on the achievements of older persons and supporting programs to make the last days of life the best days for increasing numbers of our older Americans.

IN WITNESS WHEREOF, I have hereunto set my hand this fifth day of April in the year of our Lord nineteen hundred seventy-six, and of the Independence of the United States of America the two hundredth.

GERALD R. FORD

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FOR IMMEDIATE RELEASE AUGUST 3, 1976

Office of the White House Press Secretary

THE WHITE HOUSE

TO THE CONGRESS OF THE UNITED STATES:

I am transmitting herewith the Annual Report of the Federal Council on Aging, together with two studies undertaken by the Council as required by sections 205(f-h) of the Older Americans Act (P.L. 93-29).

Last year I indicated that I was looking forward to receiving then two studies from the Federal Council on Aging. The Council recognized its responsibilities and undertook the task in a forthright manner. I appreciate the fine work that the Council has done, particularly with the severe time constraints imposed upon it.

The Council's report and studies provide documentation, from the viewpoint of our elderly citizens, which support the need for legislation along the lines of my proposed Financial Assistance for Health Care Act and the Income Assistance Simplification Act which I will be proposing shortly. My proposals would permit both Federal and State programs to be simplified and integrated into a coordinated system that would best meet the needs of our citizens.

Council Recommendations

With respect to the Supplemental Security Income (SSI) program, the Council has recommended in its program report that legislation be passed that mandates continuance of a specific State supplementation for certain recipients. The Federal Government took over this program from the States on January 1, 1974, and provided a basic payment level to recipients. For those individuals who received benefits under the State programs in December 1973 that were larger than the basic Federal payment level, and who continue to be eligible for SSI, States are required to supplement the basic Federal payment up to the level of the December 1973 payment to such recipients. The requirement does not apply to new recipients who became eligible after December 1973. The Council's legislative proposal would require that the size of the State supplementation to recipients carried over from the State programs on January 1, 1974, could not be reduced. Thus, whenever the basic Federal payment level is increased, this proposal would allow States to continue to maintain a disparity in the benefits for the carried-over recipients versus those recipients who came on the rolls after December 1973 -- a disparity equal to the amount of the original State supplementation.

Adoption of this recommendation would have two effects. First, it would dictate to the States how they should spend the taxes they assess on their residents. Such action would distort the original concept of the program of separate but complementary roles of the States and the Federal Government.

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Second, it would require the States to maintain payments to people based on the date they started receiving assistance, even though other residents of the States may have equivalent needs and incomes.

The Council also recommends that the Veterans' Administration (VA) be directed to study the problem of benefit reduction rates caused by simultaneous receipt of benefits from pensions for veterans with nonservice-connected disabilities and other Federal programs. We share the concern of the Council. This problem is being studied by the Veterans' Administration within the context of total reform of the veterans' pension program. The Agency has discussed pension reform with both the House and Senate Veterans' Affairs Committees, and is committed to continuing these discussions with Congress this year. The relationship of veterans' pensions to other Federal benefits can best be addressed in the course of these discussions.

To assess the tax burden on the elderly, the Older Americans Act also required the Council to undertake a study of the combined impact of all taxes on the elderly. Since many of the tax recommendations of the Council are directed towards State and local government, consistent with the enabling authority I am also transmitting this study to the Governors and legislatures of the States for their consideration.

In recognition of the Bicentennial and the many contributions made by older Americans to the welfare of the nation, the Council's annual report requests the promulgation of a Bicentennial Charter for Older Americans. I have asked Secretary Mathews of the Department of Health, Education, and Welfare, in consultation with the Administration on Aging, to promote discussion of these vital matters at forums of older persons organized by Advisory Committees to the Area Agencies on Aging.

The Federal Council on Aging Annual Report and attendant studies reflect an earnest effort to deal with the lack of equity and efficiency in the present patchwork of income security programs. This unfortunate situation, which has developed over the years, presents problems not only to the elderly and other population groups, but to the taxpayer who must pay the added costs resulting from such inefficiency. My legislative proposals reflect careful consideration of how best to resolve these issues, and I urge prompt action on them by the Congress.

Additional mention should be made of the substantial contribution of the two studies undertaken by the Federal Council on Aging. The efforts of those that participated in the studies will contribute to our effort to provide necessary income and services to our less fortunate elderly citizens in an efficient manner.

These reports will be sent for review and analysis to those Federal agencies serving older persons. After this review, decisions on the recommendations contained in the Council's report will be reflected in future legislative proposals and administrative actions of this Administration.

GERALD R. FORD

THE WHITE HOUSE,
AUGUST 3, 1976

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