Dear:

The medicare program as finally approved in 1960 empowers the Secretary of Health, Education and Welfare to establish guidelines for administrative action by the states in setting up the program. Considerable flexibility was necessary because most states already have health programs dealing with recipients of old age assistance and in some cases by beneficiaries of Old Age and Survivors Insurance.

Under the circumstances it appeared prudent to give states maximum latitude in handling the proposed program that it might be integrated with the proper state agency. It is entirely possible that in some states a new agency might be created whereas in others existing agencies might administer it.

Both House and Senate by majority votes determined that the plan should be operated by the states, in line with certain basic criteria developed by the Federal Government, that it should be financed by state and federal governments with the federal share coming out of general revenues, and that it should be limited to the medically needy.

I consider this a sound approach and it is a significant step forward in the field of health care for the aged. As time goes on this program can be refined within this basic framework and become a truly effective program.

Sincerely,

Everett McKinley Dirksen
Dear:

The Medical Assistance for the Aged Program, established by Congress in 1960, is based on the belief that all people over 65 who seriously need help in meeting medical expenses should have such help available and that the taxpayers should provide no care for those needing no help.

The Law, commonly known as the Kerr-Mills Act, provides that the plan should be operated by the States, that it should be financed by State and Federal governments, and that it should be limited to those who would otherwise be subject to serious financial hardship in meeting medical expenses.

It has been described by Mr. Jules Berman, who has responsibility for its federal administration, as "unique among the grant-in-aid legislation Congress has enacted ... in its liberality and flexibility. I have been associated with administration of grants-in-aid for many years and never have I seen legislation offering the States such generous federal help with such little federal control."

In Illinois, individuals with annual incomes under $1800 and couples with incomes under $2400 are eligible for help if they have assets worth less than $1800 and $2400, respectively. Such assets exclude the homestead, regardless of value, personal property, an automobile, $1000 life insurance and $1000 of tools used in earning income. Income is net after allowance for the cost of voluntary health insurance.

I consider this a sound approach and a significant step forward in the field of health care for the aged. As time goes on this new program can be refined and become truly effective.

One refinement already proposed in my bill (S. 2811) would provide that a simple statement regarding income and assets by applicants for help would, in itself, be sufficient basis for determining eligibility. A statement discussing this proposal is enclosed.

Sincerely,

Everett McKinley Dirksen

Enclosure
Dear:

Thank you for your comments on the medical needs of older people. It shows your understanding of the concern that we all share even though opinions as to methods may differ. Some of my views are set forth in the enclosed statement made at a hearing held in St. Louis by the Senate Special Committee on Aging, of which I am a member. A statement on the Kerr-Mills Act is also enclosed.

I believe the Kerr-Mills Act now on the statute books will meet the most pressing and best documented medical needs of older people. I do not believe it is perfect. I have already introduced one amendment to it. Other refinements will come as we develop further experience in its administration. Possible defects do not, however, warrant abandonment of the sound principles on which it is based. Conceivably further federal legislation may be needed to supplement it. This is now under study.

I see no basis, in logic or fact, for support of the present administration’s proposal for a limited medical care plan under Social Security. Many older people have told me they have serious objections to a compulsory program to be operated by an all-powerful federal bureaucracy. They are fearful of costs to be borne by their children, medical care quality, and interference with their individual freedom. Older people who have supported the proposal have usually done so on the erroneous assumption that it would take care of almost all their medical needs. That it will not is shown by the enclosed analysis which appeared in the Congressional Record.

It is the cruellest sort of hoax to create the impression among older people that the administration's proposal will meet their needs, which they know are usually for physician services and drugs. This intensely emotional deception seriously impedes orderly development of practical solutions to a highly complicated problem.

Sincerely,

Everett McKinley Dirksen

Enclosures (4)
Dear Friend:

I am always reluctant to send a form letter in reply to correspondence from constituents, however, the volume of mail on the medical care issue has reached such tremendous proportions that it has become necessary to do so in this instance.

In response to your comment on the issue of medical care for our elderly citizens now pending before the Congress and in view of the President's statement to the country on the administration's proposal, commonly referred to as the King-Anderson bill, let me make the following comments:

1. Strangely enough the President did not once mention the fact that there is already on the statute books a medicare program -- usually referred to as the Kerr-Mills Act -- which is operating in the State of Illinois and twenty-seven other states.

2. Under the King-Anderson measure the patient must pay his own doctor bill and pay for all drugs and medicine after he is out of the hospital and just when he needs these services.

3. The patient must, out of his own pocket, pay $10 per day or a total of $90 for the first nine days that he is in the hospital.

4. The patient, out of his own pocket, must pay $20 for each diagnosis of his case.

5. The $90 which he is called on to pay for hospital services is virtually equal to half the hospital costs in quite a number of areas in the country.

To be sure the Kerr-Mills Act -- now available to our elderly citizens if they will only apply for its benefits -- is not perfect, but whatever weakness and imperfection develops could be easily remedied by the Congress without throwing this entire working program overboard.

Moreover, the Kerr-Mills Act is based on the sound principle of making hospital, nursing home and medical care available to all who may need help without extending its benefits to those who can well afford to pay their own way. This seems to me an entirely fair approach.

On March 15th I presented a statement to the Senate and had it printed. A copy is attached. In brief form, it sets out the whole medicare program and I do hope you will read it very carefully.

Sincerely,

Everett McKinley Dirksen

Enclosure
MEDICAL ASSISTANCE FOR CERTAIN ELDERLY PEOPLE WITHOUT INVESTIGATION PRIOR TO CERTIFICATION

Mr. DRIKSEN. Mr. President, on behalf of myself, the Senator from North Dakota (Mr. Young), and the Senator from Utah (Mr. Bennett), I introduce, for appropriate reference, a bill to amend the Kerr-Mills Act which would provide that older persons seeking help under State medical assistance for the aged programs would not be subject to investigation prior to certification for care.

The bill provides that a simple statement under oath as to his financial status must be presumed to be accurate in determining an older person's eligibility for care under State medical assistance for the aged programs using funds provided through the Kerr-Mills Act. Effective date for the new provision would be October 1. States not complying after that date would be ineligible for Federal grants-in-aid under the act.

Adoption of this proposal will remove a psychological barrier for lower-income people over 65 who, while otherwise independent, may need help from the State in obtaining medical care. It will also accelerate the speed with which these needs of these persons are met.

The persons whom the medical assistance for the aged programs are designed to help are honest and proud people. If the Nation's senior citizens cannot be trusted to accurately report their income and assets in application for help, the country as a whole is in serious trouble.

This proposal would, in essence, apply the same presumption of honesty on the part of citizens as is employed in the Veterans' Administration medical care program and the income tax.

While there is no evidence that people requesting care under the State medical assistance for the aged programs have been subject to humiliating investigation, many senior citizens fear that it might happen and resent the idea of a caseworker embarrassing them in their own neighborhoods. It is to prevent such a possibility that this proposal has been made.

Under present law, States are encouraged to develop medical assistance programs for those normally able to provide for their own needs who would be unable, however, to meet the cost of serious illness. It was the intent of Congress that these persons should be helped, as needed, without being forced onto public assistance rolls or subjected to pauperization. From 60 to 80 percent of the funds required by a State for the program are available from the Federal Government.

Most State plans provide that persons whose income and assets fall below a specified level shall be eligible for benefits. The States now may make a comprehensive and detailed investigation to determine income and assets before providing help. This would not be possible after approval of the Dirksen amendment. Instead, the applicant's word would have to be accepted as presumption of his financial qualification.

The proposal would in no way alter the States right to determine the income level or other standards necessary to make a person eligible for help. Nor would it interfere with the States right to prosecute or recover funds in case of fraud.

In Illinois, individuals with annual incomes under $1,800 and couples with incomes under $2,400 are eligible for the medical assistance for the aged program if their assets do not exceed $1,800 and $2,400 respectively. Not counted as assets for this purpose are a homestead, regardless of value; personal property; an automobile; $1,000 of life insurance; or $1,000 of tools used in earning income.

Mr. President, I ask unanimous consent that the bill be permitted to lie on the table for 2 additional days for co-sponsors.

The VICE PRESIDENT. The bill will be received and appropriately referred and, without objection, the bill will lie on the desk, as requested by the Senator from Illinois.

The bill (S. 2811) amending title I of the Social Security Act so as to require that, in the administration of State programs for medical assistance for the aged established pursuant to such title, a statement of a claimant for assistance under any such program with regard to his financial status shall, if made under oath, be regarded as factually correct for purposes of determining his eligibility for assistance under such programs, introduced by Mr. DRIKSEN (for himself and other Senators), was received, read twice by its title, and referred to the Committee on Finance.
THE MEDICARE ISSUE

Mr. DIRKSEN. Mr. President, because it is a partial nationalization of health care which may seriously endanger our whole voluntary medical system, any proposal directly involving the Federal Government in administration of medical care for people over 65 should be shunned.

Any compulsory health plan embracing all people, or all people in a special group regardless of whether they want or need the proposed services, constitutes a major infringement on individual responsibility and liberty. It should be opposed.

There is serious question as to whether it is proper for the Federal Government to use taxpayers' money to purchase health care services for any individual without regard to his actual need.

H.R. 4222, the King-Anderson bill, would violate all three of these precepts. Because of this, Congress, in 1960, wisely rejected similar proposals and adopted the Kerr-Mills Act, Public Law 86-778.

The Kerr-Mills Act provides Federal funds for State-administered medical programs for the aged who need help. Congress intended that such programs, designed for older people not on public assistance rolls, should prevent pauperization through illness and that under them the recipient's basic independence should be retained.

Kerr-Mills Act grants to the States are unusually generous. The States are free to develop virtually any program they see fit. Determination of what constitutes need is completely at the States' discretion.

In most States, automatic eligibility is provided the individual whose income and assets fall below a predetermined amount.

A number of new bills have been introduced in the current Congress which would avoid some obvious defects in H.R. 4222. Wide publicity has been given proposals for new State-administered plans with an individual option to elect voluntary health insurance, and proposals for tax credits for voluntary health insurance and medical expenses of people over 65.

It would appear, however, that further action in this area at least should be deferred until the full effect of the Kerr-Mills Act can be evaluated. Such study, of course, should be based on results following wholehearted efforts to implement it.

Under the Constitution, the national responsibility for such all-out promotion of the law now rests with the Executive branch.

Unfortunately, activities of responsible spokesmen for the current administration have been concerned primarily with campaigning for a proposal previously rejected by Congress. As long as this administrative reluctance to give the Kerr-Mills Act full support continues, it would appear wise for the Congress to stand firm.

Despite the foot-dragging and attacks on the Kerr-Mills Act by major administration spokesmen, the speed of its implementation by the States has been remarkable.

This gives promise that the Kerr-Mills and other existing assistance programs, coupled with expanding voluntary health insurance, will continue to provide older people with the world's best medical care unhampered by Federal bureaucracy.