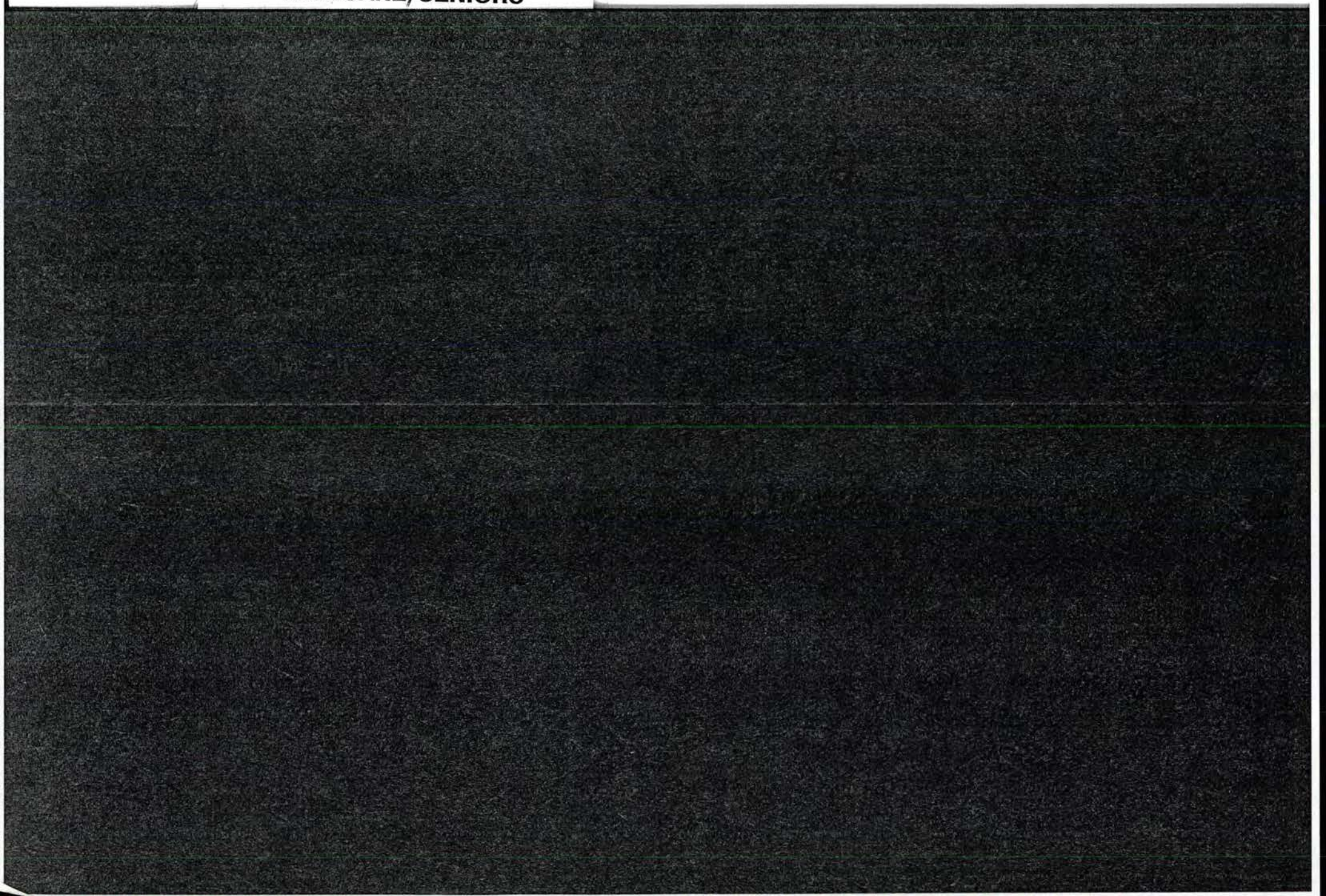
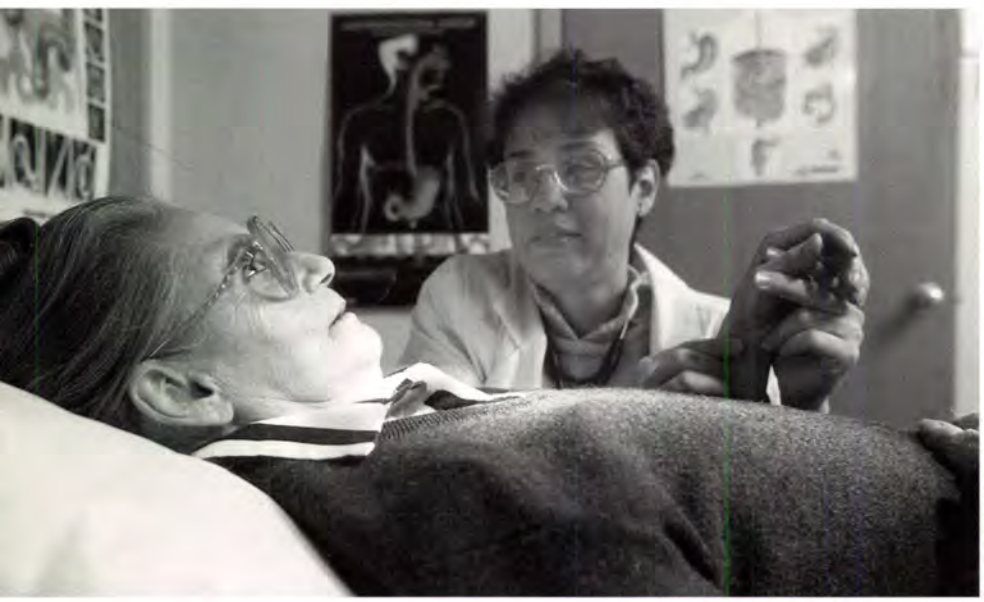


MEDICARE / SENIORS

Managed Medicare



Richard A. Bloom

It's time for elderly Americans to join the managed care revolution that has become a way of life for their children and grandchildren, many congressional Republicans say. But attempts to put medicare patients into HMOs have run into trouble.

BY MARILYN WERBER SERAFINI

As painful as they may seem, cuts in the medicare budget this year won't provide a lasting cure for what ails the program. Unless medicare is overhauled, this money-hungry dinosaur will continue to eat huge holes in the Treasury, and its hospital insurance trust fund will go broke in about five years.

That's the emerging consensus among key congressional Republicans who are contemplating sweeping changes in medicare. Their chief goal: to shepherd the program's 34 million beneficiaries into health maintenance organizations (HMOs), preferred provider organizations (PPOs) and the other managed care structures that have become a way of life for the children and grandchildren of elderly Americans. Many lawmakers also want to offer medicare beneficiaries a choice of options for their health coverage, including vouchers and medical savings accounts.

Medicare has changed little since its creation in the 1960s. Most care is provided on a fee-for-service basis—an arrangement that many private-sector health plans now shun because of its reputation for encouraging higher costs and overuse of services. Medicare costs are rising by 10.9 per cent a year—compared with an over-all health care inflation rate of about 6.7 per cent.

"What we're doing is fundamentally reconceptualizing the whole approach to seniors and medicine," said Rep. William M. Thomas, R-Calif., who chairs the Ways and Means Health Subcommittee.

Sound familiar? It does to Harris Berman, president of the Tufts Associated Health Plan, a Boston-based HMO. In the mid-1980s, Tufts was one of more than 100 HMOs that contracted with the Health and Human Services Department's Health Care Financing Administration (HCFA) to serve medicare beneficiaries. The contracts required the HMOs to provide medicare recipients with comprehensive care for a set monthly fee—an arrangement known as risk contracting.

Some of those ventures succeeded and are still flourishing. But plenty more collapsed quickly, offering a cautionary tale for those who prescribe managed care as a miracle cure for medicare.

Tufts, already well established in New England, had no problems attracting medicare patients. The challenge was caring for them on the budget provided by the government. Too late, the HMO discovered that the kind of care its medicare recipients required was different from what its other enrollees needed. "We managed these patients the same way we managed our commercial population," Berman said. "As a result, hospital utilization was enormous. On that we lost our shirts." Three years and $5 million later, Tufts hoisted the white flag and retreated from medicare.

As Republicans seek to bring medicare into the world of managed care, they will have to grapple not only with complaints from HMOs about inadequate government payments, but also with resistance from senior citizens who have long-standing relationships with doctors and hospitals. What's more, studies have found that the medicare managed care plans haven't saved the government a penny so far.

introduced a bill that is similar to the House-passed measure, although not as far-reaching.

The House vote was a major victory for an odd but effective coalition that included accounting firms and high-technology companies. Accounting firms have paid an estimated $1.6 billion in penalties and settlements relating to their role in the savings and loan debacle of the 1980s. Meanwhile, high-tech companies have found themselves defending hundreds of cases brought by investors when the value of company stock drops.

The accountants, led by the American Institute of Certified Public Accountants and the Big Six accounting firms, mobilized accounting professionals in every congressional district. And the industry's political action committees upped their campaign spending in congressional races by 50 per cent from 1991-92 to 1993-94, according to an analysis by the nonpartisan Center for Responsive Politics.

"They sensed a tremendous opportunity, and they have really poured it on," said Washington lawyer Jonathan W. Cuneo, who represents the National Association of Securities and Commercial Law Attorneys (NASCAT), a pro-plaintiff organization. "They have laced the House with political contributions."

The accountants have retained a slew of lobbyists, including former Rep. Anthony Toby Moffett, D-Conn., now the president of Strategic Policy Inc., a Washington public affairs firm; Gitenstein of Mayer, Brown & Platt, a former chief counsel to the Senate Judiciary Committee; Jeffrey J. Peck, Gitenstein's successor in the Judiciary post and now the managing director of government affairs in Arthur Andersen & Co.'s Washington office; and W. Michael Kitzmiller, a former staff director of the House Energy and Commerce Committee who's now a partner in the Washington lobbying firm of Johnson, Smith, Dover, Kitzmiller & Stewart.

Nor were Republicans ignored. The accountants hired Michael J.P. Boland, a former GOP aide on the Energy and Commerce Committee, and Peter T. Madigan, a onetime State Department lobbyist in the Bush Administration. Both are now lobbyists with Cassidy and Associates, a Washington public affairs firm.

And the powerhouse Washington public relations firm of Powell Tate was hired to handle PR for the accountants.

The accountants set up the Coalition to Eliminate Abusive Securities Suits, which produced a sophisticated grass-roots campaign with computer software that allowed accountants and their corporate clients to send personalized messages to Members of Congress. Heading up the grass-roots effort is Gail L. Harrison, executive vice president of the Wexler Group, a Washington public affairs firm.

Meanwhile, biotechnology companies and groups such as the American Electronics Association and the National Venture Capital Association mobilized on behalf of the high-tech industry.

All that firepower smoothed House passage of the legislation. Conservative Democrats such as W.J. (Billy) Tauzin of Louisiana labored mightily for the bill, helping to craft compromises to bring in moderate Democrats. A key provision that would protect companies from most lawsuits if their stock unexpectedly drops was offered by Rep. Norman Y. Mineta, D-Calif., who represents Silicon Valley.

In the end, 99 Democrats voted for the bill and 98 against it—even though 2 Democratic lions, John D. Dingell of Michigan, the former head of the Energy and Commerce Committee and a longtime power on securities issues, and Edward J. Markey, D-Mass., the former head of the Energy and Commerce Subcommittee on Telecommunications and Finance, opposed it.

Richard A. Bloom

Linda A. Lipsen of trial lawyers' association
She sees "a feeding frenzy" for interest groups.

As the fight begins in the Senate, opponents are marshaling their resources. Besides NASCAT and consumer organizations, leading foes of the legislation include state securities regulators, the American Association of Retired Persons and the International Brotherhood of Teamsters. Other groups may come on board as investors realize that the legislation would limit their right to recoup financial losses. The scandal over derivatives, which caused Orange County, Calif., to declare bankruptcy recently, may also be used as an argument against the bill, opponents say.

Moreover, some consumer activists say that accountants and high-tech firms may not stick together because they support different parts of the bill. Accountants want to be spared from a joint and several liability requirement that can force them to pay all damages even when they are responsible only for a portion. High-tech companies, on the other hand, are mostly interested in a provision that would change standards for the definition of fraud.

Lobbyists for the accountants scoff at the notion of a divide-and-conquer strategy. "Wishful thinking," Gitenstein snapped.

Backers of the securities bill say they expect victory. "The 325 votes took the wind out of the sails of people who might be inclined to oppose us" in the Senate, accountants' lobbyist Moffett said.

On April 6, Securities and Exchange Commission chairman Arthur Levitt Jr. urged a Senate Banking, Housing and Urban Affairs Committee panel to make some changes in the legislation. But Levitt also said that he agreed with the objectives of the bill.

Lobbyists pushing for comprehensive reforms are cautiously optimistic. But veterans caution that it won't be easy to get the 60 votes needed for cloture votes—let alone a possible filibuster after conference with the House or a veto.

"There are plenty of places to stop the bill. That is why legislation is about accommodation and consensus when all is said and done," a business lobbyist said. "Everything seems to be moving quickly. But the biggest danger you face if you go downhill too fast is that eventually you fall on your face." ■

Members of Congress say they are crafting proposals that would fix some fundamental problems in risk contracting and provide incentives for participation by medicare beneficiaries and managed care plans alike.

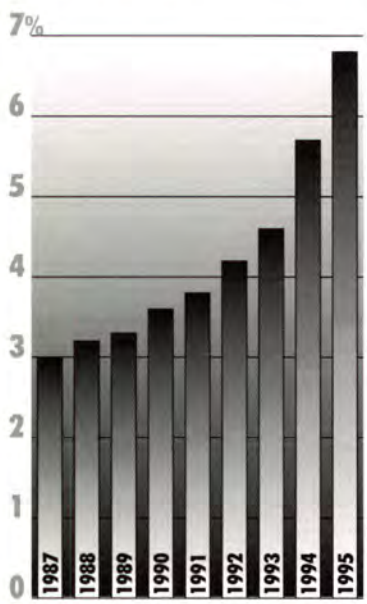
And despite its rocky introduction to medicare, the managed care industry appears eager to tap the market. HMOs already provide care for 50 million Americans; medicare is the next logical step.

"It's the realization of the maturity of the managed care market," William L. Roper, senior vice president and chief medical officer of the Prudential Insurance Co. of America and a former HCFA administrator, said, explaining why Prudential last year opened its HMOs to medicare beneficiaries. "I believe the time is right now for a substantial push into managed care."

GROWTH CURVE

Percentage of People Eligible for Medicare Enrolled in HMOs

A relatively small percentage of the medicare population is served by HMOs, but the numbers are rising steadily.



SOURCES: New York Times; Health Care Financing Administration

EFFICIENCY GETS PUNISHED

Still, medicare is likely to bring up the rear of the managed care revolution until some problems are fixed.

Foremost, HMOs want Congress to change the way HCFA pays them under medicare risk contracts. The payment rate varies widely according to location. HMOs in the Miami area get a monthly fee of $615 per participant, for example, while those in the Minneapolis area get only $362.

"In many urban areas and most rural areas, the . . . payments to managed care organizations are not sufficient to cover the costs of caring for an older person," K. James Ehlen, the president of the Minneapolis-based Allina Health System said in recent testimony before the House Budget Committee.

HCFA sets a payment rate for each county, based on the average cost of treating medicare beneficiaries who are not in managed care plans. HMO operators complain that the system punishes efficiency. When HMOs began accepting medicare patients in the mid-1980s, Ehlen said, the payment rate in Minnesota was high enough for HMOs to offer generous benefits, including prescription drug coverage that is unavailable to most medicare beneficiaries. "Seniors flocked to the program," he said.

But at about the same time, health care cost inflation in the Minneapolis area began to slow dramatically, thanks to a surge in local enrollment in managed care plans that, experts say, also curbed the prices charged by doctors and hospitals outside those plans. As a result, HCFA's monthly medicare payments in the area leveled off for several years; many local HMOs curtailed their benefits packages, and some stopped accepting medicare beneficiaries. Meanwhile, though, the rates continued to rise in cities where fee-for-service medicine prevailed.

The same pattern has occurred across the country, Ehlen said. "Seniors enrolled in HMOs in some high-payment areas can receive coverage which often includes prescription drugs for zero premiums per month," he said. But those in lower-payment areas, "if they have access to HMO coverage at all, are unlikely to have such benefits and may pay premiums of $40-$60 per month, and some over $100 a month."

In Minneapolis, most HMOs no longer accept a monthly fee for medicare patients. Instead, they have reverted to a fee-for-service approach in which HCFA reimburses them for services provided. HCFA officials say they want to move away from this arrangement because it offers no incentives for efficiency.

But lawmakers contend that HMOs will not accept a set monthly fee unless the payment system is improved. Some have suggested basing the payment calculation on a wider geographic area. Others—including House Budget Committee chairman John R. Kasich, R-Ohio—are interested in a modified form of competitive bidding, in which each HMO in an area would tell HCFA what it considered a fair monthly fee for treating medicare patients. The agency then would set a fee based on an average of the bids submitted.

HCFA is also contemplating some form of competitive bidding, although it may not want to move as quickly as congressional Republicans do. The agency has contracted with New Jersey-based Mathematica Policy Research Inc., to help prepare a proposal. Mathematica is expected to complete its report later this year. "We want to look at more delivery systems, what types of geographical areas we should be in, what type of premiums should be involved, so we can be prepared to deal with competitive bids," said Rodney C. Armstead, director of HCFA's office of managed care. "Republicans don't have the information to do it now."

But Thomas is impatient. "We've got a bureaucracy dragging its feet," he said.

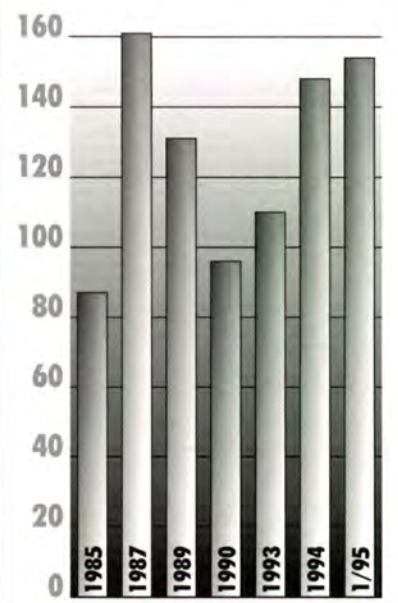
Like other Republican lawmakers, Thomas envisions a revamped medicare program in which beneficiaries could choose among several options.

They might be given vouchers to buy HMO coverage, for example. Although some senior citizens' groups have criti-

BUMPY RIDE

Medicare HMO Risk Contracts

The number of HMOs treating medicare patients for a fixed fee soared in the 1980s but then declined sharply. Now it's climbing again.



SOURCE: Health Care Financing Administration

cized that idea, Thomas said, "simply giving people a check and putting them into the cruel world of HMOs to be battered about in the wind isn't exactly what we have in mind." Beneficiaries would use the vouchers to enroll in plans that have contracts with HCFA, he said, and the plans could not turn them away.

Thomas is also exploring the idea of allowing medicare beneficiaries to stay in employer-sponsored health care plans. Under this approach, employees who turn 65 could remain in their employers' plans, even after they retire. Medicare would reimburse employers for their monthly premiums; the employers might get a tax break as an added incentive. The idea is to keep elderly people in a pool with younger, healthier people, to lower the cost of coverage and allow them to stay in a plan they're familiar with.

Thomas and many Republicans also want to expand a demonstration project now under way in 15 states that allows PPOs to sign up medicare beneficiaries for portions of their coverage. The project, known as Medicare Select, generally works like a traditional fee-for-service plan, however. HCFA pays the PPOs on a per service basis, and they offer discounted prices because patients agree to use certain medical providers.

Sen. Judd Gregg, R-N.H., wants medicare beneficiaries to be able to choose from a variety of plans, with those who choose lower-cost plans being allowed to pocket the savings. "I think there will be as many new ideas for packages as the marketplace can create," he said. "There will be a variety of add-ons and price mechanisms used to tailor health care plans to seniors in the community."

Many Republicans would also like to see medical savings accounts made available to medicare beneficiaries. Under that approach, the government would provide catastrophic coverage with a high deductible; HCFA would put enough money into a savings account for each beneficiary to cover the deductible each year; and the beneficiary could keep any money left over in the account at the end of the year. *(For more on medical savings accounts, see NJ, 4/1/95, p. 804.)*

MOVING INTO THE MARKET

Even if Congress does nothing, HMOs are gearing up to enter what many view as the final frontier in the health care market.

In a recent survey by the Group Health Association of America, the major HMO industry association, roughly three-fourths of HMOs said they were interested in expanding access to the medicare population, Karen Ignagni, the group's president, said.

"It's an enormous market," said Westcott W. Price III, the chief executive of California-based FHP International Corp., one of the largest HMO medicare providers. "If you're not in the medicare business, you're not really in the health care delivery business. Fifty per cent of health care dollars in the country are spent on people aged 65 and older."

"The seniors are becoming a larger population. Don't ignore it. Start working with it," said Fred A. Jacot, the chief executive of the Spokane-based Medical Service Corp. of Eastern Washington, a Blue Shield plan that is preparing to begin a medicare risk contract with HCFA. "If you don't do it, somebody else will," Jacot added.

Already, more than 150 HMOs have risk contracts with HCFA, and 78 proposals are pending for new or expanded contracts. Almost 7 per cent of medicare beneficiaries have signed up, and HCFA predicts a 20-25 per cent increase this year. In some areas, such as Portland, Ore., and San Diego, more than half of medicare recipients are in HMOs.

Even Tufts is rejoining the movement. Last year, it teamed up with PacifiCare Health Systems Inc. of Cypress, Calif., one of the largest medicare HMOs, which has begun selling its technique for managing elderly patients. In essence, Tufts has a PacifiCare franchise. Berman sends doctors to a PacifiCare facility in Texas for a crash course on the most efficient ways to coordinate care for seniors. There's another class for marketing.

Costly hospital stays were a big problem for HMOs that ventured into medicare. More recently, HMOs have learned that elderly patients who see their doctors frequently are less likely to be hospitalized.

Richard A. Bloom

Although Tufts is not making money on the enterprise yet, Berman said, it appears to be a promising line of business.

Craig S. Schub, PacifiCare's senior vice president for medicare, couldn't agree more. PacifiCare has moved its medicare venture, known as Secure Horizons, into a half-dozen states since 1985 and is talking about partnerships with other HMOs.

What separates HMOs such as PacifiCare from those that failed in medicare contracts? The secret is in treating elderly people like elderly people, Schub said. "When the population ages, you have little things that don't kind of work perfectly," he said. "They're not life-and-death, but they happen every day. Their need for care from the system is not so much high-powered and onetime, but every day."

PacifiCare provides comprehensive

care, coordinated by a primary care physician. Doctors see medicare patients more frequently and try to catch problems early. They try to keep patients out of the hospital or shorten stays by using home health care. By using this method, PacifiCare has made its medicare managed care plans as profitable as its commercial plans, Schub said.

Costly hospital stays were a major problem for Tufts, which saw its hospital usage rate grow tenfold when medicare beneficiaries joined the HMO. But by following PacifiCare's model, the HMO has seen remarkable results, Berman said. In the first five months of its new medicare venture, hospital usage for elderly enrollees was about the same as for younger ones. "The key is doing what needs to be done in the appropriate location," he said. "Don't just send them to the hospital because that's where old people should be."

In addition, Tufts doctors have a financial stake in keeping hospital stays down. Tufts sets a target for hospital stays for each doctor's patients. If the patients use fewer days, the doctor gets to keep the savings. If they use more, the doctor pays the extra cost.

But such financial incentives worry the American Association of Retired Persons (AARP) and Families USA, a Washington-based advocate of comprehensive health reform. "It's a classic conflict of interest," Families USA executive director Ron Pollack said. "When a patient sees a doctor, that patient has reason to expect that doctor will make a decision based on one factor and one factor only—what's in the best interest of the patient."

There's another factor restraining HMOs' entry into the medicare market. Under federal law, medicare and medicaid patients cannot make up more than 50 per cent of any HMO's total enrollment. An HMO must develop a commercial base in each market before it can get medicare contracts, and that can take years. That's why HMOs such as PacifiCare are looking for franchise-style arrangements in which they team up with other HMOs.

TERRIFIED SENIORS

Moving medicare into managed care will be no easy task, though. For one thing, there's no evidence that existing medicare managed care plans are saving the government money.

In fact, the Mathematica consulting firm concluded in a 1993 study for HCFA that the agency was overpaying HMOs with which it had signed medicare risk contracts. The youngest, healthiest medicare recipients tend to choose HMOs, the study found, while payments to the HMOs are pegged to the average cost of treating all medicare patients in a given geographic area.

Although some critics have questioned the study, the Congressional Budget Office in February released a report supporting its premise. "Medicare's costs generally increase for each enrollee who switches to an HMO under the current payment system," the report said. "This happens because medicare's per capita payment to the HMO—which is based on what enrollees cost in the fee-for-service sector—does not adequately reflect the generally healthier population that chooses the HMO option."

The GOP also faces a political complication. Many senior citizens are terrified that Congress will force them into health plans they don't want. And the elderly represent a growing proportion of the GOP's voter base; in the November elections, elderly voters reversed a long trend by casting more ballots for Republicans than for Democrats in congressional races.

The last thing seniors want is to be pushed, a spokeswoman for the AARP said. "Managed care isn't for everybody, and people need to feel comfortable with changes." The AARP says that it favors making managed care available to medicare beneficiaries, but that no one should be forced to join a managed care plan.

John Eisele

Rep. William M. Thomas, R-Calif.
"We've got a bureaucracy dragging its feet."

Although no Member of Congress has talked about requiring beneficiaries to sign up, there is "more than one way to be forced in," the AARP spokeswoman said. "If what really happens is that fee-for-service becomes so expensive, that's not a real choice anymore."

The American Medical Association (AMA), which has resisted the move to managed care, has also argued that safeguards are needed to protect consumers. "People who get into managed care should be informed of what they're buying, what's covered, what hospitals they can go to, so they can make an informed decision when they decide how to choose," Thomas R. Reardon, an AMA trustee, said.

House Speaker Newt Gingrich, R-Ga., is showing some sensitivity to the AMA's concerns. In a recent speech to the group, he called for congressional hearings on managed care. But he and other GOP lawmakers still consider managed care the long-term solution to medicare's problems.

Thomas argues that Congress should act soon on overhauling medicare. "We have to get it done fairly quickly" because the hospital trust fund is expected to run dry about 2001 or 2002 if costs continue to rise at the present rate. Growing enrollment is fueling the sense of urgency about revamping the program.

Initially, Thomas and other Republicans had talked about delaying action on medicare reforms until after they complete work on the budget. But there's increasing discussion about attaching a medicare overhaul package to the budget reconciliation bill—on the theory that longer-term changes in the program might make short-term budget cuts more politically palatable. The question, though, is whether seniors will accept the deal. ■

The Ax Files

In a project coordinated by the office of House Majority Leader Richard K. Armey, R-Texas, conservatives are aiming to "Defund the Left" by stopping the flow of federal money to not-for-profit organizations that have been associated with liberal causes.

BY JEFF SHEAR

With its dark legacy of witch-hunts and enemies lists, the Republican Party is once again collecting names. In a project coordinated by the office of House Majority Leader Richard K. Armey, R-Texas, conservatives are working hard to identify political advocacy organizations that get federal money. And they're obviously not gunning for their ideological brethren.

"Defunding the Left" is the catchphrase for the campaign to stop the flow of federal funds to not-for-profit organizations that are associated with liberal causes, and it's gained powerful new impetus through the GOP's takeover of the House. In its latest incarnation, the drive aims to disrupt the liberal infrastructure that supports the legacy of the New Deal. It differs from earlier efforts because it is more narrowly targeted, and because the GOP controls the Congress.

Conservatives say that they are preparing to storm the ramparts of the "welfare-industrial complex"—the "iron triangle" of federal departments and agencies, liberal advocacy groups and their allies in Congress. These organizations fuel the federal government's runaway spending, they say. Yanking them off the federal teat is fundamental to dismantling Big Washington, a key goal of the House GOP's Contract With America.

While the leaders of liberal organizations that may end up on the Republican hit list say that they've been bracing for something like this, they've yet to discern any coordinated maneuvers by conservatives to go after them. They're wary, but like their Democratic allies on Capitol Hill, they're not privy to the machinations of the Republican leadership.

Though still in its formative phase, the "project," as it's sometimes referred to by those involved, will heavily rely on the House Appropriations Committee. Already, the committee has struck hard, pruning back funds promised in the fiscal 1995 budget to the Corporation for Pub-

Richard A. Bloom

Grover G. Norquist, a leading Republican strategist
"We will hunt them down one by one and extinguish their funding sources."

MEDICARE UNDER HEALTH CARE REFORM

The Health Security Act proposes to slow the rate of growth of costs in the Medicare program, as well as to provide enhanced benefits to Medicare enrollees. The changes we propose will be within the framework of a thorough reorganization of the health care system in which everyone stands to gain.

- In the context of a plan that will bring down private sector costs, we can achieve Medicare savings without shifting costs to the private sector or endangering beneficiaries' access to services. The President's plan -- and virtually every Democratic and Republican health care plan that has been proposed -- recognizes that we can save money by lowering the rate of growth in Medicare and Medicaid.

- Our bill identifies $124.4 billion in specific, scorable, line-by-line savings in the Medicare program. That's $124.4 billion dollars to redirect in the interest of the health of all Americans and in the interest of the nation's economy.

- This amount is comparable to the savings proposed by the Senate Republican plan, and less than the savings called for by some single-payer proposals. And while the amount of our savings may seem high today, we must keep in mind they will be taken from a future base of $1.2 trillion in projected Medicare spending over the years 1995 to 2000. What's more, the $124.4 billion will only reduce the growth in Medicare spending from triple the inflation rate to double.

- A significant portion of the savings from these proposals are largely a result of eliminating or reducing payments to providers that were originally intended to ease the financial pressures created by uncompensated care. With universal coverage, virtually all care will be compensated.

- Lowering the rate of growth in Medicare program expenditures is perhaps the most important thing we can do for beneficiaries. Lower expenditures over time mean that beneficiaries pay less out-of-pocket in the form of coinsurance and deductibles. It also means that future Medicare beneficiaries can look forward to a stronger, more financially sound, Medicare program because reducing costs in both sectors of the economy will serve to improve the long-term integrity of the Medicare trust funds.

Medicare Savings under Health Care Reform
($ in millions, by FY)

	1994	1995	1996	1997	1998	1999	2000	Total 1994 - 2000
Part A								
Hospital Update at MB-2% in '97-2000	0	0	0	930	2,870	5,610	8,750	18,160 *
IME (3% 1996, incr. by under-65 premiums)	0	0	2,470	3,110	3,470	4,130	4,660	17,840 *
Reduce Medicare Payments for Capital	0	0	995	1,400	2,005	2,610	3,315	10,325 *
Phase Down DSH as States Enter HCR System	0	0	430	1,330	3,670	4,390	4,810	14,630
Moratorium on New LTC Hospitals	0	20	40	70	100	130	170	530 *
Extend OBRA 93 SNF Savings	0	0	80	160	180	200	210	830 *
GME (pay to AHCs, increased by CPI)	0	0	-30	-60	-150	-20	-20	-280 *
Part A Interactions	0	0	0	-110	-300	-510	-730	-1,650 *
Subtotal Part A	0	20	3,985	6,830	11,845	16,540	21,165	60,385
Part A Revenue Proposal								
State and Local Employees before 4/1/86	0	0	1,535	1,518	1,470	1,420	1,366	7,309 #
Part B								
Base MVPS on Real GDP Per Capita (Prim. Care=GDP+1.5%)	0	0	0	275	1,075	1,975	2,775	6,100 *
Set Cumulative Physician Expenditure Goals	0	0	0	-85	1,825	2,475	1,600	5,815 *
Reduce CF by 3% in 1996, Except Primary Care	0	250	475	525	550	575	600	2,975 *
Eliminate Formula-Driven Overpayment in Hospital OPDs	150	1050	1,300	1,690	2,190	2,750	3,480	12,610 *
Competitively Bid for Medicare Labs	0	140	220	260	290	320	360	1,590
Competitively Bid for Part B Services	0	110	190	210	240	270	300	1,320
Income Related Premium ($90K/$115K, $15 K phase-in)	0	0	350	950	930	1,060	1,200	4,490 ##
Interaction	0	0	0	-15	-30	-75	-130	-250
Reestablish Lab Coinsurance (20%)	0	650	1,070	1,230	1,380	1,540	1,720	7,590 *
Part B Premiums	0	0	0	0	0	1,770	4,310	6,080 *
Interaction	0	0	-710	-1,090	-2,140	-2,770	-3,180	-9,890 *
High Priced Medical Staffs	0		0	0	500	780	1,040	2,320 *
Prohibition on balance billing	0	0	-130	-250	-260	-270	-290	-1,200 *
Subtotal, Part B	150	2,200	2,765	3,700	6,550	10,400	13,785	39,550
Parts A & B								
Extend OBRA 93 Home Health Savings	0	0	0	480	600	650	690	2,420 *
Home Health Limits: 100% Median	0	0	0	10	160	230	250	650 *
10% HHA Coins. (after 30 days post-discharge)	0	230	1,400	1,560	1,680	1,800	1,920	8,590 *
Expand Centers of Excellence								
Part A	0	0	60	70	70	70	70	340
Part B	0	0	40	40	40	40	40	200
Extend Medicare Secondary Payor (MSP) Data Match	0	0	0	0	0	195	330	525 *
MSP Disabled: change threshold from 100 to 20, 1/1/98	0	0	0	0	150	240	260	650 *
Extend OBRA 93 Provision on MSP for Disabled	0	0	0	0	0	990	1,340	2,330 *
Extend OBRA 93 MSP ESRD Provision	0	0	0	0	0	75	105	180 *
HMO Payment Improvement	0	30	90	165	250	350	400	1,285 *
Subtotal Part A & B	0	260	1,590	2,325	2,950	4,640	5,405	17,170
SAVINGS, TOTAL PACKAGE	150	2,480	9,875	14,373	22,815	33,000	41,721	124,414

* indicates OACT pricing.
# indicates net Treasury pricing.
includes Treasury estimates of change in income and OACT estimates of reduced outlays for those who drop Part B coverage.

November 17, 1993

MEDICARE SAVINGS PROPOSALS for HEALTH REFORM
($ in millions)

PART A PROPOSALS

Reduce the Hospital Market Basket Index (HMBI) Update by 2% in FY 1997-2000. Medicare changes the inpatient per-discharge standardized amount by a certain amount every year to reflect input cost changes and Congressional direction. OBRA 93 reduced the HMBI in FYs 94 - 97 by 2.5, 2.5, 2, and 0.5 percentage points respectively, to reflect greater efficiencies in hospitals. This proposal would reduce the market basket updates by 2% for FY 1997 - FY 2000. Since the market basket is projected to increase 5% annually, and case mix is projected to increase 2% per year, hospitals can still expect an overall 5% increase per year.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$0	930	2,870	5,610	8,750	$18,160

Reduce Indirect Medical Education (IME) Adjustment to 3.0% in FY 1996. A portion of the IME is intended to compensate hospitals for uncompensated care. Universal coverage, however, will ensure payment for all patients and essentially eliminate uncompensated care. In 1996, the IME adjustment will be lowered to 3.0% under this proposal. Beginning in FY 1997, the aggregate amount of IME payments will be increased by the projected national average increase in premiums for the under-65 population for those States that opt into the reformed system; by 1998, all Medicare IME payments will be made in this fashion. These payments will be appropriated to a national pool to finance the higher costs of academic health centers. The cash flow effect for IME payments is built into these estimates.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$2,470	3,110	3,470	4,130	4,660	$17,840

Adjust Inpatient Capital Payments to Reflect Better Cost Data. This proposal combines three inpatient capital payment adjustments to reflect more accurate base year data and cost projections. The first piece would reduce inpatient capital payments to hospitals excluded from Medicare's prospective payment system (PPS) by 15% for FY 1996 - 2000. PPS-excluded hospitals, currently paid at full costs, do not have an incentive for efficiency. The second piece would reduce PPS Federal capital payments by 7.31 percent and hospital-specific amount by 10.41 percent to reflect new data on the FY 1989 capital cost per discharge and the increase in Medicare inpatient costs from FY 1990 to FY 1992. The last piece would reduce payments for hospital inpatient capital through a 22.1% reduction to the FY 1996 - 2000 updates of the capital rates. Current data indicate that Medicare inpatient capital cost per discharge increased 77.5% during the years immediately before the introduction of prospective payment for capital-related costs (FY 1986 - FY 1991). The identifiable variables for capital costs only increased 38.2% over the same period. This proposal would reduce the update to the capital rates by 4.9% each year during FY 1996-2000 to recover excess capital spending.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$995	1,400	2,005	2,610	3,315	$10,325

Revise the Disproportionate Share Hospital (DSH) Adjustment. Hospitals that treat a disproportionate share of low-income patients receive an additional payment. Studies show that the additional payment overcompensates for the higher costs associated with treating low-income Medicare patients. In the reformed system with universal coverage, DSH can be reduced. This proposal would replace the current DSH program with a new program as States come into the new system. The new program would assist hospitals serving the largest share of low-income patients.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$430	1,330	3,670	4,390	4,810	$14,630

Moratorium on PPS-Exempt Long-Term Care Hospitals. Long-term care hospitals, which have an average length of stay of over 25 days, are currently exempt from the PPS system, receiving cost-based reimbursement from Medicare, subject to a rate-of-increase limit. This proposal would pay new long-term care hospitals under the PPS system. Alternatively, these hospitals could seek reclassification as psychiatric or rehabilitation hospitals, or become certified as skilled nursing facilities (SNFs), for example, and be paid under the SNF cost limit structure.

Savings

1995	1996	1997	1998	1999	2000	1995 - 2000
$20	40	70	100	130	170	$530

Extend OPRA 93 Provision; Eliminate Catch-Up after SNF Freeze Expires. OBRA 93 established a two-year freeze on updates to the cost limits for skilled nursing facilities (SNFs). A "catch-up," however, is allowed after the SNF freeze expires on October 1, 1995; new cost limits would be established that do not reflect the effects of the freeze. This proposal would eliminate the "catch-up" by recalculating the percent of the mean that would serve as the cost limit. The recalculation would be calibrated to result in the same amount of savings as a continuation of the freeze.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$80	160	180	200	210	$830

Graduate Medical Education: Effect of National Pool. Under the legislation, Medicare would pay into two national pools: one for direct medical education, and one for academic health centers. The projected Medicare spending for direct and indirect medical education would be transferred to the Secretary for those States that have opted into the reformed system; by 1998, all States will be folded into the new system. These funds will be transferred out of the Trust Funds faster than they are currently paid to hospitals. This will result in a slight cost to Medicare. The costs displayed here are the cash flow effect for direct graduate medical education.

Costs

	1996	1997	1998	1999	2000	1996 - 2000
	($30)	(60)	(150)	(20)	(20)	($280)

Interaction Costs

PART A INTERACTION	($0)	(110)	(300)	(510)	(730)	($1,650)

PART A REVENUE PROPOSAL

Subject All State and Local Employees to Hospital Insurance Tax. State and local jurisdictions can opt to pay the HI payroll tax for State and local workers hired before April 1, 1986, but are not required to do so. The proposal would extend the payroll tax to all remaining exempt State and local workers, who would thus be treated like all other covered workers. Additional revenues would exceed benefit payments for a long time, since 90% of retired State and local workers already receive Medicare benefits through other covered jobs or spousal employment; only about 70%, however, worked in State or local government jobs on which HI taxes were paid.

Savings

1996	1997	1998	1999	2000	1996-2000
$1,535	1,518	1,470	1,420	1,366	$7,309

(Estimates for this proposal were calculated by Treasury Department staff.)

PART B PROPOSALS

Base MVPS on Real GDP Per Capita. This proposal would change the statutory formula that is used to determine the Medicare Volume Performance Standard (MVPS), a target for the rate of growth in Medicare physician expenditures. Currently, the MVPS is based on the average annual growth in the volume and intensity of physicians' services over the preceding five fiscal years. This proposal would substitute the five-year average of growth in real GDP per capita for this volume and intensity factor and the performance standard factor. This change would directly connect the MVPS to the growth rate of the nation's economy. The MVPS for all three categories of physician services (surgical, primary care, and all other) would continue to be adjusted for projected increases in physicians' fees, beneficiary enrollment, and changes resulting from regulatory and legislative activity. The MVPS for primary care services would be given an additional 1-1/2 percentage point upward adjustment. Under current law, there is no upper limit on physician fee increases, but fees cannot decrease by more than five percentage points. This proposal would eliminate the floor on physician fee reductions.

Savings

1996	1997	1998	1999	2000	1996-2000
$0	275	1,075	1,975	2,775	$6,100

Establish Cumulative Growth Targets for Physician Services. Currently, the MVPS for each year is based on the prior year's actual rate of growth in outlays, without regard to the prior year's target rate of growth in outlays. This process weakens the ability of the MVPS to serve as a meaningful target for sustainable growth in Medicare physician spending. Under this proposal, the MVPS for each category of physician services would be built upon a designated base-year MVPS (FY 1995). This initial target would be updated annually for changes in beneficiary enrollment and inflation, but not for actual outlay growth above or below the target. Essentially, physician fee changes in any one year would no longer distort the MVPS for the following years. The annual process for calculating physician fee updates would not change from current law.

Savings

1996	1997	1998	1999	2000	1996-2000
$0	(85)	1,825	2,475	1,600	$5,815

Reduce the Medicare Fee Schedule Conversion Factor by 3% in 1995, Except Primary Care Services. The conversion factor is a dollar amount that converts the fee schedule's relative value units (RVUs) into a payment amount for each physician service. This proposal would reduce the conversion factor by 3% in CY 1995 to account for the excessively high FY 1992 target and 1994 update that is anticipated, except that primary care services would not be reduced.

Savings

1995	1996	1997	1998	1999	2000	1995-2000
$250	475	525	550	575	600	$2,975

Eliminate Formula-Driven Overpayment in Hospital Outpatient Departments. Under current law, Medicare pays for hospital outpatient ambulatory surgery, radiology, and other diagnostic services using a blended payment methodology. Because of a flaw in the statutory payment formula, which assumes a lower coinsurance payment than is actually made, hospitals receive more than the intended payment amount. This proposal would eliminate the flaw in the payment methodology and the resulting overpayment, effective July 1, 1994. In addition, the current payment method gives hospitals strong incentives to increase charges for these services, thus raising beneficiary coinsurance liabilities. Fixing the formula-driven overpayment would mitigate the hospital incentive to raise the charges to Medicare enrollees.

Savings

1994	1995	1996	1997	1998	1999	2000	1994 - 2000
$150	1,050	1,300	1,690	2,190	2,750	3,480	$12,610

Contract Competitively for All Part B Laboratory Services. The Secretary would be required to establish the same kind of competitive acquisition system for Medicare laboratory services as for other selected Part B items and services beginning January 1, 1995. Pricing assumes that competitive contracting will reduce the price of laboratory services by 10%. Medicare laboratory payments currently are projected to grow by 15% to 18% per year. This proposal seeks to curtail the growth rate by lowering the price of tests and reducing the profit incentive for physicians to order unnecessary tests. If the competitive system does not result in a reduction of at least 10 percent in the price of all laboratory services from the price that would otherwise occur in 1996, then the Secretary would reduce Medicare fees for these selected services to achieve an overall 10 percent reduction in price.

Savings

1995	1996	1997	1998	1999	2000	1995 - 2000
$140	220	260	290	320	360	$1,590

Competitively Bid Selected Medicare Part B Items and Services. This proposal would require the HHS Secretary to contract competitively for Medicare services and supplies, based on quality and other standards. The initially planned items for competitive procurement are MRIs, CAT scans, oxygen services, and enteral nutrients. Pricing assumes a 10% reduction in price for these services and supplies. If the competitive system does not result in a reduction of at least 10 percent in the price of these selected services from the price that would otherwise occur in 1996, then the Secretary would reduce Medicare fees for these selected services to achieve an overall 10 percent reduction in price.

Savings

1995	1996	1997	1998	1999	2000	1995 - 2000
$110	190	210	240	270	300	$1,320

Income-Related Part B Premium, Fully Phased-in to 75%. Currently, all Medicare enrollees pay the same Part B premium, regardless of income. This premium is set at approximately 25% of program costs, beginning in 1996; the balance is paid by general revenues. This proposal would charge high-income enrollees a premium up to 75% of program costs. The increase in the premium for single individuals would begin at modified adjusted gross incomes (plus taxable Social Security benefits) of $90,000 and phase up to 75% for those individuals with incomes equal to or above $105,000. The increase for couples would begin at $115,000, with the maximum 75% premium being paid by couples in which both are eligible for Medicare with a combined income of over $130,000.

Savings (includes interaction)

1996	1997	1998	1999	2000	1996 - 2000
$350	935	900	985	1,070	$4,240

Re-establish 20% Coinsurance for Laboratory Services. This proposal would re-establish a 20% coinsurance on all physician office, outpatient, and independent laboratory tests under Medicare Part B, effective January 1, 1995. Congress eliminated the required coinsurance on laboratory services for independent labs and those in hospital outpatient departments in 1984. In 1985, Congress eliminated the coinsurance for physician office laboratory services. Clinical laboratory services are the only services provided under Medicare Part B for which no coinsurance is now required.

Savings

1995	1996	1997	1998	1999	2000	1995-2000
$650	1,070	1,230	1,380	1,540	1,720	$7,590

Extend OBRA 93 Provision: 25% SMI Premium through 2000. OBRA 93 established the Part B premium collections at 25% of program costs for 1996-1998. This proposal would extend the OBRA 93 provision requiring that Part B premium collections cover an estimated 25% of program costs.

Savings

	1996	1997	1998	1999	2000	1996-2000
	$0	0	0	1,770	4,310	$6,080
Interaction	($710)	(1,090)	(2,140)	(2,770)	(3,180)	($9,890)
NET	($710)	(1,090)	(2,140)	(1,000)	1,130	($3,810)

Limit Payments to High-Cost Medical Staffs. This proposal would establish limits on Medicare physician payments per inpatient hospital admission, similar to limits used in other parts of Medicare. The proposal would take effect in 1998. Payment limits would be established based on the median of hospital-specific case-mix adjusted relative value units per admission. For urban hospitals, the limit would be 125% of the national median in 1998 and 1999, and 120% in 2000 and thereafter. For rural hospitals, the limit would be 140% of the national median in 1998 and thereafter. Annually, a hospital-specific per admission relative value would be projected for the upcoming year for each hospital. This projection would be adjusted for each hospital's teaching status and disproportionate share. At the beginning of each year, Medicare would establish a 15% withhold for medical staffs projected to be over the national limit. After the end of each year, Medicare would compare the actual RVUs per admission per hospital to the limit for that year. For medical staffs above the limit, either none or only a portion of the withhold would be returned. For medical staffs below the limit, the entire withhold would be returned.

Savings

1995	1996	1997	1998	1999	2000	1996 - 2000
$0	0	0	500	780	1,040	$2,320

Prohibition on Balance Billing. Physicians and other providers of Part B services are said to "accept assignment" on Medicare claims when they accept the Medicare approved amount as payment in full for covered services. Balance-billing (also called extra-billing) occurs when providers charge more than the Medicare approved amount -- Medicare pays 80% of the approved amount and the beneficiary or other payor (e.g., Medigap insurance) is responsible for paying the balance. Balance-billing is prohibited under current law for most Part A and B services. Physicians may not charge more than 15% over the Medicare approved amount for their services, and only about 6% of all physician dollars are billed on an unassigned basis. Elimination of balance-billing remaining in Medicare will make for consistent treatment of all services within Medicare and between Medicare and the health alliance-approved plans serving the under-65 population. It will also reduce beneficiary confusion, enhance beneficiaries' financial protection, and simplify carrier administration. This proposal will mandate assignment and prohibit all balance-billing by providers of Part B services effective January 1, 1996. The costs from this proposal arise largely from elimination of the participating physician payment differential.

Costs

1996	1997	1998	1999	2000	1996 - 2000
($130)	(250)	(260)	(270)	(290)	($1,200)

PARTS A AND B PROPOSALS

Extend OBRA 93 Provision: Eliminate Catch-Up after Home Health Freeze Expires. OBRA 93 eliminated the inflation adjustment to the home health limits for two years, FY 1994-1995. This proposal would eliminate the inflation "catch-up" -- currently allowed after the freeze expires on July 1, 1996 -- by recalculating the percent of the mean that would produce the same amount of savings as if the freeze continued. HCFA actuaries estimate this to be 100% of the mean.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$0	480	600	650	690	$2,420

Lower Home Health Limits to 100% of Median. Home health is projected to rise over 10% a year through 1998, including 33% growth in 1994. This proposal would lower the cost limits to 100% of the median for cost reporting periods beginning on or after July 1, 1997. In other words, Medicare would reimburse home health agencies at a rate no higher than the costs encountered by half of the agencies.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$0	10	160	230	250	$650

Require a 10% Copayment on All Home Health Visits for Visits other than Those Occurring 30 Days after a Hospital Discharge. Home health is one of the fastest growing benefits in Medicare, with a projected increase in home health outlays of nearly 33% in 1994. Medicare enrollees do not currently pay cost-sharing on home health care. This provision would charge a copayment on all home health visits except those received within 30 days of an inpatient hospital discharge; these visits are less discretionary and more intensively rehabilitative. Enrollees who receive home health without an inpatient stay would pay the 10% copayment on all services. The copayment would be equal to 10% of the average cost per visit.

Savings

1995	1996	1997	1998	1999	2000	1995 - 2000
$230	1,400	1,560	1,680	1,800	1,920	$8,590

Expand Centers of Excellence. HCFA has initiated two bundled payment demonstration projects that show potential for Medicare savings. These projects involve contracting with "Centers of Excellence" that perform coronary artery bypass graft (CABG) surgery and cataract surgery. By expanding this concept to all urban areas, contracting with individual centers using a flat payment rate for all services associated with the cataract or CABG surgery, Medicare would be able to reduce costs. The Secretary also would be granted the authority to designate other services that lend themselves to this approach. Beneficiaries would not be required to receive services at these centers, but would be encouraged to do so through rebates representing 10% of the government's savings from the center. Pricing assumes a 10% discount in the price of services for the 20 percent of beneficiaries who are assumed to use the centers.

Savings

	1996	1997	1998	1999	2000	1996 - 2000
Part A	$60	70	70	70	70	$340
Part B	$40	40	40	40	40	$200

Extend OBRA 93 Provision: Medicare Secondary Payor (MSP) Data Match with SSA and IRS. OBRA 93 included an extension of the data match between HCFA, IRS, and the Social Security Administration to identify the primary payors for Medicare enrollees with health coverage in addition to Medicare. This proposal would extend that provision beyond its scheduled expiration date of 1998.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$0	0	0	195	330	$525

Establish a Threshold of 20 Employees for MSP for the Disabled. OBRA 93 extended through 1998 an OBRA 90 provision making Medicare the secondary payor for disabled enrollees with employer-based health insurance. The provision is applicable to all employers with 100 or more employees. This proposal would lower the employee threshold from 100 to 20 employees beginning on January 1, 1998. With community rating under health care reform, small employers will no longer be vulnerable to paying higher premiums for covering disabled or other high-risk individuals. A separate provision in the Health Security Act addressing alliance enrollment of Medicare beneficiaries who work or whose spouses work would eliminate the employee threshold. The provision would require all employer-sponsored plans to cover workers, dependents of workers and workers' spouses who are eligible for Medicare.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$0	0	150	240	260	$650

Extend OBRA 93 Provision: MSP for Disabled. OBRA 93 extended through 1998 an OBRA 90 provision making Medicare the secondary payor for disabled beneficiaries with employer-based health insurance. This proposal would extend this provision permanently.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$0	0	0	990	1,340	$2,330

Extend OBRA 93 Provision: Medicare Secondary Payor Provisions for ESRD Patients. OBRA 93 extended through FY 1998 a provision that makes Medicare the secondary payor for individuals with end stage renal disease (ESRD) enrolled in employer group health plans for 18 months after they become eligible for Medicare benefits. This provision permanently extends the MSP provision for individuals with ESRD. A separate provision in the Health Security Act addressing alliance enrollment of Medicare beneficiaries who work or whose spouses work would provide for coverage of individuals with end stage renal disease for as long as the individual requires care. The provision would require all employer-sponsored plans to cover workers, dependents of workers and workers' spouses who are eligible for Medicare.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$0	0	0	75	105	$180

HMO Payment Improvement. Medicare pays 95% of the average adjusted per capita cost (AAPCC) for Medicare enrollees in Medicare-contracted HMOs. This proposal would establish a range around the Part A and Part B components of the AAPCC that would presumably encourage HMOs to participate in Medicare while establishing reasonable limits on reimbursement for high-cost counties. The ceiling would be 150% of the national average Part B component of the AAPCC and 170% for the Part A component of the AAPCC, with a floor established at 80%. The range would be phased-in over a four-year period, beginning in 1995.

Savings

1995	1996	1997	1998	1999	2000	1995 - 2000
$30	90	165	250	350	400	$1,285

TOTAL SAVINGS

1994	1995	1996	1997	1998	1999	2000	1994-2000
$150	2,480	9,875	14,373	22,815	33,000	41,721	$124,414

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

November 16, 1993

TO: IRA MAGAZINER
MELANNE VERVEER
BOB BOORSTIN
MARLA ROMASH
GENE SPERLING

FROM: NANCY-ANN MIN Nam

RE: MEDICARE SAVINGS PROPOSALS FOR HEALTH REFORM

Attached is a description of each of the Medicare savings proposals that are included in the $124 billion package to finance the health care reform proposal. Both the Energy & Commerce and Ways and Means Committees have requested this information for several weeks now, and it appears that Bruce Vladeck will be testifying later this week before Energy & Commerce on the specifics of the Medicare savings proposals. I would appreciate your reviewing these descriptions -- which have been developed by OMB staff in conjunction with HHS staff -- and letting me know whether we can make this available to the Hill and other interested parties.

Please let me hear from you by Wednesday early afternoon, as the Energy & Commerce hearing is currently scheduled for Thursday.

cc: Barry Toiv

November 14, 1993

MEDICARE SAVINGS PROPOSALS for HEALTH REFORM
($ in millions)

PART A PROPOSALS

Reduce the Hospital Market Basket Index (HMBI) Update by 2% in FY 1997-2000. Medicare changes the inpatient per-discharge standardized amount by a certain amount every year to reflect input cost changes and Congressional direction. OBRA 93 reduced the HMBI in FYs 94 - 97 by 2.5, 2.5, 2, and 0.5 percentage points respectively, to reflect greater efficiencies in hospitals. This proposal would reduce the market basket updates by 2% for FY 1997 - FY 2000. Since the market basket is projected to increase 5% annually, and case mix is projected to increase 2% per year, hospitals can still expect an overall 5% increase per year.

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$0	930	2,870	5,610	8,750	$18,160

Reduce IME Adjustment to 3.0% in FY 1996. A portion of the IME is intended to compensate hospitals for uncompensated care. Universal coverage, however, will ensure payment for all patients and, in theory, eliminate uncompensated care. In 1996, the IME adjustment will be lowered to 3.0% under this proposal. Beginning in FY 1997, the aggregate amount of IME payments will be increased by the projected national average increase in premiums for the under-65 population for those States that opt into the reformed system; by 1998, all Medicare IME payments will be made in this fashion. These payments will be appropriated to a national pool to finance the higher costs of academic health centers. The cash flow effect for IME payments is built into these estimates.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$2,470	3,110	3,470	4,130	4,660	$17,840

Adjust inpatient capital payments to reflect better cost data. This proposal combines three inpatient capital payment adjustments to reflect more accurate base year data and cost projections. The first piece would reduce inpatient capital payments to PPS-excluded hospitals by 15% for FY 1996 - 2000. PPS-excluded hospitals, currently paid at full costs, do not have an incentive for efficiency. The second piece would reduce PPS Federal capital payments by 7.31 percentage points to reflect new data on the FY 1989 capital cost per discharge and the increase in Medicare inpatient costs from FY 1990 to FY 1992. The last piece would reduce payments for hospital inpatient capital through a 22.1% reduction to the FY 1996 - 2000 updates of the capital rates. Current data indicate that Medicare inpatient capital cost per discharge increased 77.5% during the years immediately before the introduction of prospective payment for capital-related costs(FY 1986 - FY 1991). The identifiable variables for capital costs only increased 38.2% over the same period. This proposal would reduce the update to the capital rates by 4.9% each year during FY 1996-2000 to recover excess capital spending.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$995	1,400	2,005	2,610	3,315	$10,325

Phase Down the Disproportionate Share Hospital (DSH) Adjustment to 25% by 1998. Hospitals that treat a disproportionate share of low-income patients receive an additional payment. Studies show that the additional payment overcompensates for the higher costs associated with treating low-income Medicare patients. In the reformed system with universal coverage, DSH can be reduced. This proposal would replace the current DSH program with a new program as States come into the new system. The new program would assist hospitals serving the largest share of low-income patients.

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Savings

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$20	40	70	100	130	170	$530

Expand Centers of Excellence. HCFA has initiated two bundled payment demonstration projects that show potential for Medicare savings. These projects involve contracting with "Centers of Excellence" that perform coronary artery bypass graft (CABG) surgery and cataract surgery. By expanding this concept to all urban areas, contracting with individual centers using a flat payment rate for all services associated with the cataract or CABG surgery, Medicare would be able to reduce costs. The Secretary also would be granted the authority to designate other services that lend themselves to this approach. Beneficiaries would not be required to receive services at these centers, but would be encouraged to do so through rebates or reductions in coinsurance representing 10% of the government's savings from the center. Pricing assumes a 10% discount in the price of services for the 20 percent of beneficiaries who are assumed to use the centers.

Savings

	1996	1997	1998	1999	2000	1996 - 2000
Part A	$60	70	70	70	70	$340
Part B	$40	40	40	40	40	$200

Extend OBRA 93 Provision: Eliminate Catch-Up after SNF Freeze Expires. OBRA 93 established a two-year freeze on updates to the cost limits for skilled nursing facilities. A "catch-up," however, is allowed after the SNF freeze expires on October 1, 1995, by reverting back to using the most recent audited cost data and applying a market basket update to come up with new cost limits. This proposal would eliminate the "catch-up" by recalculating the percent of the mean that would serve as the cost limit. The recalculation would be calibrated to result in the same amount of savings as a continuation of the freeze.

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$0	480	600	650	690	$2,420

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Costs

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Savings

1996	1997	1998	1999	2000	1996-2000
$1,535	1,518	1,470	1,420	1,366	$7,309

(Estimates for this proposal were calculated by Treasury Department staff.)

PART B PROPOSALS

Base MVPS on Real GDP Per Capita. This proposal would change the statutory formula that is used to determine the Medicare Volume Performance Standard (MVPS), a target for the rate of growth in Medicare physician expenditures. Currently, the MVPS is based on the average annual growth in the volume and intensity of physicians' services over the preceding five fiscal years. This proposal would substitute the five-year average of growth in real GDP per capita for this volume and intensity factor and the performance standard factor. This change would directly connect the MVPS to the growth rate of the nation's economy. The MVPS for all three categories of physician services (surgical, primary care, and all other) would continue to be adjusted for projected increases in physicians' fees, beneficiary enrollment, and changes resulting from regulatory and legislative activity. The MVPS for primary care services would be given an additional 1-1/2 percentage point upward adjustment. Under current law, there is no upper limit on physician fee increases, but fees cannot decrease by more than five percentage points. This proposal would eliminate the floor on physician fee reductions.

Savings

1996	1997	1998	1999	2000	1996-2000
$0	275	1,075	1,975	2,775	$6,100

Establish Cumulative Growth Targets for Physician Services. Currently, the MVPS for each year is based on the prior year's actual rate of growth in outlays, without regard to the prior year's target rate of growth in outlays. This process weakens the ability of the MVPS to serve as a meaningful target for sustainable growth in Medicare physician spending. Under this proposal, the MVPS for each category of physician services would be built upon a designated base-year MVPS (FY 1995). This initial target would be updated annually for changes in beneficiary enrollment and inflation, but not for actual outlay growth above or below the target. Essentially, physician fee changes in any one year would no longer distort the MVPS for the following years. The annual process for calculating physician fee updates would not change from current law.

Savings

1996	1997	1998	1999	2000	1996-2000
$0	(85)	1,825	2,475	1,600	$5,815

Reduce the Medicare Fee Schedule Conversion Factor by 3% in 1995, Except Primary Care Services. The conversion factor is a dollar amount that converts the fee schedule's relative value units (RVUs) into a payment amount for each physician service. This proposal would reduce the conversion factor by 3% in CY 1995 to account for the excessively high FY 1992 target and 1994 update that is anticipated, except that primary care services would not be reduced.

Savings

1995	1996	1997	1998	1999	2000	1995-2000
$250	475	525	550	575	600	$2,975

Competitively Bid Selected Medicare Part B Items and Services. This proposal would require the HHS Secretary to contract competitively for Medicare services and supplies, based on quality and other standards. The initially planned items for competitive procurement are MRIs, CAT scans, oxygen services, and enteral nutrients. Pricing assumes a 10% reduction in price for these services and supplies. If the competitive system does not result in a reduction of at least 10 percent in the price of these selected services from the price that would otherwise occur in 1996, then the Secretary would reduce Medicare fees for these selected services to achieve an overall 10 percent reduction in price for services and supplies provided after January 1, 1995.

Savings

1995	1996	1997	1998	1999	2000	1995 - 2000
$110	190	210	240	270	300	$1,320

Contract Competitively for All Part B Laboratory Services. The Secretary would be required to establish the same kind of competitive acquisition system for Medicare laboratory services as for other selected Part B items and services beginning January 1, 1995. Pricing assumes that competitive contracting will reduce the price of laboratory services by 10%, but that some savings will be offset by volume increases. Medicare laboratory payments currently are projected to grow by 15% to 18% per year. This proposal seeks to curtail the growth rate by lowering the price of tests and reducing the profit incentive for physicians to order unnecessary tests. If the competitive system does not result in a reduction of at least 10 percent in the price of all laboratory services from the price that would otherwise occur in 1996, then the Secretary would reduce Medicare fees for these selected services to achieve an overall 10 percent reduction in price.

Savings

1995	1996	1997	1998	1999	2000	1995 - 2000
$140	220	260	290	320	360	$1,590

Limit Payments to High-Cost Medical Staffs. This proposal would establish limits on Medicare physician payments per inpatient hospital admission, similar to limits used in other parts of Medicare. The proposal would take effect in 1998. Payment limits would be established based on the median of hospital-specific case-mix adjusted relative value units per admission. For urban hospitals, the limit would be 125% of the national median in 1998 and 1999, and 120% in 2000 and thereafter. For rural hospitals, the limit would be 140% of the national median in 1998 and thereafter. Annually, a hospital-specific per admission relative value would be projected for the upcoming year for each hospital. This projection would be adjusted for each hospital's teaching status and disproportionate share. At the beginning of each year, Medicare would establish a 15% withhold for medical staffs projected to be over the national limit. After the end of each year, Medicare would compare the actual RVUs per admission per hospital to the limit for that year. For medical staffs above the limit, either none or only a portion of the withhold would be returned. For medical staffs below the limit, the entire withhold would be returned.

Savings

1995	1996	1997	1998	1999	2000	1996 - 2000
$0	0	0	500	780	1,040	$2,320

Eliminate Formula-Driven Overpayment in Hospital Outpatient Departments. Under current law, Medicare pays for hospital outpatient ambulatory surgery, radiology, and other diagnostic services using a blended payment methodology. Because of a flaw in the statutory payment formula, which assumes a lower coinsurance payment than is actually made, hospitals receive more than the intended payment amount. This proposal would eliminate the flaw in the payment methodology and the resulting overpayment, effective July 1, 1994. In addition, the current payment method gives hospitals strong incentives to increase charges for these services, thus raising beneficiary coinsurance liabilities. Fixing the formula-driven overpayment would mitigate the hospital incentive to raise the charges to Medicare enrollees.

Savings

1994	1995	1996	1997	1998	1999	2000	1994 - 2000
$150	1,050	1,300	1,690	2,190	2,750	3,480	$12,610

Re-establish 20% Coinsurance for Laboratory Services. This proposal would re-establish a 20% coinsurance on all physician office, outpatient, and independent laboratory tests under Medicare Part B, effective January 1, 1995. Clinical laboratory services are the only services provided under Medicare Part B for which no coinsurance is required.

Savings

1995	1996	1997	1998	1999	2000	1995-2000
$650	1,070	1,230	1,380	1,540	1,720	$7,590

Extend OBRA 93 Provision: 25% SMI Premium through 2000. OBRA 93 established the Part B premium collections at 25% of program costs for 1996-1998. This proposal would extend the OBRA 93 provision that Part B premium collection cover an estimated 25% of program costs through 2000.

Savings

	1996	1997	1998	1999	2000	1996-2000
	$0	0	0	1,770	4,310	$6,080
Interaction	($710)	(1,090)	(2,140)	(2,770)	(3,180)	($9,890)
NET	($710)	(1,090)	(2,140)	(1,000)	1,130	($3,810)

Income-Related Part B Premium, Fully Phased-in to 75%. The monthly Part B premium paid by enrollees currently is projected to cover 25% of Part B costs through 1998. All enrollees pay the same amount, regardless of age or income. This proposal would charge high-income enrollees a premium up to 75% of program costs. The increase in the premium for single individuals would begin at modified adjusted gross incomes (plus taxable Social Security benefits) of $90,000 and phase up to 75% for those individuals with incomes equal to or above $105,000. The increase for couples would begin at $115,000, with the maximum 75% premium being paid by couples in which both are eligible for Medicare with a combined income of over $130,000.

Savings (includes interaction)

1996	1997	1998	1999	2000	1996 - 2000
$350	935	900	985	1,070	$4,240

Prohibition on Balance Billing. Physicians and other suppliers of Part B services are said to accept assignment on Medicare claims when they accept the Medicare approved amount as payment in full for covered services. Under current law, physicians who do not accept assignment may charge up to 115% of the Medicare approved amount -- Medicare will pay 80% of the approved amount and the beneficiary or other payor (e.g., Medigap insurance) must pay the remainder. Only a limited amount of balance billing is permitted for physicians' services, but elimination of extra-billing in Medicare will make for consistent treatment of all services within Medicare and between Medicare and the rest of the system. Moreover, it will reduce beneficiary confusion and simplify carrier administration. This proposal will prohibit all providers of Part B services from charging more than 100% of the Medicare allowed amount effective January 1, 1996 and thereafter.

Costs

1996	1997	1998	1999	2000	1996 - 2000
($130)	(250)	(260)	(270)	(290)	($1,200)

PARTS A AND B PROPOSALS

Extend OBRA 93 Provision: Medicare Secondary Payor (MSP) Data Match with SSA and IRS. OBRA 93 included an extension of the data match between HCFA, IRS, and the Social Security Administration to identify the primary payors for Medicare enrollees with health coverage in addition to Medicare. This proposal would extend that provision beyond its scheduled expiration date of 1998.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$0	0	0	195	330	$525

Extend OBRA 93 Provision: MSP for Disabled. OBRA 93 extended through 1998 an OBRA 90 provision making Medicare the secondary payor for disabled beneficiaries with employer-based health insurance. This proposal would extend this provision permanently.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$0	0	0	990	1,340	$2,330

Establish a Threshold of 20 Employees for MSP for the Disabled. OBRA 93 extended through 1998 an OBRA 90 provision making Medicare the secondary payor for disabled enrollees with employer-based health insurance. The provision is applicable to all employers with 100 or more employees. This proposal would lower the employee threshold from 100 to 20 employees beginning on January 1, 1998. With community rating under health care reform, small employers will no longer be vulnerable to paying higher premiums for covering disabled or other high-risk individuals. A separate provision in the Health Security Act addressing alliance enrollment of Medicare beneficiaries who work or whose spouses work would eliminate the employee threshold. The provision would require all employer-sponsored plans to cover workers, dependents of workers and workers' spouses who are eligible for Medicare.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$0	0	150	240	260	$650

Extend OBRA 93 Provision: Medicare Secondary Payor Provisions for ESRD Patients. OBRA 93 extended through FY 1998 a provision that makes Medicare the secondary payor for individuals with end stage renal disease enrolled in employer group health plans for 18 months after they become eligible for Medicare benefits. This provision permanently extends the MSP provision for individuals with ESRD. A separate provision in the Health Security Act addressing alliance enrollment of Medicare beneficiaries who work or whose spouses work would provide for coverage of individuals with end stage renal disease for as long as the individual requires care. The provision would require all employer-sponsored plans to cover workers, dependents of workers and workers' spouses who are eligible for Medicare.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$0	0	0	75	105	$180

HMO Payment Improvement. Medicare pays 95% of the average adjusted per capita cost (AAPCC) for Medicare enrollees in Medicare-contracted HMOs. This proposal would establish a range around the Part A and Part B components of the AAPCC that would presumably encourage HMOs to participate in Medicare while establishing reasonable limits on reimbursement for high-cost counties. The ceiling would be 150% of the national average Part B component of the AAPCC and 170% for the Part A component of the AAPCC, with a floor established at 80%. The range would be phased-in over a four-year period, beginning in 1995.

Savings

1995	1996	1997	1998	1999	2000	1995 - 2000
$30	90	165	250	350	400	$1,285

TOTAL SAVINGS

1994	1995	1996	1997	1998	1999	2000	1994-2000
$150	2,480	9,875	14,373	22,815	33,000	41,721	$124,414

file

control." In addition, the Clinton health plan "will cut the deficit by $58[B] by the year 2000. ... More importantly, health care reform fundamentally lowers the growth of health care spending -- and thus lowers the structural deficit in the years beyond 2000" (release, 11/19).

***5 MEDICARE: CUTS TO HIT HOSPITALS HARDEST**

HCFA Admin. Bruce Vladeck testified 11/18 that Medicare "can be cut $124[B] over five years to help finance President Clinton's health plan without 'putting Medicare beneficiaries at risk,'" WASH. POST reports. Vladeck told the Energy and Commerce health subcmte. that the cuts, mostly in payments to doctors and hospitals, "will only reduce the growth in Medicare spending from triple the inflation rate to double." Vladeck: "In the context of a plan that will bring down private-sector costs, we can achieve Medicare savings without shifting costs or endangering beneficiaries' access to services."

DETAILS ON THE CUTS: POST notes the testimony marked "the first time" the proposed cuts were detailed to Congress and that "by far the biggest Medicare cuts in the $124[B] package come from hospitals." The admin. proposes to: "reduce annual hospital payment increases" ($18B); "reduce special bonuses for the training of interns and residents" ($17.8B); "reduce Medicare payments to cover hospitals' capital expenditures" ($10.3B); "change the payment formula for outpatient services to eliminate an overpayment in the current formula" ($12.6B); and "phase down special payments to hospitals with a disproportionate share of low-income and uninsured patients" ($14.6B). POST notes that "doctors also would face cuts in Medicare payment levels" and that patients would pay higher copayments "for home health services and clinical lab services" and a higher premium if their income exceeds $90,000 or $115,000 for couples.

MEMBERS' REAX: Subcmte. Chair Rep. Henry Waxman (D-CA): "I am disturbed by the magnitude of these cuts. I believe they are excessive and could adversely affect the quality and availability of services for beneficiaries." Waxman noted that Medicare "already pays doctors 30 percent less than private-sector insurers" and asked "who will treat Medicare patients if payment rates are cut even more?" Vladeck said that the cuts had to be made "only in tandem" with controls over the growth of costs in the private sector. Rep. Thomas Bliley (R-VA) "called the Clinton plan a 'guarantee for insolvency.'" Rep. Alex McMillan (R-NC) joined Bliley in "question[ing] the accuracy" of the projections "in view of past errors" in estimating the cost of other health proposals by the CBO "and others."

PROVIDER REAX: AHA said that faced with Medicare cuts "on top of the $56[B] over five years just voted as part of the budget bill, hospitals 'might have to reduce their work forces, reduce services or both'" (Spencer Rich, 11/19). AHA's Rick Pollack "questioned how hospitals will make up the $79[B] in Medicare cuts to hospitals ... crippling those hospitals that can least afford cuts of any kind." Particularly hard hit would be hospitals "treating large numbers of low-income, elderly or rural patients." He noted the new cuts would be "larger than the

hospital community has ever sustained" and would be "simply too big a risk to take." Pollack: "Let's be candid. You can't affect human institutions without affecting human beings" (AHA release, 11/18). The AMA says the proposed cuts reflect "cynicism about physicians as 'deep pockets' from which either reductions in the deficit or health system reform can be funded" (Rich, 11/19). USA TODAY identifies nurses as "losers" under the revised plan, because their Medicare reimbursements "would not be as high as previously set" (Richard Wolf, 11/19).

==== ELEMENTS OF REFORM ====

***6 CIGARETTE TAX: SOUTHERN LAWMAKERS VOICE CONCERN**

W.S. JOURNAL writes about the deals and commitments that Pres. Clinton made that "clinched" the NAFTA win, noting that two NC lawmakers who voted for NAFTA -- Reps. Charlie Rose (D) and Stephen Neal (D) -- had tied their votes to a reduction in the proposed $.75 tobacco tax increase. While a connection could not be confirmed and WH officials "denied that there were any tobacco deals" for the two votes, JOURNAL reports that House Ways and Means Chair Rep. Dan Rostenkowski (D-IL), who had been meeting recently with the tobacco state lawmakers, "sidestepped questions late [11/18] about whether he'd offered any assurances to them that his committee would try to cut the proposed tax increase when the panel drafts a health bill next year" (Jackie Calmes, 11/19).

DAY OF THE GREAT AMERICAN SMOKEOUT: The House Ways and Means Cmte. heard testimony 11/18 about the proposed tobacco tax increase. Lexington HERALD-LEADER reports that while tobacco farmers told the cmte. about the potential for job-loss, House "members also told their own personal stories on the other side of the issue -- stories told of family members who had lost not just their jobs, but their lives." Rep. Scotty Baesler (D-KY) "said he was not arguing against the deadly effects of tobacco or even the high health care costs that it produces. Instead, he charged that alcohol also produces serious health problems and should be part of any tax increase." Baesler: "It is the height of arrogance and hypocrisy to fault and target tobacco and ignore the truth about alcohol abuse." But Rep. Hal Rogers (R-KY) countered: "What business is it of this committee or this government to tell an individual ... whether they should smoke? Or eat Twinkies?" Rep. Sander Levin (D-MI) "said that perhaps the tax should be increased beyond 75 cents and the extra money should be set aside to help farmers" (Bob Geiger, 11/19). Rostenkowski said in an interview, "It's an issue that could be very well be adopted in the committee," however, "we're not going to kill an industry" (Peter Hardin, 11/19). Frank K. Chaloupka, testifying for the American Lung Assn., said public health researchers and economists have concluded that "higher cigarette excise taxes are the single most effective public policy measure for reducing cigarette smoking."

UNIONS: AP/INVESTOR'S BUSINESS DAILY reports that union officials claimed Clinton's cigarette tax proposal "would destroy 81,000 jobs." KY AFL-CIO Pres. Robert Curtis: "Asking one group

The Health Security Plan

MEDICARE

Under the Health Security plan, Older Americans will see little difference in where, how or from whom they receive their health care. The plan does not cut Medicare-- it reduces the growth in Medicare spending from triple the inflation rate to double.

What older Americans pay -- their share of the cost of health premiums -- will actually decline as growth in the cost of Medicare comes under control, reducing annual cost increases not only for Medicare but also for Medigap policies. Those beneficiaries with incomes of more than $100,000 per year will see a slight rise in monthly payments.

For Medicare benefits will be expanded to cover the costs for prescription drugs. A new program will also be established to provide home- and community-based long-term care. The expected savings in Medicare will be rechanneled into those new benefits.

Slows Spending. Stops Cost Shifting

- The plan to slow the growth in Medicare spending by $124 billion over five years is comparable to the most serious entitlement caps called for during the budget process But because it is done within the context of comprehensive health care reform, it will not shift costs to the private sector and will, in fact, help increase health benefits to older Americans.

- Limits on the growth of private health care spending will help eliminate the massive problem of cost shifting.

- Calls for strict caps on Medicare divorced from such limits would only increase today's hidden tax on private sector premiums. If Medicare payments were simply cut -- so that a hospital was paid $100 for a service that they used to pay $150 -- the hospital would likely charge everyone else $50 more, as it does today.

Provides Prescription Drug Benefits

- Under the new drug benefit, Americans eligible for Medicare will automatically enroll in the new prescription drug benefit when they enroll in the Part B benefit, which cover 97 percent of eligible individuals today. In keeping with current requirements, Part B premiums will increase to cover 25 percent of the cost of the new drug benefit.

- The new drug benefit will carry a $250 annual deductible before coverage begins. Beneficiaries also pay 20 percent of the cost of each prescription up to $1,000. Prescription costs in excess of $1,000 are fully covered by the new benefit. The prescription drug benefit covers all drugs and biological products, including insulin, approved by the Food and Drug Administration and prescribed for medically accepted indications.

Gives Medicare Beneficiaries New Options

- Medicare will continue primarily as a fee-for-service health program but will offer beneficiaries a wider range of health plans, including the option to enroll in a preferred provider networks, or a health maintenance organizations.

- After a state joins the new system, newly eligible Medicare beneficiaries will be able to choose to join Medicare or remain in their alliance-certified health plan.

- States will eventually have the option of integrating all their citizens, including Medicare beneficiaries , into alliances or a single payer system.

- But they will be required to submit a plan to the Secretary of Health and Human Services for approval. They must guarantee that all Medicare beneficiaries have equal or better coverage in the new system than under Medicare, at no additional cost to the Medicare program.

The Health Security Plan

OLDER AMERICANS

Despite federal efforts to meet the health care needs of older Americans at an affordable cost, rising health care fees and changing demographics, have strained our ability to pay. Many older Americans face a choice between medication and food. Long-term care services are largely unavailable unless people virtually impoverish themselves. All too often, early retirees lose their health insurance when employers, faced with overwhelming health care costs, are forced to scale back or drop coverage.

At the same time, the success of Medicare has made Americans over age 65 the only age group that has any degree of health care security today. The Health Security plan preserves this by continuing the Medicare program.

Older Americans will see little change in the new system. They will continue to receive Medicare benefits and see the same doctor or doctors if they choose. But they will also be given new help in paying for prescription drugs and long-term care and opportunities to choose among a broader set of plans.

Prescription Drug Benefit

- Current Medicare benefits will be enhanced to include prescription drug coverage filling a major gap in the health security of older Americans.

- After meeting an annual deductible of $250, the elderly will no longer have to pay the full costs of prescription drugs out-of-pocket.

- Beneficiaries will also pay 20 percent of the cost of each prescription up to a $1,000 annual cap. Prescription costs in excess of $1,000 will be fully covered by the new benefit.

- Aggressive steps will be taken to slow down the costs of prescription drugs which can cost three times more in the United States as in other industrialized nations.

- Education efforts on proper administration of medications will enhance the quality of care and quality of life for older Americans.

Long-Term Care Options

- The Health Security Plan will establish a new home and community-based care program. This will enable 2.2 older Americans to remain in their own homes or with their loved ones, yet still receive the financial support and care they need.

- The Health Security plan will enhance Medicaid nursing home coverage to allow nursing home residents to keep $100 per month for living expenses and retain up to $12,000 in assets instead of today's $2,000. An estimated 1.2 million nursing home residents will benefit from this change.

- Under the Health Security plan, all Americans will be better able to protect themselves against the high cost of long-term care. Private long-term care insurance will be improved through the adoption of new federal standards. Qualified policies will receive the same tax preference as health insurance, making them more affordable as well.

Early Retiree Protection

- People who retire early will no longer have to live in fear of losing their health benefits. Retirees, like working Americans, will be responsible for no more than 20% of the average cost of health premiums.

- Retired people between the ages of 55 and 65 who have worked for at least 10 years but are not yet eligible for Medicare will receive financial assistance from the federal government to cover the employer's share of their premium.

- Early retirees also may get assistance for their share of the premium, if their former employers have a contractual obligations or chose to pay for retiree health benefits. Retirees with incomes near the poverty level will receive assistance from the federal government to assist with these costs.

Why Not "Medicare for All"?

Medicare for all means federal management of the entire health care system. The federal government would effectively set all prices for every reimbursable event, every procedure, every doctor and hospital. Such a system would entangle Washington, even more than today, in the fate of every institution and provider group. The health care system today suffers from a huge overload of excess investment in hospital capacity and technology. Will the federal government be able to make direct, explicit decisions to shut down or consolidate particular hospitals? Because Medicare rates are national, local regions do not receive any benefit if they hold Medicare costs below national levels. Low costs in Rochester, New York, do not translate into lower federal taxes in Rochester. Boston's high costs do not mean higher taxes. Consequently, under Medicare for all, local regions will not have any incentive to resist new, uncalled-for investments in health care. Indeed, such investments will actually represent a way of extracting revenue from taxpayers elsewhere in the country. Medicare for all would pit the federal government against all local interests in a hopeless effort to impose cost-control-from-a-distance. It won't work.

Medicare for all would perpetuate the incentives in health care toward higher volumes of high-cost services. Medicare gives providers no incentive to control inappropriate or unnecessary care or to weigh carefully the value of high-cost, low-benefit technology. Indeed, as with all fee-for-service, Medicare does the opposite: it encourages higher volumes of services, especially technologically intensive ones. Medicare's rate-setting methods do nothing to solve this problem since they affect price but not volume. Nor do the recently imposed volume performance standards for physicians help, since they're enforced through ratcheting down prices. Such price reductions, much research has shown, will actually produce an increase in volume--that is, greater consumption of real resources. Attempting to control expenditures through price reductions not only doesn't work in the long run (there's a limit to how much prices can be ratcheted down before access becomes a problem): the reductions actually penalize conscientious physicians who prescribe appropriately and reward physicians who jack up volume with unneeded procedures and return visits.

Medicare for all would perpetuate the biases toward specialized, high-cost practice and against preventive services. Incentives are built into Medicare's benefit package and pricing structure that skew the allocation of resources in health care toward more

specialized services. The development of the resource-based relative value scale didn't fundamentally change this pattern. This is just another aspect of the politicization of prices: When decisions about relative prices are explicit matters of policy, the prices will favor those groups with the most influence. Medicare for all will mobilize every entrenched interest in the current incentive system to fight to maintain it.

Medicare for all would provide Americans with poor financial protection. Medicare's high cost-sharing puts it below the tenth percentile among private health insurance benefit packages. Its coverage limitations and lack of any catastrophic, stop-loss protection make it a very weak protection. Yet to improve coverage while keeping Medicare's fee-for-service framework is spectacularly expensive. Hence the irony: If we offered Medicare for all to the public, it would be a step down for the great majority. And if we brought Medicare coverage up to par, it would break the bank--and put us on a course toward even more massive increases in health care spending than are forecast today.

Medicare for all would undermine incentives for organized systems of care. Medicare's point of reference is fee-for-service payment; it treats organized systems of care as a side issue and provides little incentive for beneficiaries to sign up or for providers to create such systems. Medicare for all would actually undermine the progress toward integrated health systems being made among the under-65 population. To be sure, we could change Medicare's current treatment of capitation plans. But most advocates of Medicare for all do not contemplate setting up an incentive system that would require beneficiaries to pay the difference in cost between providing the same comprehensive benefit package through integrated health plans and fee-for-service. Such an incentive system would require that the premium for fee-for-service be regional, not national (because integrated health plans are regional); that the benefit packages be uniform to give beneficiaries a basis of price and quality comparison; and that there be an annual enrollment, risk-adjusted capitation payments to the plans, and an independent manager of the competition among the different systems. That arrangement, of course, is managed competition.

Finally, Medicare for all has all the political drawbacks of any single-payer plan. It requires the federal government to raise all the revenue for health care. The money must go to Washington, and then back to the localities, diminishing the sense of a local stake in cost containment or any direct, local control of policies affecting the allocation of the nation's health care resources. One reason that Medicare is subject to immense amounts of fraud is that providers feel no compunction among milking a public fund, which they believe is underpaying them anyway. Given the huge volume of transactions in a fee-for-service system (as well as Medicare's reliance on private intermediaries), the

system has very little way of imposing effective discipline on health care costs. The classic deterrent of indemnity insurance--high cost-sharing--is undermined by the purchase of Medigap policies that, for a large part of the population, remove any deterrent whatsoever. The controls on prices actually produce ever greater volumes. For every attempt at control, there is an equal and opposite pressure group reaction. Medicare's entire history should be a lesson on how not to structure a national health program.

"ABC News has learned that much of the cost of the President's grand design for health care reform will come from funds spent on the poor and the elderly.

Secret documents from the Health Care Task Force reveal the Administration intends to help finance the plan with cuts up to $200 billion over 4 years in Medicare and Medicaid."

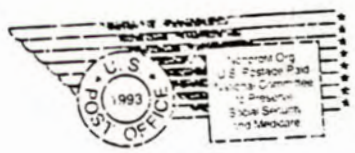
-ABC News

Send Congress this Message:

"Seniors Oppose Unfair and Ill-conceived Cuts in Medicare to Fund Health Care Reform!"

PETITION TO CONGRESS ENCLOSED FOR MR. [redacted]

1



National Committee to Preserve Social Security and Medicare
Martha A. McSteen, President
202-822-9459

ABC NEWS REPORTS DOCUMENTS THAT DISCLOSE PLAN TO FINANCE HEALTH CARE REFORM WITH MEDICARE AND MEDICAID BUDGET CUTS OF UP TO $200 BILLION!

IMMEDIATE ACTION REQUESTED: PETITION TO CONGRESS ENCLOSED

[redacted]

DEAR MR. [redacted]

I urgently request that you sign the enclosed official Petition to Congress.

Members of Congress must receive a strong message from senior Americans.

AND SPECIFICALLY, FROM YOU, MR. [redacted]

Our message is simple:

We oppose recommendations to help pay for a national health car system by excessive cuts in Medicare.

The cuts that have been proposed are simply preposterous.

What's next?

Medicare has already been cut by $100 billion in the 1990 and 1993 budgets. And yet, not one single program has been identified as over-funded.

Will you help me send a strong message to Congress?

(please turn page)

We must say loud and strong:

> "Seniors oppose unfair and ill-conceived cuts in Medicare to pay for health care reform!"

I hope you are among those seniors who were alerted when ABC News recently reported that much of the cost of the President's grand design for health care reform will come from funds spent on the poor and the elderly!

ABC based their report on documents from the Administration's Health Care Task Force. These documents revealed that the Administration intends to help finance new health plans with Medicare and Medicaid cuts of over $200 billion over 4 years.

The media have continued to report proposals for huge cuts in Medicare.

Does this make you angry? This is what Representative Henry Waxman – Chairman of the House Energy and Commerce Subcommittee on Health and the Environment – had to say:

> "I don't think that we are going to be able to finance health care for all Americans on the backs of cutting programs for the elderly and the poor."

What else did Waxman say? Vote to follow up

He even goes as far as to say:

> "If they propose to cut back on Medicare and Medicaid to add funds to the health care system, and at the same time jeopardize the health of the elderly and the poor, they are not going to be able to count on my support."

Representative Pete Stark, Chairman of the Ways and Means Health Subcommittee, said in the *New York Times*:

> "This is like cold fusion. You get all these wonderful results with no effort, no problem. There is a remarkable level of naiveté in their assumptions about what Federal and state legislators will do."

Representatives Waxman and Stark are the chairmen of the House subcommittees that are responsible for Medicare

(next page please)

and Medicaid – they are good friends to have on our side!

But meanwhile, listen to what the White House is saying:

> "No one will be hurt by the plan. In the long run it will provide a universal system where everyone is covered, it will help hold down the cost of health care and improve the system of health care in this country." (White House Press Secretary Dee Dee Myers)

I believe that the Administration is sincere in its efforts to reform our health care system without hurting anyone. But it is completely unrealistic to think that cutting Medicare by almost $125 billion will not hurt seniors.

Remember that phrase that has tripped up so many politicians – "No new taxes"?

The President has promised that no new broad-based tax will be required to pay for his proposal.

But the money must come from somewhere! Regrettably, Mr. Clinton seems to be eyeing Medicare, and Administration officials are considering a proposal to squeeze more than $200 billion of additional savings from Medicare and Medicaid, the federal health programs for the elderly and poor.

I have warned you before and I will do so once again: Further cutbacks of this size in Medicare could mean serious consequences for American seniors.

The Clinton Administration says that these cuts are just a "down payment" on health care reform.

But I ask you to consider, why are seniors the only Americans asked to make this down payment? The answer is, because Medicare is where the money is.

If the President wants older Americans to support his health reform plan, he must insure that all generations, young and old alike, are treated fairly and equitably.

Anything less simply will not fly.

I'm certain you agree with me and I am certain that you yourself are concerned that as the Administration and Congress

(continue on...)

try to control the growth of health care spending – seniors must not be singled out as the ones to suffer.

I've said it before and I'll say it many times in the future – seniors are quite willing to sacrifice. They have already sacrificed.

They believed the promises made by their government. They paid their taxes in good faith and now they are entitled to their Social Security and Medicare benefits.

And they are still willing to do their fair share. But how far can they be expected to go? Medicare has already been cut by $56 billion over five years in this summer's round of budget cuts.

All in all, there is considerable concern and confusion on Capitol Hill and around the country about the proposals of health care planners to put a lid on Medicare costs.

[redacted], YOU AND I MUST JOIN IN THIS CONTROVERSY.

Our voices must be heard. We must send a strong message to Congress. We must say:

> "Seniors oppose unwise and ill-conceived cuts in Medicare to fund health care reform!"

We must send this message now. Immediately.

That's why I urge you to sign the enclosed official Petition and mail it back to me and I will bring it to the attention of your Congressional representatives.

My lobbyists and I are already talking to Senators and Representatives, the Administration and the press, telling them that these cuts are wrong and unfair to seniors.

Please sign your official Petition this very moment and send a message to Capitol Hill saying:

> "Seniors oppose unwise and ill-conceived cuts in Medicare to fund health care reform."

And finally, when you send me your signed Petition, I hope you will also be able to include your personal check of $25

(next page please)

to help us carry on this struggle and our other work on behalf of America's seniors.

As you know, we are strictly a grassroots organization. Our strength comes from individuals like yourself.

We represent you with vigor and we do it in a way that allows you to speak your mind, and at the same time puts us in a position of being able to enter into a dialogue with the Administration, Congress, and the "powers that be" on Capitol Hill.

But to get this job done, we must depend on your support. Your gifts of $25 are a tremendous help to us.

Many of our National Committee Members must live on strict budgets. So whenever anyone sends a gift, I certainly understand the sacrifice involved and deeply appreciate the support.

I want to thank you for reading this letter and I look forward to hearing from you just as soon as possible.

Sincerely,

Martha A. McSteen

Martha A. McSteen, President
National Committee to Preserve
Social Security and Medicare

P.S. I repeat: Help us send a message to Congress.

The message is plain and simple:

"Seniors oppose unfair and ill-conceived cuts in Medicare to fund health care reform! Period!"

The enclosed Petition is registered in your name. Please sign and return it to me immediately.

And if you possibly can, also enclose a gift of $25 to help the National Committee speak out for your rights as seniors.

Again...thanks.

Prepared and mailed by the National Committee to Preserve Social Security and Medicare, a nonprofit, tax-exempt organization, 2000 K Street, N.W., Suite 800, Washington, D.C. 20006.

The National Committee is totally independent of Congress, every government agency, and all political parties. This organization has not been approved or endorsed by the federal government, and this offer is not being made by an agency of the federal government.

Contributions or gifts to the National Committee are not tax-deductible. You need make no special contributions other than annual dues.

Based upon the last three fiscal years, the National Committee spends its budget in approximately the following way: legislative advocacy 32%, educational activities 26%, fund-raising 16%, administration 20%, reserve 6%. Detailed financial reports are available from the National Committee at 2000 K Street, N.W., Suite 800, Washington, D.C. 20006, 202-822-9459, and from the charitable solicitations departments of most states; New York residents should write the NYS Department of State, Office of Charities Registration, 162 Washington Ave., Albany, NY 12231; Virginia residents may obtain a copy of a financial statement from the State Division of Consumer Affairs, P.O. Box 1163, Richmond, VA 23209; West Virginia residents may obtain a summary of the registration and financial documents from the West Virginia Secretary of State, State Capitol, Charleston, WV 25305; Maryland residents should contact the Office of the Secretary of State, State House, Annapolis, MD 21401. The official registration and financial information of the National Committee to Preserve Social Security and Medicare may be obtained from the Pennsylvania Department of State by calling toll-free, within Pennsylvania, 1-800-732-0999. Registration does not imply endorsement. Washington residents may obtain registration and financial information from the Secretary of State by calling toll-free, within Washington, 1-800-332-4483. FLORIDA RESIDENTS MAY OBTAIN A COPY OF THE OFFICIAL REGISTRATION AND FINANCIAL INFORMATION FROM THE DIVISION OF CONSUMER SERVICES BY CALLING TOLL-FREE, WITHIN THE STATE, 1-800-HELP-FLA. REGISTRATION WITH ANY OF THESE STATE GOVERNMENTAL AGENCIES DOES NOT IMPLY ENDORSEMENT, APPROVAL, OR RECOMMENDATION BY THE STATE.

Official Petition
to the
United States Congress

FROM:

[redacted]

PETITION NO:
01116553--3267000210749

WHEREAS: The Health Care Task Force has been considering the possibility of paying for a large part of the proposed national health care system by excessive cuts in Medicare; and

WHEREAS: Medicare was just subjected to $56 billion in cuts for deficit reduction and cannot withstand additional cuts; and

WHEREAS: These cuts will impact most severely the senior citizens and the disabled of America.

THEREFORE, let it be known that I am saying to you, as my representatives in Congress, that there should be no unwise and excessive cuts in Medicare to fund health care reform!

I urge you to find a fair way to fund America's health care reform program, and I urge you to resist unwarranted cuts in Medicare that deprive senior citizens of benefits they have paid for and are eligible to receive.

SIGNED: _____ **DATE:** _____

[redacted]

PLEASE DO NOT DETACH

Don't Cut My Medicare!
Petition Reply

❑ **YES!** I have signed my Petition to the United States Congress telling them not to cut my Medicare to fund health care reform. I have also enclosed my contribution:

❑ **$25** ❑ **Other $**_____

Please make your check payable to NCPSSM (or National Committee to Preserve Social Security and Medicare). Thank you.

❑ No, I can't afford to help you with a contribution, but I have signed my Petition to Congress to fight any attempts to cut Medicare to fund health care reform.

Contributions or gifts to the National Committee are not tax-deductible.

(Please make any necessary corrections to your name and address below.)

TO: **Martha A. McSteen, President**
National Committee to Preserve
Social Security and Medicare
2000 K Street, N.W., Dept. 3267
P.O. Box 96692
Washington, D.C. 20090-6692

FROM:

[redacted]

Why Do We Ask for Special Donations?

Dear Friend,

Your Membership dues in the National Committee have always been only $10 a year.

We haven't increased them in the almost 10 years since our founding because many of our Members simply can't afford more.

We ask for additional donations on an ENTIRELY VOLUNTARY basis because annual dues fall far short of funding our work on your behalf.

We don't expect you to contribute each time we ask. But we hope you will do so when you can — as you always have in the past.

There are 535 Senators and Representatives and hundreds more in the Administration and elsewhere with whom we have to deal. We simply cannot cope with this work without special donations.

So please remember, we ask only because extra donations are essential — but we only expect you to help when and as you can.

We are deeply appreciative for the extra help we have always received and thank you very much for it.

Sincerely,

Martha A. McSteen

Martha A. McSteen
President

PLEASE RESPOND TODAY!

We want to hear from you as soon as possible!

1. Sign and mail the Petition to Congress.
2. Please enclose the Don't Cut My Medicare! Petition Reply and a generous contribution to help the National Committee continue the battle to protect and improve your benefits.] X

DRAFT - 9/29 1:30 pm

THE NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY:
"SELLING FEAR AT A HANDSOME PROFIT"

PART I: HISTORY

THEY HAVE BEEN INVESTIGATED BY CONGRESS THREE TIMES:
On three separate occasions, the National Committee was investigated by Congressional committees for deceptive mailings to older Americans.

HEARING #1 -- April 10, 1987
"Misleading and Deceptive Mailings to Social Security Beneficiaries"
Hearing before House Subcommittee on Social Security of the Committee on Ways and Means

HEARING #2 -- November 20, 1989
"Deceptive Social Security Mass Mailings to the Elderly"
Hearing before Subcommittee on Social Security and Family Policy of the Senate Finance Committee,

HEARING #3 -- May 14, 1992
"Deceptive Mailings and Solicitations to Senior Citizens and Other Consumers"
Hearing before Subcommittee on Social Security and the Subcommittee on Oversight of the House Committee on Ways and Means

COMMITTEE ADMITS THAT THEY "DO VIOLENCE TO THE FACTS":

- In October of 1989, the National Committee "**acknowledged that its shorthand broadsides sometimes did violence to the facts.**" [emphasis added, New York Times, 10/9/89]

- Martha McSteen: "Mr. Chairman, I am aware of past criticism of our organization and indeed **there may have been some misunderstanding concerning some of our communications.**" [emphasis added, Testimony to the Subcommittee on Social Security and Family Policy of the U.S. Senate Committee on Finance, 11/20/89)

- Mrs. McSteen acknowledged that she was hired last April to give the organization greater professionalism and prestige. She said that "**although there may have been some misinformation because of shorthand attempt to provide information, our direct mail operations have changed dramatically.**" [emphasis added, New York Times, 10/9/89]

1988 CATASTROPHIC ACT: CASE STUDY IN SUCCESSFUL DECEPTION:

- In 1988, the Roosevelt Group played an instrumental role in overturning the Catastrophic Coverage Act -- "the largest expansion of Medicare benefits since the program's inception in 1965." [1989 CQ Almanac, p. 150]

- "Adding to the confusion was misinformation provided by groups that opposed some or all of the new law. The group most criticized ... was the National Committee to Preserve Social Security and Medicare ... " [1989 CQ Almanac, p. 150]

- "Many [seniors] were energized by **emotional, often misleading mass mailings** from the National Committee to preserve Social Security and Medicare ... But its **loud shrills** would not have succeeded had they not tapped the graying citizens basic insecurity." [Washington Post, 9/19/89]

- "The Group sent retirees letters soliciting $10 membership fees to help kill the `seniors-only income tax increase'. The letter read, "*1989 income taxes for seniors will increase up to $1,600 ($800 for singles) -- it's a tax on seniors only and it must be stopped.*" [St. Petersburg Times, December 17, 1989]

- "**Officials of the organization later conceded that they could have misled members into believing that all beneficiaries would have to pay the $800 maximum.**" [1989 CQ Almanac, p. 150]

- In fact, only 5.6 percent of the wealthiest beneficiaries would have had to pay the $800 and the vast majority of Medicare beneficiaries would have paid nothing for these generous new benefits. [1989 CQ Almanac, p. 150]

- "Asked about [these allegations], Mrs. McSteen [President of the National Committee and author of the current letter] replied that `**it is difficult to discuss details in a flier.**'" [New York Times, 10/9/89]

A PATTERN OF DECEPTIVE MAILINGS:

EXAMPLE #1:

- The Committee -- in the guise of a front organization "All American Life Insurance Company" -- mailed a "**PREMIUM NOTICE**" to seniors warning that "*Time is running out to activate your insurance .. mail your premium today to **keep this valuable protection***". The mailing was sent to senior citizens who had no connection to the All American company with the clear implication that failure to mail in the premium due -- "136.56" -- could result in losing benefits under the Social Security/Medicare program.

EXAMPLE #2:

- The National Committee tried to represent itself as an official government entity in its mailings but "In May 1984, the Justice Department requested that the NCPSSM cease using the Great Seal of the United States on mailings. The NCPSSM subsequently altered the seal used on its stationary to reverse the head of the eagle." [U.S. Congress. House. Committee on Ways and Means. Subcommittee on Social Security. Misleading and Deceptive Mailings To Social Security Beneficiaries. 100th Cong., 1st sess, Serial 100-2).

EXAMPLE #3:

- In 1983 the Postal Inspector began investigating the NCPSSM for mail fraud. Although no formal charges were brought, the NCPSSM was forced to alter some of its mailings, including envelopes reading: "IMPORTANT SOCIAL SECURITY DOCUMENTS ENCLOSED".[U.S. Congress. House. Committee on Ways and Means. Subcommittee on Social Security. Misleading and Deceptive Mailings To Social Security Beneficiaries. 100th Cong., 1st sess, Serial 100-2).

CONGRESS PEOPLE FROM BOTH PARTIES DENOUNCE COMMITTEE:

- *Congresswoman Marcy Kaptur (D-Ohio)*: NCPSSM's had a "slick deceptive direct mail strategy." Later she stated that NCPSSM was "a cruel hoax, one that we in Congress must stop." [U.S. Congress. House. Committee on Ways and Means. Subcommittee on Social Security. Misleading and Deceptive Mailings To Social Security Beneficiaries. 100th Cong., 1st sess, Serial 100-2).

- *Congressman Bill Green (R-N.Y):* testified that NCPSSM was "worrisome" and that their mailings "carry deceptive information." [site same as above]

- *Rep. Sherwood Boehlert (R-N.Y.):* "Specifically, I wish to direct my attention to the National Committee to Preserve Social Security and Medicare, an organization which I feel is selling fear at a handsome profit, and giving virtually nothing in return. They use people by misleading them. They send out literature needlessly frightening senior citizens. The bottom line, I guess, is that they are making a whole lot of money." [site same as above]

- *Congressman Donnelley (D-MA):* "The National Committee has outraged many lawmakers with its sharp-edged mailings warnings of huge 'seniors-only income tax increases.'" [New York Times, July 24, 1989]

- *Congressman Donnelley (D-MA):* "From my perspective, they use scare tactics." [New York Times, July 24, 1989]

- *Congressman Tom Lewis (R-Fl):* "Preying on the fears of senior citizens by disseminating information which alleges threats to their carefully protected benefits is unfair and self-serving." [New York Times, July 24, 1989]

- *Governor Lawton Chiles (D-FL):* slammed the Committee mailings as: "doomsday letters' replete with `shaky half-truths' about the state of the Social Security system." [St. Petersburg Times, 9/11/88]

THE NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY:
"SELLING FEAR AT A HANDSOME PROFIT"

PART II: CURRENT MAILING

CURRENT MAILING FILLED WITH DISTORTIONS TO TERRIFY ELDERLY:

DISTORTION: *"There should be no unwise and excessive cuts in Medicare to fund health care reform ... But I ask you to consider, why are seniors the only Americans asked to make this down payment?"*

FACT: There are no Medicare cuts in the President's proposal. This proposal involves spending Medicare money differently, by reducing the growth in payments to providers and increasing benefits for older Americans.

Not a single dollar from the Medicare program goes to fund health reform. In fact health reform will involve spending $32 billion more on Medicare beneficiaries as Medicare savings of $124 billion are more than offset by new Medicare expenditures of $152 billion. Reform is financed primarily by asking those not now paying for their health care to make a contribution. In addition, we are going to place a tax on tobacco and on large corporations that form their own alliances.

DISTORTION: *"But it is completely unrealistic to think that cutting Medicare by almost $125 billion will not hurt seniors."*

FACT: In fact, under the President's proposal, what most older Americans pay -- their share of the cost of health premiums -- will actually decline as growth in the cost of Medicare comes under control, reducing annual cost increases, not only for their Medicare, but also for their Medigap policies. Most Medigap policies today cover prescription drugs and rise each year along with the skyrocketing increases in the cost of these drugs. The Health Security plan will cover the lion's share of prescription drug costs, resulting in a substantial decrease in Medigap premiums for the majority of older Americans.

DISTORTION: *"I urge you to resist unwarranted cuts in Medicare that deprive senior citizens of benefits they have paid for and are eligible to receive."*

FACT: Again, this proposal does not cut benefits to seniors. It protects what they have and gives them more -- prescription drugs and better long-term care. Every cent -- and then some -- of Medicare savings will go to new benefits for Medicare recipients.

The prescription drug benefit -- totaling $80 million -- gives invaluable security to the 75% of older Americans who spend more of their out-of-pocket funds on prescription drugs than any other item.

The long term care benefit invests $72 billion dollars in providing improved access to home and community based care for older and disabled Americans.

- As Senate Majority Leader George Mitchell (D-ME) said: "*If I take eight dollars out of your left pocket and put ten dollars into your right pocket, are you better off or worse off than before?*" (Evening News," CBS, 9/9).

CURRENT MAILING IS ANOTHER FUND RAISING GIMMICK:
The group asked for donations 6 times in this one mailing.

1. "I hope you'll also be able to include your personal check of $25... "
2. "Your gifts of $25 are a tremendous help to us"
3. "And if you possibly can, also enclose a gift of $25 to help . . . "
4. "YES! I have signed the petition . . . I have also enclosed my contribution"
5. "We don't expect you to contribute each time we ask. But we hope you will do so when you can . . ."
6. "Please enclose . . . a generous contribution to help the National Committee . . . "

THEY QUOTE HENRY WAXMAN . . .

BUT : They fail to mention that Congressman Waxman has signaled that his initial anger and surprise -- when asked to react without any knowledge of the Administration's proposal -- was replaced by confidence in the Administration's intentions.

- "*I have a lot of confidence in her (HRC) and in her understanding of some of the important nuances of health reform, particularly as they effect disadvantaged people in our society.*" [New York Times, 9/17/93]

THEY CALL PETE STARK "A FRIEND" . . .

BUT: Representative Stark has vocally denounced the group on numerous occasions.

- Stark: "*Confusion was exacerbated by a fraudulent campaign by the owners of the mail order firm, this Jimmy Roosevelt operation,* ***whose sole interest is to generate mailing lists and membership fees. They plied their trade on the most fragile members of our society who are easily confused, frightened, and misled.***" [emphasis added, New York Times, October 9, 1989]

- Stark: "*He [James Roosevelt] is an absolute obscenity. He defames the memory of his father, who I hold up as a hero.*" [St. Petersburg Times, July 26, 1989]

NCPSSM VS. THE FACTS:

"INACCURATE AND MISLEADING STATEMENTS"

The 1987 hearings for deceptive mailings had a listing of a number of inaccurate and misleading statements disseminated by the NCPSSM. The following is a list of the NCPSSM's mistruths as prepared for the Subcommittee on Social Security by the subcommittee staff (U.S. Congress. House. Committee on Ways and Means. Subcommittee on Social Security. *Misleading and Deceptive Mailings To Social Security Beneficiaries*. 100th Cong., 1st sess., Serial 100-2).

- February, 1983

STATEMENT: Persons sending a $10 annual membership were promised "a regular newsletter" and a Legislative Alert Service to "immediately advise you, by telegram or letter, of fast breaking developments in Washington..."

FACT: While the NCPSSM raised $1.7 million in 1983, the first newsletter did not come out until June, 1984. In a May 2, 1984 letter to Chairman J.J. Pickle, James Roosevelt said, "we are producing our first newsletter..." Similarly, contributors did not begin receiving information on legislation until the Spring of 1984. A formal Legislative Alert Service was not established until much later (Source: ibid).

- November, 1983

STATEMENT: "The Medicare Fund has borrowed $12,400,000.00 ($12.4 Billion dollars!) from the Social Security Fund. Medicare is in so much trouble it has been unable to even pay the interest on this loan! This debt endangers both Social Security and Medicare!"

FACT: The Medicare trust fund did not borrow from the social security trust fund; it was the other way around. Neither fund was endangered by this temporary loan (Source: ibid).

- March, 1984

STATEMENT: In a solicitation, "And, most importantly, you will be helping to make it possible to continue our work here in The Capitol

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to protect, defend and improve the Social Security and Medicare Programs."

FACT: The NCPSSM could not have continued its work in the Capitol since it had not hired a lobbyist and did not register to lobby until April, 1984 (Source: ibid).

- Spring, 1984

STATEMENT: In the NCPSSM's Social Security News Chairman's Report, Roosevelt stated, "I have put my entire staff onto the notch year issue."

FACT: When the newsletter was issued, the NCPSSM had virtually no staff, and Jim Corman had just been hired to lobby for the NCPSSM (Source: ibid).

- November, 1985

STATEMENT: In an URGENT-ACTION-GRAM the NCPSSM told its members it had to raise "$250,000 immediately to support legislative and legal action to restore all money taken from social security trust fund monies." The ACTION-GRAM went on to say, "Lawyers must be hired and lawsuits prepared."

FACT: While Chairman of the Subcommittee on Social Security James R. Jones, other Members of Congress, and several senior organizations including the American Association of Retired Persons brought a lawsuit before the ACTION-GRAM was mailed, the NCPSSM never filed any legal action (Source: ibid).

- February, 1983

STATEMENT: Contributions were offered a "FREE personal confidential computer analysis of your Social Security Account status - according to official government records."

FACT: Prospective contributors were led to believe that they would receive something more than the earnings record which they could obtain free from the Social Security Administration (Source: ibid).

- November, 1983

STATEMENT: "Just recently, the National Commission on Social Security suggested taxing Social Security as ordinary income! Another proposal would increase the minimum age for receiving Social Security

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to 68."

FACT: The National Commission on Social Security Reform recommended taxing benefits in January 1983. Increasing the retirement age to 68 was among the proposals discussed. This NCPSSM statement was mailed out 6 months after enactment of the Social Security Amendments of 1983 which resolved these issues (Source: ibid).

- Spring, 1984

STATEMENT: One of the first NCPSSM newsletters listed "projects and Accomplishments." Under the heading "forums and Speeches" was "Blue Ribbon panel report on Bailout Bill."

FACT: There was no forum. The report was created by cutting and pasting comments and past testimony of former Commissioner of Social Security Bob Ball, former Chief Actuary Robert Myers, and others into a format that appeared to be the give-and-take of an actual forum (Source: ibid).

- Fall, 1984

STATEMENT: "Last year, six months of our cost-of-living increases were deleted. This loss equaled 2.4% of each Social Security recipient's income. Then came a ridiculous law that suspends cost-of-living increases entirely if inflation falls below 3.0%."

FACT: The last sentence implies that the Congress passed a law in 1984 to deny the COLA. In fact, the 3% COLA trigger was placed in the law in 1972 and would not have eliminated a COLA but simply delayed it a year. Further, the letter went out after the Senate had already overwhelmingly passed legislation to guarantee that a COLA would be paid in 1985 (Source: ibid).

- 1986

STATEMENT: In a mailing about the Treasury's disinvestment of the Trust Fund, the NCPSSM said "Fortunately, thanks to your past support, the National Committee acted. After intense lobbying pressure, Congress returned the Trust Fund's assets."

FACT: According to NCPSSM's report to the Clerk of the House, the organization mailed out Legislative Alerts to its members on November 8, 1985 to generate letters and phone calls to Members of Congress on restoring trust fund assets and issued 3 press releases in November and December. While the final Gramm-Rudman-Hollings

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legislation containing the provision restoring assets did not become law until early December, 1985, the restorative provision had already passed the House as a part of debt limit legislation on November 1 - seven days before the NCPSSM Legislative Alert was mailed. There was never any doubt that this provision would be enacted (Source: ibid).

THE WHITE HOUSE

WASHINGTON

October 13, 1993

Martha McSteen
President
National Committee to Preserve
Social Security and Medicare
2000 K Street N.W., Suite 800
Washington, D.C. 20006

Dear Martha:

I wanted to thank you and the National Committee to Preserve Social Security and Medicare for your valuable advice throughout the process of putting together the President's health reform package. We share your commitment to providing prescription drug coverage to senior citizens, and beginning to phase in long term care coverage with a special emphasis on home and community-based care. The legislation we are presenting to Congress reflects those shared goals.

We will continue to talk about the issue of how fast the rising medicare costs can be brought under control. We have studied this issue very carefully, and are convinced the rate of growth in Medicare costs can be slowed without endangering services and benefits to senior citizens. As you know, every plan currently before the Congress makes the same assumption. We have to cut waste, fraud, and abuse in the entire health care system, and doing that will provide tremendous savings. We pledge to you that so long as you keep working with us in good faith to pass health reform legislation that's good for all Americans, we'll continue working constructively with you to pass a health reform package that's good for senior citizens. And let us be clear: we are moving forward on health reform in order to help make senior citizens' lives, and all Americans' lives, better than they are today.

Thank you again for all your ideas. Working together, we will provide health security for all Americans.

Sincerely yours,

Hillary Rodham Clinton

Hillary Rodham Clinton

Jeli

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

August 18, 1993

MEMORANDUM FOR THE FIRST LADY

From: Donna E. Shalala

Subject: Medicare Cuts Under Reform

Background

We understand the necessity of significantly reducing health care inflation for health care reform financing, but we are convinced that the level of Medicare cuts Scenarios 1 and 2 call for would be bad policy and worse politics. The first impression of the health plan will be crucial to its success; the first impression of either Scenario 1 or 2 as applied to public programs will be deadly. Even Scenario 3 runs some serious risk of alienating our friends at the onset.

Serious further cuts in Medicare are necessary to make health reform work, provided these cuts are captured for reform purposes as opposed to deficit reduction. We can then use savings rather than substantial new revenues to help form the centrist coalition of Democrats and Republicans necessary to pass health reform. If Medicare cuts can serve the dual purpose of meeting entitlement caps and financing a portion of reform, the liberal Democrats could be mollified somewhat. The lesson of budget reconciliation is that a balanced financing package is essential. As Exhibit 1 shows, however, Scenario 1 Medicare cuts would exceed the cost of expanded Medicare benefits by $88 billion; Scenario 2 cuts exceed expansion by $62 billion. We believe both numbers are much too high.

The danger is that a proposal to use Medicare to finance so large a part of reform will raise a firestorm of immediate protest from our strongest supporters. Supportive physician groups such as the American College of Physicians and the American Academy of Family Physicians will face enraged members who view further Medicare payment cuts as another broken government promise. Members of the American Hospital Association will see themselves as unable to survive the twin onslaught of aggressive pricing from qualified health plans and continued Medicare erosion. The elderly will raise the very legitimate question of why they are paying more for reform than they will receive in benefits to themselves. A major change in the current positions of any of these supporters could doom the plan at the onset.

Provider and beneficiary response will greatly influence the Hill's reaction. Senator Moynihan and the Ways and Means members will be inclined to protect teaching and urban hospitals if they appear to be in danger. Both House and Senate rural caucuses will focus on the impact on providers, particularly hospitals, in their districts. Mr. Waxman will be sympathetic to the protests of physician groups.

In choosing the amount of financing to come from Medicare, we are operating in the context of new savings from Reconciliation, which have yet to take effect, that will total $56 billion over 5 years. Scenario 3 cuts in Medicare are more stringent than the entitlement caps in the Nunn/Domenici proposal and will be very difficult to achieve both technically and politically. If we move to Scenario 1 cuts we will be asking the Medicare program to provide, in new savings, an amount equal to four times the savings already achieved under the Reconciliation bill. Even Scenario 3 cuts would require almost three times the Reconciliation savings.

This is not just a political problem, but a technical one as well. Public programs simply cannot provide the same savings to support the plan as can the private sector, which has operated largely unchecked during a decade of Medicare restrictions. It would be inappropriate, from a policy point of view, to impose the same degree of expenditure limitation on Medicare and the private sector when the number of persons covered by Medicare is growing more rapidly than the rest of the population. Equal total growth rates for the two segments will mean lower per capita growth for Medicare. In addition, our strategy for achieving the targets for private sector savings relies very heavily on one time reductions in administrative costs, savings which are not available in Medicare.

One result of ten year's worth of cost containment efforts in Medicare is that provider payments under the program are already fully one third less than the private sector's with the result that the better group model HMOs are increasingly reluctant to accept Medicare capitation rates. In fact, bringing the private sector to current levels of Medicare spending, age and risk adjusted, by itself would save tens of billions of dollars.

The attached document reviews some of the most pertinent facts with respect to proposed Medicare savings.

Attachment

MANY RURAL AND INNER CITY HOSPITALS COULD GO OUT OF BUSINESS

- Almost 2/3 of all hospitals currently have negative Medicare margins -- that is, they spend more on Medicare patients than Medicare pays them. In 1991, Medicare losses nearly equaled losses for uncompensated care. Some hospitals make up these losses by charging private payers more. Under health care reform, however, hospitals will be experiencing cutbacks from private payers as well. Hospitals that are squeezed from all sides are likely to respond by reducing staff and/or services -- or closing altogether.

- About 30 percent of sole community hospitals, 39 percent of small rural hospitals, and 24 percent of large urban hospitals are currently operating in the red overall. Another 25 percent of large urban hospitals are teetering on the edge -- their margins are only .1 percent. While operating efficiencies may be possible, many hospitals will not be able to respond quickly enough. The additional Medicare payment cuts along with private reductions may force closures.

- Many inner-city hospitals, particularly public hospitals, are facing crumbling infrastructures. Taken together, the Medicare and private sector cuts will mean less capital to invest and rebuild. Given their deteriorating structures, quality problems will eventually surface. Such hospitals cannot compete in the health care market.

PROMISES TO PHYSICIANS, ESPECIALLY PRIMARY CARE PHYSICIANS, WILL BE BROKEN

- We are committed to increasing Medicare payments for primary care services. Significant cuts in Medicare physician payments under health care reform (on top of billions in reconciliation cuts) will prove politically very difficult to deliver if all physician fees must be reduced to the extent required to meet Scenario 1 or 2 levels.

- Further significant cuts in physician payments could allow gaps in access to develop in certain areas. Reconciliation essentially froze Medicare physician fees in real dollar terms and will lead to substantial geographic redistribution in order to keep our promises with respect to primary care. Reductions needed to reach Scenarios 1 or 2 would require substantial reductions in Medicare payment levels. While access to physicians by Medicare beneficiaries may not be a problem immediately or in all areas, pockets of problem areas are sure to crop up.

EMPLOYMENT COULD SUFFER

- Almost 4 million individuals are employed by community hospitals. The annual payroll (including fringe benefits) of these employees is about $140 billion year. Cuts in Medicare hospital payments could jeopardize the jobs of many of these workers and negatively affect the economy in their communities. Hospitals are now the largest employers in many distressed cities; their employees are disproportionately women and minorities so the job loss will worsen the effects of the current economy on the most vulnerable individuals and communities.

- Hospitals are also major employers in rural America. Studies show that the presence of a hospital in a rural area guarantees an inflow of funds. If hospitals significantly cut back on staffing or close, rural areas especially could be hard hit by layoffs.

STATES WOULD SPEND MORE

- Medicaid pays Medicare cost-sharing amounts for poor beneficiaries. If the Medicare cost-sharing is increased, the States would have additional liability. Each extra billion in beneficiary cost-sharing translates into $470,000 more in State dollars.

- Given the continued inadequacy of the Medicare benefit package compared to the comprehensive package under health reform, cuts of the Scenario 3 magnitude will make it impossible for any State to integrate Medicare beneficiaries into its system.

UNINTENDED CONSEQUENCES ON BENEFICIARIES

- It is difficult to predict the effect of increasing beneficiary cost-sharing on beneficiaries, since cost-sharing amounts depend on the type of service provided and whether or not the beneficiary is covered by supplemental insurance. However, we have concerns that some beneficiaries may be negatively affected.

    + For example, there are 240,000 elderly living in families with incomes $200 or less above the poverty line. 290,000 live in families from $200 to $250 above poverty. Policies requiring beneficiaries to pay $200 or $250 more out-of-pocket per year could be detrimental to individuals teetering above the poverty line.

Medicare in Health Care Reform
($'s in Billions)
Scenario 1

	1994	1995	1996	1997	1998	1999	2000	1996–2000
New Benefits								
Drug Benefit w/rebate	0	0	13	14	15	16	17	75
Long-term Care	0	0	3	7	11	16	22	59
Sub-total	0	0	16	21	26	32	39	134
Reductions								
Medicare savings to meet global budget	0	0	-7	-17	-30	-45	-62	-161
Income Test Premiums	-2	-2	-2	-2	-3	-3	-3	-13
Offset for Employed Bene's	0	0	-9	-9	-9	-10	-10	-47
Sub-total	-2	-2	-18	-28	-42	-58	-75	-221
Total, Scenario 1	-2	-2	-2	-7	-16	-26	-36	-87

Scenario 2

	1994	1995	1996	1997	1998	1999	2000	1996–2000
New Benefits								
Drug Benefit w/rebate	0	0	13	14	15	16	17	75
Long-term Care	0	0	3	7	11	16	22	59
Sub-total	0	0	16	21	26	32	39	134
Reductions								
Medicare savings to meet global budget	0	0	-6	-13	-25	-38	-52	-134
Income Test Premiums	-2	-2	-2	-2	-3	-3	-3	-13
Offset for Employed Bene's	0	0	-9	-9	-10	-10	-11	-49
Sub-total	-2	-2	-17	-24	-38	-51	-66	-196
Total, Scenario 2	-2	-2	-1	-3	-12	-19	-27	-62

Scenario 3

	1994	1995	1996	1997	1998	1999	2000	1996–2000
New Benefits								
Drug Benefit w/rebate	0	0	13	14	15	16	17	75
Long-term Care	0	0	3	7	11	16	22	59
Sub-total	0	0	16	21	26	32	39	134
Reductions								
Medicare savings to meet global budget	0	0	-4	-10	-19	-30	-42	-105
Income Test Premiums	-2	-2	-2	-2	-3	-3	-3	-13
Offset for Employed Bene's	0	0	-9	-9	-10	-10	-11	-49
Sub-total	-2	-2	-15	-21	-32	-43	-56	-167
Total, Scenario 3	-2	-2	1	0	-6	-11	-17	-33

plan and not get through at all."

For the moment, that strategy appears to be working. The Energy and Commerce Committee, which seemed to be at a stalemate two weeks ago because Democratic leaders could not round up votes for any proposal, now seems to be back on track.

Chairman John D. Dingell, D-Mich., has been asking members one by one what they want, so he can figure out what deals need to be cut to win a majority. He is putting together a bill that he expects ultimately will win approval of the committee, which will start work after the Easter break.

However, like the Ways and Means Committee, which is unlikely to write a bill that attracts Republican votes, Energy and Commerce Democrats probably would push through a package on their own, Dingell said. "We have told our Republican colleagues that we would be pleased to have their assistance, and they have indicated that that assistance is not forthcoming," he said.

In the Senate, where bipartisanship is both a tradition and a necessity because Democrats have too few members to break a filibuster, the focus is on forging a compromise. To that end, the Finance Committee plans a two-day retreat March 20-21 in which members of both parties will talk out their ideas.

Underscoring the willingness of Senate Democrats to compromise, several senators said recently that they would be willing to reduce — but not eliminate — the Clinton bill's requirement that employers pay for 80 percent of their employees' health insurance.

Controversial Proposals

The so-called employer mandate remains one of the stickiest for lawmakers. The subject came up repeatedly during discussion of Stark's bill, which would require all employers to pay 80 percent of premium costs for a nationally defined package of benefits. Unless Stark's mandate is softened, he risks losing support of two key Democrats, Benjamin L. Cardin of Maryland and Sander M. Levin of Michigan.

"There are no subsidies for small employers in the bill," said Levin, who probably will offer an amendment proposing a tax credit or deduction for small employers.

Levin also is concerned about a timetable requiring that employers with more than 100 employees pay for 80 percent of their insurance starting in 1995. A Congressional Research Service study found that at least 3.2 million full-time employees in firms of more than 100 people do not have health insurance.

Stark's subcommittee has a 7-4 split of Democrats to Republicans, and people expect Republicans to vote unanimously against Stark's proposal. In addition, Democratic panel member Michael A. Andrews of Texas is a cosponsor of a more market-based bill (HR 3222) that has no employer mandate. He is unlikely to be comfortable voting for Stark's bill. Ranking Republican Bill Thomas of California is hoping Andrews will vote with the Republicans on some measures, indicating support for a less regulatory approach.

"If we can get some votes that create some understanding of the universe of bipartisan agreement, then that shows the bipartisan way," Thomas said. ■

How Medicare Works

Congress created Medicare, the federal health insurance program for the elderly, in 1965 as part of President Lyndon B. Johnson's Great Society. The law (PL 89-97), 20 years in the making, was considered the most important welfare program since the Social Security Act of 1935.

Medicare consists of two sections — Part A and Part B — and covers the hospital and physician needs of qualified people age 65 and older. Coverage for disabled people under 65 began in July 1973.

People enroll in Medicare in two ways. Those turning 65 can apply for Part A, Part B or both at any Social Security office. Coverage for the disabled automatically begins two years after they start receiving disability benefits.

Under a draft health-care overhaul plan released March 8 by Rep. Pete Stark, D-Calif., Medicare would expand by 1997 to cover those who do not have private insurance and would put them under a program called Medicare Part C. It would include Part A and Part B coverage. Stark would require that employers either provide health insurance for their employees or contribute to the Part C fund. *(Story, p. 609)*

Part A and Part B

Part A, funded by a 1.45 percent payroll tax, pays for hospital and short-term nursing care after patients meet a $676 deductible. Because of the tax, Part A does not require most patients to pay premiums. But for people who have not worked long enough to qualify for premium-free coverage, Part A coverage can be purchased for $245 a month.

As of March 1993, Medicare Part A covered 35.5 million people at an annual cost of $90 billion, according to the Health Care Financing Administration (HCFA). The government tries to control Part A costs through the Prospective Payment System, adopted in 1983. The system determines reimbursement rates for hospital services.

Part B, known as Supplementary Medical Insurance, covers physician services, health care at home and outpatient services. Unlike Part A, Part B requires that individuals pay a premium of $41.10 a month. After patients meet a $100 deductible, Medicare covers 80 percent of certain physician and non-hospital costs. Besides premiums, the program is financed by general federal revenues. As of March 1993, Medicare Part B covered 34.2 million people at an annual cost of $55 billion, according to HCFA. To control Part B costs, the government instituted the Relative Value Scale (RVS) in January 1992. The RVS assigns a value to each medical procedure, based on complexity, then uses a conversion factor to translate the value into a dollar amount to be paid to doctors.

Part C, according to Stark, would cover about 60 million people and cost $80 billion to $100 billion a year. It would replace Medicaid, the federal-state health insurance program for the poor.

—Brad Wong

Divisions Behind the Scenes

The House Ways and Means Committee is beginning its toughest challenge in years with its chairman's future in doubt and its members badly divided about how to proceed on health care legislation.

Beset by legal difficulties for the past two years, Chairman Dan Rostenkowski, D-Ill., is fighting for his political future back home in Chicago and is in danger of losing a primary election March 15. Even if Rostenkowski survives the primary, he remains under investigation in a broad federal probe into possible financial misdeeds, including allegations that he embezzled cash from the House Post Office. *(Weekly Report, p. 457)*

Behind the excitement that accompanied the opening deliberations of the Ways and Means Health Subcommittee, members say there is considerable uncertainty. Distracted by his primary, Rostenkowski has not exerted firm control over the committee's proceedings and probably will not do so until the full committee begins its deliberations next month. The 24 Democrats on the 38-member committee are badly fractured, both on specifics and broad approaches to health care reform.

Ways and Means is one of three committees putting together health care overhaul plans. And House leaders appear to be unsure which one will emerge as the preferred vehicle that meets Clinton's goals and has the best chance to attract the 218 votes required to pass on the House floor.

R. MICHAEL JENKINS

Members say that Rostenkowski, distracted by political difficulties, has not exerted firm control over the Ways and Means panel.

"I think they're just crossing their fingers and hoping we put something together," said Rep. Jim McDermott, D-Wash. "That's the only direction we've had — keep working until you get something done."

Rostenkowski is central. His deal-cutting skills are unmatched in the House, and Clinton has done everything short of endorsing him to see that Rostenkowski emerges from his primary with the party nomination. Lawmakers say they expect Rostenkowski to step into the middle of the committee's health care deliberations once the primary is over.

If Rostenkowski is defeated, his clout may diminish , but he will remain chairman unless he is indicted. "When he gets back, he's going to want to make his mark, whether he wins or loses," says Ways and Means member Mike Kopetski, D-Ore. "He's very adept at putting something together that we can sell on the floor."

Rostenkowski has said he expects the Health Subcommittee, headed by Pete Stark, D-Calif., to produce a draft health reform bill that will rely more heavily on the government to run the health care system than the bill that ultimately will leave the full committee. At this point, the 11-member subcommittee's ability to get a six-vote majority for any bill remains in doubt.

If Stark succeeds, lawmakers say that Rostenkowski likely will use the subcommittee bill as his own vehicle, since it already will have at least six votes behind it. If committee Republicans indicate little willingness to support the final product, Rostenkowski likely will caucus in private with his Democrats in an effort to work out changes or additions to Stark's bill that could attract a solid majority of the committee.

Despite his primary worries, Rostenkowski already has been working with the White House to lay the groundwork for a compromise. He has spoken of the need to attract small-business support for the bill, which could help him win over some conservative Democrats. "They've got to line up some pretty conservative guys," said Michael J. Rock, a lobbyist for the American Hospital Association.

Among the more conservative Democratic members of the committee on this issue are Peter Hoagland, D-Neb., Barbara B. Kennelly, D-Conn., Bill Brewster, D-Okla. and L. F. Payne Jr., D-Va. Rostenkowski's challenge will be to attract them without alienating the more liberal members of his committee, including key members of the Congressional Black Caucus: Charles B. Rangel, D-N.Y., Harold E. Ford, D-Tenn., John Lewis, D-Ga., William J. Jefferson, D-La., and Mel Reynolds, D-Ill. The caucus has yet to define its views on health care.

Nervous House members are looking for protection before they will vote for controversial elements of Clinton's plan, such as the mandate on employers to pay for 80 percent of their employees' insurance. Specifically, House members want assurances that their votes will not go for naught because the provisions are dropped in the Senate. Rostenkowski's aides have begun discussions with their counterparts in the Senate already, lawmakers say.

"Members want better assurances that the House and Senate aren't too far apart," said Kopetski.

If Rostenkowski can hold together the Democrats, opportunities for critics of the administration plan to attract supporters for alternative plans will be slim. There is only modest support on the committee for one of the leading alternatives to Clinton's plan, a more moderate plan sponsored by Rep. Jim Cooper, D-Tenn. The plan has so little chance of passing that one of its sponsors, Rep. Fred Grandy, R-Iowa, said he had not even decided whether to offer it for a vote.

—David S. Cloud

From the Desk of
MELANNE VERVEER

file medicare
debate

...S SHYING ...JOHNSON GOALS

Leaders Doubt All of 5-Point Program Will Be Enacted

By JOHN D. MORRIS
Special to The New York Times

WASHINGTON, April 18—President Johnson has given Congress a five-part legislative task that Democratic leaders regard as all but impossible to accomplish in the next three months.

In announcing the assignment at his news conference Thursday, the President listed five of the most controversial bills now before Congress and said he hoped they would be passed before the national political conventions.

"We'll do what we can," was a typical comment as the Administration's Congressional leaders scanned the list. "But we would have our work cut out for us even under normal circumstances. With the Senate tied up in a civil-rights filibuster, it's hard to see how much of anything else can be accomplished this year."

President Johnson put the civil-rights bill at the top of his list. Other measures on it were health care for the aged under Social Security; a Federal pay rise, the anti-poverty program and a food stamp plan to aid the needy.

Aside from the Senate's inability to transact any business so long as the filibuster continues, work on other legislation is hampered by enforcement of a rule against committee meetings while the Senate is sitting.

The rule has been waived to permit an occasional session by one committee or another, and several committees have been able to work for an hour or so some days by convening at 8:30 or 9 A.M.

However, with the Senate usually sitting from 10 A.M. to 8 P.M. or later, no major legislation has emerged from any Senate committee since the civil rights debate began six weeks ago.

Five house-approved appropriation bills are among the measures already stacked up behind the rights bill. Seven more will be added before the end of June.

In addition to the 12 appropriation bills, other legislation classified as imperative, although routine by comparison with items on the Johnson list, must be enacted by June 30. This includes an increase in the national debt limit, the annual extension of excise-tax rates and renewal of the renegotiation act for recouping excess profits on Government contracts.

Some Congressional leaders have assumed that the session's work would be done when civil rights, appropriations and other relatively routine business had been disposed of. None would be greatly surprised if the assumption proved to be correct. There is some hope, however, for approval of a fairly substantial part of the five-point program if the civil rights bill can be steered to passage in a month or six weeks. This would give the Senate and its committees a month or two to work on the other four bills before the Republican National Convention meets July 13.

Senate committees have not yet considered any of them. Here is a rundown of the present status of the five bills:

Civil Rights—The House-approved measure, designed to combat racial discrimination in employment, public accommodations, voting and other fields, faces continued Senate debate with around-the-clock sessions possible. Leaders are pressing for votes on amendments next week.

Health Care — The Administration bill calling for hospitalization and nursing care benefits for persons over 65 years old, is under consideration by the House Ways and Means Committee. Hearings have been completed, but the Administration has not been able to muster a majority of the 25-member group for approval of the measure or for any compromise.

Food Stamps—The House has passed a bill under which families on public assistance rolls would receive stamps that could be exchanged for food in local stores. Senate committee hearings are awaiting disposal of the civil rights bill.

Poverty—A House subcommittee is holding hearings on the Administration's omnibus bill, which includes provisions to aid community antipoverty programs and to create youth training and employment facilities. A bill embodying a similar youth training and employment plan was passed by the Senate last year. House leaders have kept it in the Rules Committee because of uncertain prospects of passage if it were taken to the floor.

Federal Pay—The House defeated one Administration bill last month. A modified version is now under consideration by the Post Office and Civil Service Committee, with chances of favorable House action now rated about even.

Democratic strategists are not greatly concerned over the doubtful outlook for most of the five bills. They are confident that the election-year session will produce a record of substantial accomplishment regardless of whether all of them are enacted.

These appraisals are based on the assumption that a strong civil rights bill will be written into law. The party then would be able to point to the rights legislation, the tax reduction enacted early in the session and the recently approved cotton and wheat subsidy law as major elements of a politically appealing record.

Adding to it at least one or two features of the Johnson anti-poverty program is regarded as a modest goal that would round out the legislative picture to the party's further benefit.

HOUSE VOTE NEAR ON POVERTY BILL

Showdown Expected Today —Outcome Still in Doubt

By MARJORIE HUNTER
Special to The New York Times

WASHINGTON, Aug. 6 — President Johnson faces one of the most crucial tests of his political career as his anti-poverty bill heads for a showdown on the House floor tomorrow.

The outcome, still in doubt tonight, could have a far-reaching effect on the Presidential campaign this fall, for the anti-poverty program has already become a highly partisan issue.

While a handful of Democrats and Republicans angrily exchanged words on the House floor today, there was feverish behind the scenes as ies sought to line up

"If I live through this without getting two ulcers, I'll be lucky," Representative Phil M. Landrum of Georgia, floor leader for the bill, said good-naturedly as he hurried from one off-floor caucus to another.

Southerners in Doubt

Attention centered on a small number of uncommitted Southern Democrats, whose votes could either defeat or pass the bill.

Leaders on both sides met with the uncommitted in back corridors and private offices and party cloakrooms.

"I'm more confused than ever," Representative Ralph J. Scott, Democrat of North Carolina, one of the uncommitted, said as he wandered through the crowded corridors in late afternoon.

The North Carolinians, most of them uncommitted, were called to a top-level conference in Speaker John W. McCormack's office. There, they met with the House leadership, White House aides and Sargent Shriver, who would direct the antipoverty program.

Uncommitted Southerners from other delegations also were summoned to the Speaker's office from time to time during the day.

Johnson Asked Plea

President Johnson, too, had gotten into the fray personally yesterday when he posed for pictures with individual members of Congress. Uncommitted members reported later that the President, while posing with them, had asked them to support the bill.

Administration pressure on

Celebrezze Finds Aged-Care Plan Imperiled

House Social Security Bill Is Said to Ignore Key Need

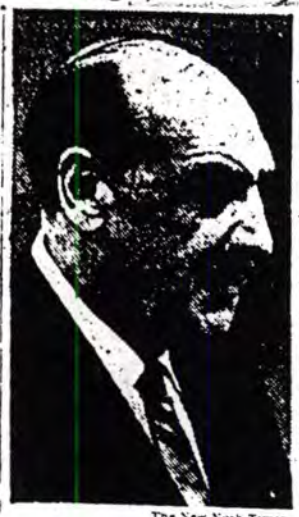
WASHINGTON, Aug. 6 (UPI) — A $1.5 billion Social Security measure, passed by the House recently, came under sharp attack in the Senate today as a "mess of pottage" that would kill chances for health care for the aged.

The criticism was made as the Senate Finance Committee opened public hearings expected to last through next week on the election-year issue of financing hospital benefits for 18 million older citizens under Social Security.

Backers of President Johnson's health-care program hope to attach it to the House measure that expands the Social Security system and provide a 5 per cent increase in cash benefits to about 20 million persons.

Anthony J. Celebrezze, Secretary of the Department of Health, Education and Welfare, told the committee that the House bill had failed completely to get at the "most critical need — hospital care for the aged."

Senator Abraham A. Ribicoff, Democrat of Connecticut, who was Secretary of the department in the Kennedy Administration, attacked the House measure as a "mess of pottage, a snare and a delusion."



The New York Times
Anthony J. Celebrezze

Mr. Ribicoff, a stanch supporter of the Administration's health-care plan, said it would be tragic to "use up the precious resources of Social Security" — those few pennies available for rate increases — to increase cash benefits "a piddling amount."

Mr. Celebrezze testified that he would favor dropping the increases in cash benefits approved by the House and using any necessary increases in taxes on payrolls to finance instead a hospitalization program for persons 65 and over.

He indicated that it might be possible to have both in one bill by scaling down the benefits, thus holding tax increases paid by employers and workers to a "reasonable limitation."

The taxable base of a worker's salary, now $4,800, might be increased to $6,600. It is raised to $5,400 in the House bill.

By using valuable tax rates for cash benefits, Mr. Celebrezze said, the House measure "seriously jeopardizes" any chances to finance a health care package "in the foreseeable future."

Despite the strong drive by Administration forces to enact this year some version of hospital insurance for the elderly under Social Security, there seemed to be little chance it could clear the hostile 15-member finance panel.

Signs indicated the vote would be about 9 to 6, against it in the committee. Supporters will probably make their strongest efforts on the Senate floor, then hope for House acceptance of some compromise.

Ribicoff Denounces Measure as a 'Mess of Pottage'

Kennedy Wry Over His Removal As Vice-Presidential Possibility

Continued From Page 1, Col. 4

white people North and South against Negro gains.

Mr. Kennedy did not answer this directly but, again with an enigmatic smile, he said:

"I talked to some of my friends last week, and I decided I wouldn't run."

Again great laughter came from the audience, who realized that nobody has a chance except the man tapped by President Johnson.

Mrs. Kennedy, asked how to rebut the "emotional appeals" of the Republicans under Senator Barry Goldwater's banner, told the school convened by the Democratic National Committee that the "way to do it was to "reply factually and — er — emotionally."

Mr. Kennedy, in calling for the election of President Johnson, said this was the way to carry out programs "begun in 1961," when President Kennedy took office.

"As for a definition of extremism, an issue which figured in the Republican convention in San Francisco, Mr. Kennedy begged off.

But then he needled Senator Goldwater by borrowing a quote from the Senator in this apocryphal anecdote:

"We had a jail break last week. We recaptured the man and as we took him back to the cell, he struggled and screeched. He hollered: 'Extremism in the defense of liberty is no vice.'"

$287 Million Plan Urged To Increase Nursing Force

WASHINGTON, Aug. 6 (AP) — Passage of a multimillion-dollar program was urged today to increase the nation's nurses by 130,000 in the next five years. Witnesses before the Senate Labor Committee said the need was acute.

The program is included in President Johnson's priority-legislative list.

The two bills involved, which have already been passed by the House, would provide $287.6 million over a five-year period for a variety of programs aimed at increasing the number of nurses. They would also authorize $69.5 million to continue training grants for professional workers needed to staff public-health agencies.

Covered in the provisions are aid in construction, student loans and training programs.

A BOUQUET TO TH
IN THE REDING

Sweep down the aisle in thi
gown of rayon and acetate fa
sleeves and scoop neckline th
back. Glorious new autumn c
romance blue, gold, seaspray
Sizes 8 to 16. By Lovejoy.

Informal Modelin
of Fall and W

in October, under the auspices of the American National [Theater] and Academy, the [script] will be performed. ... Tahse will serve as executive producer and Edward ... as director.

Miller said the director [had] been authorized to make [alter]ations necessary to conform to the requirements of ... theaters on tour. ... thrust stage, ... levels, is employed.

... [dram]atist's next play, "Incident at Vichy," which opens ... 3 at the ANTA Washington Square Theater, will use ... to depict a place of ... in Vichy, France, in ... "After the Fall" is de[void] of scenery.

Miller has another play [in m]ind, but declined to discuss it.

... Lincoln Center Repertory Company's first season ... Oct. 4, at which time Jason [Robards] Jr. will leave the ...

During the second season, which starts Oct. 29, three more [plays] are to be done in addition [to] "Incident at Vichy"—"The Changeling," "Tartuffe" and [poss]ibly "Pantagleize."

Since July 22, when 18,500 [reminde]rs were sent to subscribers for renewals, 6,532 re[spon]ses have been received. A spokesman estimated that 15,... tickets had been ordered—... third of the tickets for ... subscription season that [term]inates May 30. Next Tuesday is the deadline for subscribers to be guaranteed the ... seating or improved seat locations for the new season.

[Con]ference on Amphitheater

[Repr]esentatives of Harlem [comm]unity groups will confer [wit]h Richard Rodgers at 5 P.M. ... 19 in his offices at 598 ... Avenue regarding the amphitheater, not yet ... Mount Morris Park, ... [Av]enue and 120th Street, ... the composer is planning [to] build and give to the city. The spokesman will be Mrs. ... Stokely, chairman of the [Mou]nt Morris Park Rehabilitation Committee, representing 30 [co]mmunity groups. She said the [dis]cussion would deal with the [op]eration of the project and a [ye]ar-round program.

State Senator Jerome L. Wil[son], who will also attend, said ... Rodgers would be advised [th]at the communities near the [pa]rk wish to do with the amphitheater.

Others present will be Assemblyman Frank Rossetti; Mrs. [H]elen Bowman, secretary of [th]e rehabilitation committee; [M]rs. Gladys Coleman, president [of] the 119th Street Block Association, and Arthur Rosenblatt, [arc]hitect.

siveness and ennui that this fulfillment precipitates.

Along the way, there is a howling interruption by the father and other relatives of the girl who come roaring up from County Wicklow when they hear of the scandalous goings-on to haul the sinful lass back to the country and force her to submit to the rigid disciplines of her upbringing for a spell.

But that's about it—except for the little incidents that allow us to see the multitu[des] pop through the film and flavorsome backgrounds of Dublin and the thorny countryside.

And out of it all comes a wistful but rather hearty appreciation of this girl who is an honest, human compound of aggressions, generosity, hopes and selfishness.

It is in the exposition of these factors that Miss Tushingham is so good—so fluent with her facial expressions, so intense with her at[tention to the per]son who oversaw...

Peter Finch's performance as the lover is a bit on the negative side—too matter of fact and dead-panned, even for the acknowledged evasiveness of the character. But Lynn Redgrave is delightful as the Amazonian roommate of the hopeful girl and all the other minor Irish characters in it are played in elegant style. Mischief as well as melancholy radiates in "Girl With Green Eyes."

Theater, the art-film house on 58th Street between Park and Lexington Avenues, has been bought from Richard Davis by Walter Reade-Sterling, Inc., it was announced yesterday.

The transaction was arranged in a long-term lease calling for total payment of $1.51 million.

This gives Walter Reade-Sterling five first-run theaters here. The others are the DeMille, Coronet, Baronet and 34th Street East Cinema.

Mr. Davis, now active in distribution, opened the Fine Arts in October, 1951, with a 12-month run of "The Lavender Hill Mob." He plans to spend more time in Europe looking for films for his new company.

Comedian Weds Anne Bancroft

Anne Bancroft, winner of an Academy Award for best film actress in 1963, was married Wednesday at City Hall to Mel Brooks, comedy writer and comedian. Miss Bancroft was formerly married to Martin A. May. Mr. Brooks was married to the former Florence Baum. Both marriages ended in divorce.

occupan[ts] ... the win[dow] ...

Teen-A[ger] ... As Kill[ed]

HALI[FAX] ... (UPI)— ... rendered ... the re[st] ... sniper ... children ... cally ... night.

Chief ... ell decli[ned] ... pected ... had wa[ited] ... at the ... Airport ...

A g[i]... the sla[yings] ... to the ... said.

Those ... Hartlin[g] ... James ... and Smith ... ously w[ounded] ... and M... mother ... broadca[st] ... mother ... her son ...

NYT 8/11/64 S1:2

DEMOCRATS DIVIDED ON HEALTH CARE BILL

WASHINGTON, Aug. 10 (UPI)—Senate Democrats supporting President Johnson's plan to provide health care for the aged broke ranks today. One declared that approval of the bill this year was "very near an impossibility."

Senator Vance Hartke, Democrat of Indiana, said that a fight over the measure "at this late date" also would jeopardize chances for Social Security reforms and "millions of older people would end up with no new benefits."

Mr. Hartke is a member of the Senate Finance Committee. This panel is holding hearings on President Johnson's plan to attach the health care proposal to a bill, already passed by the House, increasing Social Security benefits by 5 per cent. The hospital care for almost 18 million persons would be financed through higher payroll taxes.

Mr. Hartke, who had been counted among the bill's supporters, said a battle now might kill its chances in the drive to finish legislative work before the Democratic National Convention, which starts Aug. 24.

Senator Abraham A. Ribicoff, Democrat of Connecticut, argued, however, that the House had failed to meet the most pressing need of elderly persons —health insurance—in its measure increasing pensions. And passage of the House bill without the health-care rider would use up precious payroll pennies and hurt chances of a hospital-care measure in the future, he said.

Stage Union Warns Beatles

TAMPA, Fla., Aug. 10 (AP) —Al Fast, a representative of the American Guild of Variety Artists, said today he would attempt to stop a performance by the Beatles in Jacksonville Sept. 11 unless they joined the union. It would require the British singers to pay $1,800 in union fees and dues.

Taxes Begin at Home For $52,000 Winner

Special to The New York Times

POUGHKEEPSIE, Aug. 10 —Mrs. A. Louis Rubin of 166 Academy Street, who won $52,322.60 in the Twin Double at Monticello Raceway last Saturday, is going to have some personal assistance in figuring her Federal tax.

Leon Greenberg, administrative vice president of the raceway, presented Mrs. Rubin with a check for the $52,322.60 today at Wallace's Department Store where she is sales promotion manager. Waiting to take her to lunch afterward was her husband, who happens to be collection manager in the Poughkeepsie area for the Internal Revenue Service.

Mr. Rubin said that he estimated that 65 to 70 per cent of the total his wife won would go for state and Federal taxes. He said he expected to take a couple of days off later this week to figure his wife's tax liability.

Foley Square Tenants Win Another Delay of Eviction

The tenants in 320 Broadway, a 16-story office building adjacent to the site of the new Federal Office Building on Foley Square, have won another delay in their fight against eviction by the Federal Government.

The United States Court of Appeals scheduled a hearing for Thursday, at which the tenants will appeal last Wednesday's Federal Court ruling ordering their immediate eviction.

The tenants are contesting the court's finding that the buildings are an immediate hazard because of excavation work on the Federal site.

MUSIC NOTES

The Municipal Concerts Orchestra, Julius Grossman, conductor, with Luci Guarardo, soprano, will perform at Astoria Park, Queens, tonight at 8:30.

Also today: Downtown Manhattan Concert Band, Vincent La Selva, conductor, Bowling Green Park, 12:15 P.M.; Sally Hill, organist, St. Paul's Chapel, Columbia University, noon.

SPEECH AFFECTED IN UNDERSEA LIFE

Continued From Page 35

[aft]er the Red Sea for a week, and [an]other group stayed four [we]eks beneath the sea at a shal[lo]wer depth.

[Y]oung (free) divers have ... to considerably great[er] ... than the four who ... at Platagenet Bank, ... no one has remained under ... pressure for so long.

The experiment, under the [s]ponsorship of the Office of [N]aval Research, the Naval Medical Research Laboratory at ... was the first in the open ocean.

The potential advantage to the Navy of establishing a sea "base," or combination work quarters and living accommodations, on the ocean floor could be of major importance in any underwater work at great depths. Very little of a diver's time—when he is working under considerable pressure — is spent in useful work; most of it is spent under decompression to eliminate the danger of the "bends," the absorption of gas in his bloodstream. After each dive an hour's bottom time at 200 feet requires two hours of decompression; the diver is winched slowly to the surface, dangling in darkness at the end of a long line.

If the diver had an underwater base with its atmosphere ...

ambition" who was making $100 a week singing with the Tommy Dorsey band.

Since the abduction, young Sinatra has become an international celebrity and has been offered $100,000 for his kidnapping story, Mr. Forde said.

'Chicanery' Is Charged

A third defense lawyer, Charles Crouch, said young Sinatra's actions "are suspect to chicanery from start to finish." He asserted the issue was "not who committed the crime, but was there a crime committed?"

Mr. Forde said evidence would be presented to show that a mysterious "financier" was involved in the abduction. He declined to elaborate.

The defense allegations came in opening statements to the jury. Earlier, the Government prosecutor, Thomas Sheridan, said that charges of kidnapping and conspiring to kidnap would

Nevada Highway Patrol roadblock shortly after the adbuction. "At no time was he tied or restrained from leaving," Mr. Forde said.

Young Sinatra arrived home last night from Europe, but was not present in the courtroom. United States District Judge William G. East is presiding.

After the defense opening, the jury of nine men and three women heard testimony from the first Government witnesses.

One witness, Howard M. Robinson, a Phoenix, Ariz., gun collector, identified Keenan as the man to whom he sold a small pistol for about $55 last October at his Phoenix home. The pistol is one of several guns seized by Federal Bureau of Investigation agents in arresting the defendants.

Another witness, E. B. Van Houten, a Pheonix gun salesman, however, was unable to identify a second pistol.

A.M.A. President Attacks Johnson's Health Message

CHICAGO, Feb. 11 (UPI)—The president of the American Medical Association said today that President Johnson's health message to Congress was a "remarkable document of inconsistency and misinformation."

Dr. Edward R. Annis, the A.M.A. president, attacked the Administration's health program in a speech before the Chicago Rotary Club.

Dr. Annis said President Johnson was inconsistent in having declared that elderly Americans should not be subjected to a test of need for health care and, at the same time, in having called for all states to enact the Kerr-Mills Law for medical care based on need.

He said that under the President's proposals, "some 18 million elderly would receive more than $35 billion in benefits during their lifetime at tax payers' expenses and they would have paid nothing for these benefits."

Delaware Budget Offered

Special to The New York Times

DOVER, Del., Feb. 11—Gov. Elbert N. Carvel asked the State Legislature today to approve a budget of $113.5 million, the largest in Delaware's history. No new taxes were requested. Nearly half, $51 million, would go for education in the fiscal year starting next July 1. Last year's budget requests totalled $101.8 million, but the amount finally appropriated by the Legislature was close to $112 million.

A.M.A. Head Urges Renewed Fight Against Administration Medicare Bill

By Austin C. Wehrwein

MIAMI Beach, Nov. 30—Dr. Donovan F. Ward, president of the American Medical Association, set the stage today for continued conflict with the Administration on [illegible] under Social Security.

"The battle must go on," Dr. Ward, a 60-year-old Dubuque, Iowa, surgeon, told the 228-member House of Delegates at the opening session of its convention here.

He called on every doctor in the 204,000-member association for renewed efforts to block enactment of the Administration's so-called medicare bill.

The delegations from the District of Columbia and Michigan formally offered proposals to compromise on the issue, which has wracked the A.M.A. in various forms for 20 years. However, Dr. Ward stood fast, declaring:

"We do not, by profession, compromise in matters of life and death. Nor can we compromise with honor and duty."

It appeared that his speech canceled any chance for a compromise. It is believed the House of Delegates, which is to pass on a hearing committee report Wednesday, will take a stand-pat position.

Alternatives Are Offered

The District of Columbia delegates suggested an alternative to both the Kerr-Mills Act and the medicare bill that would employ broadened Blue Cross-Blue Shield and commercial health-insurance coverage. The Michigan proposal called for Federal subsidies for the health insurance of elderly who are indigent and tax credits on a scale related to income for the medical expenses of those over 65 years old. The Michigan delegation also proposed a supplementary resolution urging the A.M.A. to back a plan for a combination of subsidies and tax credits that would affect all citizens.

Dr. Ward's speech was emotional [illegible] worded but he delivered it [illegible] almost bedside-manner style. The delegates listened attentively, interrupting him seven times to applaud.

Associated Press

Dr. Donovan F. Ward

He said that the results of the national elections last Nov. 3—especially the Democratic gain of 38 seats in the House of Representatives and the defeat of three Republican members of the House Ways and Means Committee, where the medicare bill has been stalled—had forced the association to "face up to certain grim realities."

However, Dr. Ward, who supported the Republican Presidential candidate, Senator Barry Goldwater, denied that the landslide for President Johnson was a mandate for medicare. He again endorsed the Kerr-Mills Act, which provides Federal aid to states for medical care to the poor.

"We have unmistakable evidence from the utterances of Administration spokesmen and other champions of the welfare state that the election results are to be translated into a mandate for quick Congressional ratification of all such welfare programs as medicare," he said. "Mandate? There was no debate of the issues in the campaign. It is generally conceded that the voting was more anti than pro."

Dr. Ward said voters "were plainly determined to keep things as they are." He also said that most of the campaign polls and surveys the A.M.A. had seen showed that "the public is opposed to voting health care for the elderly onto the Social Security system."

Special Session Possible

Dr. Ward said that if necessary a special meeting of the House of Delegates would be called in the next few months to plan further steps to oppose the medicare legislation. The next meeting would normally be held next June.

A special session would be the first of its kind for the A.M.A. in 61 years. It would, it is expected, set in motion a costly lobbying and "public education" program directed by the association's political action arm, the American Medical Political Action Committee.

Dr. Ward today anticipated such an effort when he predicted that when more of the new Congressmen "hear the whole story" they would understand that the medicare bill "threatens the foundation of the nation's protection against disease and suffering."

Dr. Ward acknowledged, however, that the election meant a "significant loss of votes" in Congress for the A.M.A. He predicted a "furious hurricane" and "assaults by the Administration, flushed by almost unprecedented victory at the polls." Organized labor, he continued, could turn its heaviest guns on the A.M.A., along with the Senior Citizens Council which, he said, was subsidized for lobbying by the Democratic National Committee.

"The outlook is neither pleasant nor easy," he declared.

Dr. Ward stressed that the A.M.A. opposed both making "older persons Federal wards" and "the invasion of the voluntary relationship between the patient and the physician." Interestingly, he did not, however, use the term "socialized medicine," which over the years has been a favorite catchword of A.M.A. spokesmen.

The medicare bill died in a Senate-House conference committee as Congress adjourned Oct. 3. However, President Johnson has given the measure a top position in his program for the next session and many observers assume it will pass in some form soon after the new Congress meets in January. Dr. Ward said in his speech that such assumptions were "an arrogant affront to the dignity and integrity of those who have just been elected."

The medicare proposal, in the form of the King-Anderson bill in the last Congress, proposed an increase in Social Security rates and a broadening of the Social Security tax base. The resulting money would be used to provide hospital and nursing home care and related benefits for those 65 or older within Social Security coverage. The benefits would range from 45 to 180 days depending on the amount the individual paid as a "deductible" charge under a preset scale.

Under the Kerr-Mills Act, which the A.M.A. clings to as the answer to medicare, matching funds are given to state welfare programs. The range of services is wider and extends to those who are not under Social Security, too. However, a means test is required, and opponents call the system essentially a charitable one.

Apart from A.M.A. fears that medicare under Social Security is an opening wedge to further Federal action in the field of medicine, the contention is made that medicare is financially unsound and that it would tax the young for the benefit of many older persons who do not need Government help.

Thirty-eight states, the District of Columbia, Guam, the Virgin Islands and Puerto Rico have so far implemented the Kerr-Mills Act.

A.M.A. Stand Is Scored

Special to The New York Times

MIAMI, Nov. 30—William R. Hutton, information director of the National Council of Senior Citizens, charged today that the A.M.A. was "desperately trying to play down the mandate for medicare which the President won."

Mr. Hutton, speaking at a meeting of senior citizens club leaders here, declared that an "incredibly twisted election analysis" offered at the A.M.A. convention "demonstrated an extraordinary capability for self-deception among conservative doctors."

"The A.M.A.'s hierarchy's reaction to organized medicine's election defeats is to propose more money for propaganda, to set up new national communications networks and to give further prestige to their already intemperate spokesmen," Mr. Hutton said.

British Envoy to Ask Cairo | Parliamentary Under Secretary.

A.M.A.'s Next Leader

Dr. James Ziegler Appel

Special to The New York Times

MIAMI BEACH, Dec. 2—Dr. James Ziegler Appel, the 57-year-old president-elect of the American Medical Association, practices medicine alone in Lancaster, Pa., a pleasant manufacturing and farming-area city in the Pennsylvania Dutch country. Dr. Appel is the epitome of the family doctors the American Medical Association idolizes. A surgeon and a general practitioner, he is the son of a doctor, and was born in the house where he now has his office.

Man in the News

He is remembered by his three sisters as a youth who would hold forth to a group of enthralled playmates. The sisters were sure he would become a clergyman, like his grandfather, but his father always insisted, "No, Jim's going to be the doctor."

The young Appel received Phi Beta Kappa honors at Franklin and Marshall College in Lancaster, where he is now director of health services. He won his medical degree at the University of Pennsylvania School of Medicine in 1932, and joined his father in practice the next year.

This was in the depth of the Depression. His wife, the former Florence Burch of Texas (she was the sister of a medical-school classmate), calls that Dr. Appel's first month of practice netted him only $40. Although he was in practice with his father, the elder Appel was in the state capital at Harrisburg most of the time then as Secretary of Health.

Roots Deep in State

His father, the late Theodore B. Appel, was president for one term of the State Medical Society. The family's roots are deep in Pennsylvania, his ancestors having migrated to the state from the Palatinate area of Germany in 1732.

Dr. Appel, who will take office in June, early showed a capacity for involvement in a variety of activities. He became a member of the State Medical Society three years after he graduated from medical school. He became a delegate to the American Medical Association in 1945 and a trustee in 1957, and has been vice chairman of the board of trustees since 1962. He relinquished this position upon being chosen president-elect today.

As chairman of the Joint Commission on Accreditation of Hospitals, he holds a position of great power in American medicine. There is hardly an aspect of medicine in which he has not been involved at one time or another.

His World War II National Guard service was cut short by a chronic mastoid condition, and today he wears a hearing aid. But he later helped reorganize the Pennsylvania National Guard, retiring in 1949 with the rank of lieutenant colonel. He is a member of the World Medical Association and for the last two years has been a United States delegate to the World Health Organization.

Associated Press Wirephoto

Still a family doctor
(Dr. Appel after his election in Miami Beach)

'Devotion and Humanism'

After his election today to a position that will require almost constant travel, he reflected on the rewards of being a general practitioner. "He becomes infused with a feeling of devotion and humanism," Dr. Appel said. "He and his patients get to know one another as persons. The rewards are soul-satisfying. I am a surgeon but I am doing general practice and I love it."

When he takes over next June as president of the A.M.A., he will virtually have to stop seeing patients. But he said that there was such a cooperative spirit in Lancaster that others doctors would help out until his term was over.

Politically, he is a Goldwater Republican who thinks the A.M.A. has done a "pretty good job" in its opposition against Federal medical programs. He said that he was not at all sure that medicare would pass if the A.M.A. continued to do a good job in opposing it, and that the more people learned about medicare and about the Kerr-Mills Act, the more they liked the Kerr-Mills system.

And if medicare is passed? "The A.M.A. believes in obeying the laws as long as they are on the books," he said.

But he is urging a strong offensive counterattack rather than a defensive position, to preserve medical practice as he knows it.

Dr. Appel, who is 6 feet, 1 inch tall and weighs 185 pounds, sails as a hobby, and has his own boat.

He is the father of five children, four daughters and a son.

A.M.A. TO STEP UP MEDICARE BATTLE

Bars Compromise and Acts to Oppose Administration

By AUSTIN C. WEHRWEIN
Special to The New York Times

MIAMI BEACH, Dec. 2—The American Medical Association's House of Delegates rejected any compromise today on its stand against medicare, reiterated its support of the Kerr-Mills Act, and began preparing its opposition to the Johnson Administration's health-care programs.

Dr. James Z. Appel of Lancaster, Pa., was chosen president-elect, to take office next June. He defeated Dr. Donald E. Wood of Indianapolis by a vote of 131 to 94. A registered Republican and a supporter of Senator Barry Goldwater of Arizona, Dr. Appel said that he had discussed medical care with President Johnson when Mr. Johnson was a Senator, and that he hoped to meet him again. But he indicated that the A.M.A. would not yield on its position.

The House of Delegates, which makes policy for the 204,000-member association, rejected by a voice vote compromise resolutions offered by the delegations from Michigan and the District of Columbia. The proposals would give the Federal Government a minimal role in providing medical care for the aged.

Any Federal action in setting up health-care programs is anathema to all but a few of the 228 members of the House of Delegates.

In the closing hours of the house's semiannual meeting, the leaders steadfastly refused to concede that the Administration's medicare measure for hospital and nursing care for those 65 or older under Social Security would pass or that such a Federal program was necessary at all.

Neither President Johnson's landslide victory over Senator Goldwater Nov. 3 nor Senator Clinton P. Anderson's confidence that a medicare bill will pass by Easter had any apparent effect on the doctors here. Mr. Anderson, a New Mexico Democrat, is co-author of the medicare measure.

Meeting to Be Dec. 13

The expression of the official House of Delegates position came in a series of moves. One was the announcement of a strategy meeting, to be held Dec. 13 at the headquarters in Chicago. The A.M.A. will pay the expenses of two delegates from each state at that session, which will open "the battle," Dr. Donovan F. Ward, the president, said here two days ago.

The house gave the trustees full authority to spend what they consider necessary, and said the delegates "heartily endorse" Dr. Ward's plea to back the Kerr-Mills law and to fight medicare. The house approved a statement saying that Dr. Ward "had correctly depicted our deep interest—our concern ty medical societies to stimulate tion."

It also adopted a weakened version of a California resolution that urged state and county medical societies to stimulate state and local governments to improve medical services by methods that would include voluntary health insurance.

By voice vote, the delegates then accepted a committee report that said the Michigan compromise was unnecessary and rejected on the merits the compromise offered by the District of Columbia.

The Michigan delegation's compromise suggested a combination of Federal tax credits and subsidies to encourage the purchase of health insurance. The District of Columbia delegation suggested that the A.M.A. ask Congress to develop a "realistic" plan for those 65 years of age or older in cooperation with Blue Cross-Blue Shield and other private insurance companies.

Both compromises envisioned a way to bypass the 20-year-old controversy that has raged between the A.M.A. and proponents of expanded Federal health activities. Neither compromise would have employed financing through Social Security. Such financing is a major source of the A.M.A.'s opposition to medicare.

On the whole the brief floor discussion was mild. Dr. Donald N. Sweeny Jr., the leader of the Michigan delegation, said he accepted the "wisdom" of the house. But he added:

"We must convince legislators that physicians do not have selfish worries about Socerns about continuing the present excellent quality of medical care, about the proper control of the cost of that excellent care."

When the District of Columbia delegation sought to modify the legislative committee's adverse report on its resolution, on the ground that the committee had "misinterpreted" the delegation's stand, the house voted the objection down.

The house also passed a resolution that changed the A.M.A.'s "neutral" stand on birth control and sexual behavior to one of outright support of birth control, even when information on it is disseminated by nonmedical bodies and tax and community-supported welfare agencies.

Dr. Wood, 55 years old, who lost his bid for the presidency, is head of the association's political arm, the American Medical Political Action Committee, which was praised by the house. Dr. Appel, 57, who has been vice chairman of the board of trustees, has had longer service in various levels of organized medicine. Traditionally, such seniority is what counts most in an election for the presidency.

The medicare bill, which was bottled up in the House Ways and Means Committee in the last session of Congress, would provide hospital and nursing home care for Social Security recipients starting at age 65. The Kerr-Mills Act provides matching grants to the states for medical services to the poor, and what the A.M.A. likes about it most is that the administration of the benefits is handled by state and local bodies.

Burns Fatal to Ohio Boy

CINCINNATI, Dec. 2 (AP)—A mile-long run by 11-year-old Sharon Millbrooks to get help for her brother in a fire turned out to have been futile. The boy, Cedric, 4, died today of burns. The police said Sharon returned home from school yesterday and found the family apartment afire. Cedric, two brothers and four cousins, all under 6 years of age, were there. None of the other children was burned seriously.

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Split of World Reds

By ROBERT C. DOTY
Special to The New York Times

ROME, Tuesday, Sept. 8—Italy's top-ranking Communist derided last night the idea that the criticism of Soviet tactics by Palmiro Togliatti shortly before his death signaled a new split in the world Communist movement.

Luigi Longo, who succeeded Mr. Togliatti as Secretary General of the Italian party, made the first authoritative comment by an Italian Communist on the Togliatti memorandum since its posthumous publication Friday. He spoke at a meeting of party members at Genzano, just south of Rome.

The memorandum was a long paper prepared by Mr. Togliatti as a basis for discussion with Soviet Communist leaders just before he died in the Crimea last month. In it the Italian party leader opposed the Soviet effort to expel the dissident Chinese Communists and criticized many aspects of Kremlin policy, including slowness in restoring personal freedoms.

Binding Ties Cited

"The ties that bind us to the Communist party of the Soviet Union and to all brother parties," Mr. Longo said tonight, "spring from our very nature as a workers' revolutionary party that fights for Socialism, spring from the unconditional support we give to the orientations expressed in the Twentieth Party Congress and to their implementation on the part of the Soviet party and, in particular, of Comrade Khrushchev."

The effect of Mr. Longo's remarks was to soften the impression of Italian Communist criticism of the Kremlin without modifying any of the specific points of difference. In fact, the new leader reiterated his predecessor's assertion of the right of each Communist party to seek its own road to Socialism without dictation from Moscow.

Criticizes Regime

Turning to internal affairs, Mr. Longo termed the current Italian governing coalition of non-Communist leftist parties with the centrist Christian Democrats a failure largely because of the exclusion of the Communists. He declared his party's willingness to follow a "common line of action" with non-Communist parties.

This is the line of Communist cooperation within the existing political system that characterized Mr. Togliatti's 20 years of party leadership. This line—and Mr. Longo — may face serious challenge from left-wing "hard line" party elements led by Pietro Ingrao, a member of the Central Committee.

Mr. Togliatti's memorandum, Mr. Longo said, impressed the world with its "profundity," "precision" and "courage."

"The memorandum disconcerted by its frankness," Mr. Longo said, "those who accuse

Senator Barry Goldwater would attempt to reduce income taxes by 25 per cent over a five-year period and to stabilize Federal Government expenditures at roughly present levels, a source close to the Republican Presidential candidate said today.

Mr. Goldwater, who spent much of the day filming an informal network television show at his home here, will make a major speech on tax policy tomorrow night at Los Angeles.

[In a Labor Day address in South Bend, Ind., the Senator's running mate, William E. Miller, warned that the policies of the Administration would flood the United States with foreign labor and goods.]

The source, familiar with Mr. Goldwater's thinking said he guessed that no tax cut could be proposed until the fiscal year 1967, beginning July 1, 1966, if Mr. Goldwater were elected President.

Polls Viewed as Accurate

The source also said today that polls showing as many as 27 per cent of Republican voters defecting from Mr. Goldwater in a so-called "frontlash" might be "accurate at the moment."

However, the source expressed the belief that most dissident Republicans would return to the party as the campaign unfolded.

"I think we are going to win in the face of all statistics and polls to the contrary," he declared.

Mr. Goldwater first broached the idea of what he calls "automatic" annual income-tax cuts in a Labor Day statement that was released Saturday.

His views evolved after consultation with such "conservative" and non-Keynesian economists as Dr. Warren Nutter of the University of Virginia and Dr. Milton Friedman of the University of Chicago, the source told newsmen here.

Mr. Goldwater's hope for a series of tax cuts or rebates is based, the source said, on

Continued on Page 16, Column 3

NYT 9/8/64 1:7

TV NETWORKS BAR A.M.A.'S SPOT ADS

Refuse to Show Dramatized Commercials Opposing Bill on Medical Care

By VAL ADAMS

The three national television networks have declined to sell time to the American Medical Association for a series of one-minute dramatized commercials opposing the Administration's medical care plan. They said it was against their general policy to sell a minute at a time for a controversial issue.

The association, an advocate of private medical care, is also seeking to buy a half-hour of time on a network for a discussion of the "care-for-the-aged issue."

The networks have not ruled against this, but say they will determine if a time period is available next month. For its spot announcements, the association is now expected to seek time on independent stations.

The medical care bill, which combines health insurance for the aged with increases in Social Security cash benefits, promises to become a sharp campaign issue between President Johnson and Senator Barry Goldwater.

Bill Pending in House

Last week the Senate approved the bill and sent it to the House, where it faces an uncertain fate. In July the House approved a medical care bill without the health insurance feature, which was tacked on by the Senate. Efforts will be made in the House tomorrow to send the bill to conference to iron out differences in the two versions.

In one of the proposed one-minute commercials, a taxi driver was to speak enthusiastically to his passenger of the benefits his elderly mother would receive from the new medical care plan. The male passenger then was to ask the driver why he and others should pay extra taxes for the plan when health care already was available in all states.

In another proposed dramatization, a housewife was to be told that no new plan was needed because of existing benefits.

"The spots hit pretty hard at the medical care plan," one source said yesterday.

Recently the medical association hired Fuller & Smith & Ross, Inc., a New York advertising agency, for the television phase of a campaign that also would utilize newspapers and radio.

Under the initial plan, about

water's views on "conventional" nuclear weapons and affirmed the inviolability of Presidential control over nuclear arms.

"Make no mistake," the President declared. "There is no such thing as a conventional nuclear weapon."

Affirms Responsibility

Noting that for 19 years no nation had made use of atomic weapons, Mr. Johnson continued:

"To do so now is a political decision of the highest order. It would lead us down an uncertain path of blows and counterblows whose outcome none may know.

"No President of the United States can divest himself of the responsibility for such a decision."

A crowd estimated at 100,000 greeted the President in the square. It was a labor crowd, one of mixed ages, colors and national origins.

Mr. Johnson addressed them vigorously in a voice that sounded almost strident as it echoed over loudspeakers throughout the square.

Desultory Applause

But while the sound was that of the political campaigner, the partisan tone was muted. As he spoke, mostly in abstractions, his listeners were stirred only to occasional desultory applause. They were not moved.

As if he sensed this, the President gave them a long impromptu epilogue in which he spoke of his "dream" for the nation as he first glimpsed it when he was a boy under the "Texas sky."

He said his dream concerned the "simple wants of people," which, he said, "is what America is really all about."

"Reality rarely matches dream, but only dreams give nobility to purpose," he said. "This is the star I hope to follow."

When he had finished speaking, the campaigner in him took over. He stepped down from the platform and into the

Continued on Page 18, Column 1

British Sell Soviet $84 Million Plant

By CLYDE H. FARNSWORTH
Special to The New York Times

LONDON, Sept. 7 — After more than six months of hard bargaining, British businessmen and Soviet officials signed today the biggest single contract in British-Soviet trade history.

The agreement between Techmashimport, the Soviet state purchasing agency, and Polyspinners, Ltd., a group of three major British companies, covers the supply by the British of the major part of a polyester fiber plant costing about £30 million ($84 million).

The plant is to be built in Krasnoyarsk, a transportation and industrial center in central Siberia. The plant, which will cover 50 acres and employ 3,500 people, will mainly produce syn-

Hurricane Moving On Southeast Coast

By The Associated Press

MIAMI, Sept. 7—A hurricane almost twice the size of the state of Georgia pointed 130-mile-an-hour winds toward the United States tonight. A hurricane watch, or preliminary alert, was in effect from Palm Beach to Wilmington, N. C.

Seas and tides along parts of the coast were already rising, and gale-force winds were expected by late tomorrow. Small craft were told to stay in port.

The hurricane, called Dora by the Weather Bureau, was about 525 miles east of Cape Kennedy, Fla., and 540 miles east-northeast of Miami.

The storm was moving on a westerly course at 13 miles an hour. The highest winds near the center were estimated at

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... was raised by the ... unity Civic Asso- ... raffle and dance ... through contribu- ... Detroit Furniture ... ompany, Inc., and ... Inc.

... $200 each ... o Ann Grif- ... , old, of Marcy ... Thomas Butler, 18, ... Marcy Houses and ... kins Houses, an- ... ject in Brooklyn.

...etry Experts ... ngress in Lisbon

... New York Times

... pt. 7—The world's ... s on photogram- ... ere today at a ... will assess prog- ... velopment of new ... nd techniques in ... which entails the ... photographs in ... mapmaking.

... delegates from 52 ... take part in the ... onal congress of ... onal Society for ... try. The last con- ... ld in London in

... can Society of ... try has more than ... led by the society ... liam Fischer.

extended 300 miles to the north and 150 miles to the south.

The storm was expected to continue in the same direction and at the same speed tonight and tomorrow, with little change in size or intensity.

Another hurricane, called Ethel, picked up forward speed to 20 miles an hour and was about 500 miles southeast of Bermuda. This was 800 miles east of the storm Dora.

Highest winds near the center of the hurricane Ethel were 80 miles an hour. Gales reached out 200 miles to the northeast and 85 miles to the southwest.

The storm's course was expected to take its gale winds into the Bermuda area tomorrow. Small craft around Bermuda were advised to remain in port.

Forecasters said the hurricane Dora probably would start raking the coast between the Carolinas and Florida with gales, smashing surf and high tides by tomorrow night.

"It's too early to say in what section of the coast the dangerous winds will be most likely," one forecaster, Paul Moore, said at Miami.

"If it makes a landfall anywhere from Florida to the Carolinas, the other areas will be aware the storm is there," he added.

The Weather Bureau, which earlier said that the storm Dora's huge area of circulation might absorb the other storm, said today that it appeared they would remain separate.

Red Cross Prepares

ATLANTA, Sept. 7 (AP)—The Red Cross began sending emergency disaster workers today to cities along the upper Florida and the Georgia coastlines, being threatened by the hurricane Dora.

Southeastern Red Cross headquarters said the workers included nurses, first-aid workers, food specialists and others who would assist in operating shelters.

It said hundreds of shelters were being prepared. They are mostly in public buildings from Jacksonville, Fla., to Elizabeth City, N.C., according to W. D. Dibrell of Atlanta, area director of disaster operations.

Philadelphia Curfew Lifted

PHILADELPHIA, Sept. 7 (AP)—Mayor James H. J. Tate announced today the lifting of a proclamation placing a 24-hour curfew on residents of the North Philadelphia area where Negro rioting and looting broke out last Aug. 28. The Mayor said the lifting of the proclamation would be effective at 8 A.M. tomorrow.

Bank in Guiana Blasted

GEORGETOWN, British Guiana, Sept. 7 (UPI)—Saboteurs dynamited the Wismar branch office of the Royal Bank of Canada today, heavily damaging the building.

quired something of the reputation as an eminent realist, a realist who with a single-placed line can restore a sense of proportion to those heady gatherings in Beverly Hills.

On the National Broadcasting Company outlet, the first public exposure of this mix of personalities led to a notably refreshing format, an off-beat colloquy wherein Mr. Ewell spoke of sundry matters that attracted his interest and Mrs. Ewell contributed the interjection that kept the proceedings on a nicely uneven keel. Theirs was the charm of two quick minds at work and at pleasure.

After Mr. Ewell started to do a book review on a new volume about the Mafia, he asked his wife if she knew anything about the organiza-

The Ewells, as a matter of fact, were only two of the day's quota of talking actors making their debuts in new shows. Robert Alda is also appearing on NBC from 10:10 A.M. to noon. His is the thankless assignment of answering telephone calls in the manner of Brad Crandall in the evening. On his premiere he had the misfortune to be stuck with a succession of bores who relentlessly asked questions that Mr. Alda was the first to say he hardly was qualified to answer.

On the Columbia Broadcasting System radio network, Lucille Ball also started a five-minute talk show, and her first guest was Danny Kaye, a C.B.S. colleague. A house commercial.

NYT 9/8/64

TV NETWORKS BAR A.M.A.'S SPOT ADS

Continued From Page 1, Col. 7

$750,000 of a $1 million budget was to go for television. It is uncertain now how much will be spent for TV.

Last Friday, A. E. Duram, senior vice president of television and radio for the agency, presented an outline of the campaign to the networks. He met with representatives of the American Broadcasting Company, Columbia Broadcasting System and the National Broadcasting Company.

"A. B. C. and N. B. C. said that if we changed the copy around and resubmitted it they would be glad to read it over," Mr. Duram said. "However, they held out no promise. But as for C. B. S., I don't think they would carry the spots in any case."

There was no indication that the medical association planned to revise the copy. Mr. Duram said he would try to place the spot announcements on independent stations throughout the country.

It is understood that the Federal Communications Act does not address itself specifically to what stand a station licensee must take with a time order such as the medical association proposal. Generally, the act requires fairness and balance in programing and presenting various points of view.

Ernest Lee Jahncke Jr., vice president of standards and practices for N.B.C., said his network required at least 15 minutes to be alloted for a controversial issue. One-minute announcements by a political candidate or party are exceptions. Both C.B.S. and A.B.C. have similar rules.

Mr. Jahncke also recalled that N.B.C. had sold a half-hour of time to the medical association a few years ago for a rally it held in Madison Square Garden. The rally was to engender opposition to a medical care plan then backed by President Kennedy.

A.M.A. Called Extravagant

Special to The New York Times

WASHINGTON, Sept. 7—Senator Clinton P. Anderson, who has led the campaign for a medical care bill, said today that the American Medical Association was "being extravagant" in its campaign against the bill.

"It's too much money, but I can't stop them," the Mexico Democrat said. "I still think we've got an excellent chance of getting our program through Congress."

Senator Anderson said not only doctors but also drug stores had been asked to contribute to the A.M.A. fund.

Nauvoo Now a Landmark

NAUVOO, Ill., Sept. 7 (AP)—This venerable town on the banks of the Mississippi River has been designated a national historical landmark. Earl Reed of the National Park Service presented a bronze plaque yesterday. It was at Nauvoo that Joseph Smith and his brother Hyrum established a colony of the Church of Jesus Christ of the Latter-Day Saints in 1839.

11:00 (2) The McCoys (R)
(4) Concentration
(7) Get the Message
(9) Genius: "Einstein"
(11) Cartoons
11:25 (5) News Report
11:30 (2) Pete and Gladys
(4) Jeopardy (C)
(5) Romper Room
(7) Missing Links
(9) Girl Talk

Afternoon

12:00 (2) Love of Life
(4) Say When (C)
(7) Father Knows Best (R)
(9) News: John Wingate
12:15 (9) Joe Franklin's Memory Lane
12:25 (2) News: Robert Trout
12:30 (2) Search for Tomorrow
(4) Truth or Consequences (C)
59:4 (5) Cartoon Playtime
(7) Tennessee Ernie Ford
12:45 (2) Guiding Light
12:55 (4) News: Ray Scherer
1:00 (2) Leave It to Beaver
(4) Bachelor Father (R)
(7) Film: "Embraceable You," Dane Clark (R)
(11) Film: "Maryland" (1940), Walter Brennan. Horse Racing (R)
1:25 (5) News Report
1:30 (2) As the World Turns
(4) Let's Make a Deal (C)
(5) Film (See 10:00 A.M.)
(9) Film (See 9:30 A.M.)
1:55 (4) News: Floyd Kalber
2:00 (2) Password
(4) Loretta Young Theater
2:20 (11) News Report
2:30 (2) Art Linkletter's House Party
(4) The Doctors
(7) Day in Court
(11) Life With Father (R)
2:55 (5) News Report
(7) Lisa Howard and News
3:00 (2) To Tell the Truth
(4) Another World (C)
(5) Bat Masterson (R)
(7) General Hospital
(9) News: Joseph King
(11) Topper (R)
3:15 (9) V.I.P.'s
3:25 (2) News: Douglas Edwards
3:30 (2) Edge of Night
(4) You Don't Say (C)
(5) Hall of Fun
(7) Queen for a Day

5:0 ... 5:3 ... 6:0 ... 6:3 ... 7:0 ... 7:3 ... 8:0

Rad...

Music

9:15-11 A.M., WNCN: Music of the Masters.
Serenade in E for Strings....Dvorak
Bachianas Brasilieras No. 1, Villa-Lobos
La Boutique Fantasque, Rossini-Respighi
Nocturne ....Borodin
10:07-Noon, WQXR: Midmorning Concert
Royal Fireworks Music Suite, Handel-Harty
Violin Concerto No. 1 in D..Paganini
Preciosa Overture ....Weber
Florida Suite: By the River....Delius
Gayne Suite ....Khatchaturian
11:05-Noon, WNCN: Recital Hall.
Quartet for Winds ....Nielson
Three Ballades ....Chopin
Noon-12:55, WNYC: Municipal Symphony
Credendum ....Schuman
Piano Concerto in A minor, Schumann
1:07-2, WQXR: Midday Symphony.
Piano Concerto No. 5 in E flat, Beethoven
Forest of the Amazon: Excerpts, Villa-Lobos
2-2:30, WHLI: Music That Lives.
Ballet Theater Orchestra, Levin, conductor.
Graduation Ball ....Strauss
3:05-4, WNCN: Afternoon Concert.
Entrata Festiva..............Peeters
Symphonie Concertante........Jongen
Fantasia on Greensleeves, Vaughan Williams
7-8:30, WNYC: Masterwork Hour.
Carnaval Overture; Cello Concerto;
Symphony No. 4..............Dvorak
8-9, WABC-FM: Stereo Evening Hour.
Symphony No. 3...........Beethoven
8-9, WBAI: Contemporary Music ...

10:0 ... 10-1 ... 11-1 ... 9:10 ... 9:30

Massachusetts Victor

Francis Xavier Bellotti

By The New York Times

BOSTON, Sept. 11 — The Democratic nominee for Governor of the Commonwealth of Massachusetts, clad in pajamas he had hardly had a chance to rumple, pointed at one of his numerous progeny this morning and said, "Tommy, take your finger out of the cereal." Then, blinking from the grogginess of an hour's sleep and the glare of photographers' lights, he plucked the nearest question out of the air and replied: "Rest awhile? I'm going to rest until this afternoon and then I've got to get going."

Man in the News

Francis Xavier Bellotti has been on the go most of his 41 years. He learned doggedness and imperviousness to rebuffs while selling magazines and house siding material door-to-door to earn his way through college. He learned attention to detail helping his wife, Maggie, to rear 12 children. He learned to like newspapermen at any hour of the day.

And although he has demonstrated how to gamble successfully in politics, some of the newspaper friends he plays poker with assert that he is only fair at five-card

Associated Press Wirephoto

Much better at politics than at poker

years ago, Mr. Bellotti unsuccessfully for District Attorney of Norfolk County, a crumbling Republican stronghold in eastern Massachusetts. The 81,794 votes he rolled up were the most amassed by a Democrat in that district. He decided to try for bigger stakes.

Big Moment in 1962

Playing it closer to his chest than he was wont to do with the boys Friday nights, Mr. Bellotti sensed a vacuum in the party power structure at the Democratic State Endorsing Convention at Springfield in June, 1962. National attention was being focused on the Senate fight between Edward M. Kennedy, the President's youngest brother, and Edward J. McCormack Jr., nephew of Speaker John W. McCormack.

With John A. Volpe, a Republican, in the Governor's chair, Endicott Peabody, a Yankee Democrat, and Lieut. Gov. Edward F. McLaughlin, an Irish Democrat, were tilting for the nomination. Mr. Bellotti, who had been courting convention delegates for the better part of a year, moved into the fight for the Lieutenant - Governor nomination.

When it appeared that Mr. Peabody would steamroller the convention, an attempt was made to get Mr. Bellotti to step aside for Mr. McLaughlin. But Mr. Bellotti had pushed too many doorbells and shaken too many hands. He stood by the cards that had been dealt him and prevailed.

The job of Lieutenant Governor entails ex-officio

was talk on Beacon Hill that "Bellotti is moving again." Mr. Peabody was on his way to compiling a creditable legislative record, but his public personality, because of an unfortunate stuffiness on television and his espousal of unpopular causes, was suffering.

Moreover, in overhauling of the State Department of Public Works, Mr. Peabody eased out Jack P. Ricciardi, an interim commissioner, Italo-Americans bristled. They contributed to Mr. Bellotti's campaign chest. So, too, did contractors who habitually donate "cover money" to both sides in an election year.

Served in the War

Although he has a dozen children, Mr. Bellotti is the only child of Mr. and Mrs. Peter Bellotti, Italian immigrants who lived in the Roxbury district of Boston. His mother, widowed early, served 20 years with the United States Immigration and Naturalization Service. She died a few weeks after her son's election in 1962.

After graduation from the English High School in Boston in 1942, Mr. Bellotti enlisted in the Navy. When he washed out as a pilot he turned to underwater demolition duty and rose from seaman to lieutenant (j.g.). After the war he turned to door-to-door salesmanship to earn his Bachelor of Arts degree from Tufts University and a law degree from Boston College. After marrying Margaret Wang of Wisconsin, Mr. Bellotti moved to Quincy to practice law and start a family.

His life left him little time for hobbies but, in addition to poker and handball, Mr. Bellotti is adept at karate, a form of judo. He is slightly under six feet in height and

MILLER ATTACKS AGED-CARE PLAN

Tours Connecticut on Hot Day for Sixteen Hours

By JOSEPH A. LOFTUS

Special to The New York Times

NORTH HAVEN, Conn., Sept. 11 — William E. Miller, the Republican Vice-Presidential candidate, divided his speechmaking time today between derision of Democratic social legislation and "setting the record straight" on Senator Barry Goldwater's views.

Representative Miller pounded the turnpikes and the blacktops to face six Connecticut audiences this humid, 16-hour campaign day.

In Hartford, Mr. Miller struck hard at the Administration's program of medical care for the aged under Social Security.

An overflow luncheon audience of about 1,000 persons in the grand ballroom of Hartford's Statler-Hilton Hotel applauded his attacks on the medical care plan and, in fact, responded readily to all applause lines in the candidate's speech.

Mr. Miller said that if the plan passed, the Democrats, if re-elected, would gradually add additional services, "including wigs and false teeth," and the Social Security tax rate would go to 25 or 30 per cent.

Mr. Miller's defense of his running mate, Senator Goldwater, has become a standard item in nearly all his speeches.

"Senator Goldwater has a wife and four children and he loves them very much," Mr. Miller said. "He has four grandchildren, and he loves them very much. I know Barry Goldwater very well and no man hates war or detests war more than Barry Goldwater."

The Republican Presidential candidate's only position on Social Security is to strengthen it, Mr. Miller said, and to be sure that people get out of it the same kind of dollars they put in.

He called the Administration's antipoverty program "the cruelest hoax foisted on the American people for the purpose of getting votes at their own expense that I have ever seen."

At Stamford, where he attended a breakfast rally, about 1,000 persons, mostly women, gave the candidate a cheering welcome at 9 A.M.

Outside the restaurant where the meeting was held, a half-dozen young men, calling themselves Independents and Republicans for Johnson and Humphrey, carried signs that read "Let's Sing Along With Barry — Call Me Irresponsible," "Who Is Bill Miller?," "Some of My Best Friends Were Republicans — Until the Cow Palace Farce."

Mr. Miller also spoke at Waterbury, Seymour and North Haven.

GOLDWATER ACCUSED OF DISTORTING CRISIS

WASHINGTON, Sept. 11

Goldwater Says Rising Power Of Presidency Imperils Nation

Continued From Page 1, Col. 4

met with derisive skepticism. When he said that, since he was not a lawyer, perhaps he should leave analysis of the Supreme Court to constitutional lawyers, there was a burst of loud applause and laughter.

A minor controversy surrounded the Senator's appearance. Dr. Herman Finer of the University of Chicago circulated a letter urging members to boycott Mr. Goldwater's appearance.

This led Mr. Pritchett to make an opening statement pointing out that Mr. Goldwater himself was a member of the association and that Lyndon B. Johnson spoke to the group in 1960 as a Vice-Presidential candidate.

Mr. Goldwater charged that the Supreme Court had abandoned the principle of "judicial restraint, with respect to acts of Congress with which it disagreed but which are founded on legitimate exercise of legislative power."

He said he was weighing his words carefully when he declared that "today's Supreme Court is the least faithful to the constitutional tradition of limited government" of the three branches of Government.

In particular, Mr. Goldwater condemned the school prayer and reapportionment cases.

He said that only a "half-hearted" effort had been made to justify the decisions as being "within the intent of the framers of the 14th Amendment to the Constitution."

Rather, he said, they are defended on the grounds that "results are desirable; that it really isn't good for children to say prayers in school and that it really is desirable to have state legislatures, in their entirety, apportioned on a one-man, one-vote basis."

This is "raw and naked power," he said. "The question under our system of government is not simply what decision is right, but also who has the right to decide. Only when the latter question is answered should the former be considered," he declared.

Wants Two Parties

Mr. Goldwater deviated from his text to explain that he did not like "me-tooism" in politics because it endangered the two-party system.

He said that he was worried about a "bastard, if you will excuse the bad language, which can be born to a sad marriage" and that can be a third party.

Mr. Goldwater said the United States must resist the rise of a third party and therefore resist the coming together of the two major parties because this would promote splinter political action.

In an allusion to his controversial views on extremism, he said that both parties "had to contend with the fringe" the Democrats with extreme leftists and the Republicans with extreme rightists. He said this had always been true, "so let's not get excited by this problem."

Some of his audience snickered or otherwise showed disstitutional detours that would kill or cripple the Federal system of Government even though the diffusion of power in that system appears to slow or to stop reform.

"On the contrary," Mr. Goldwater said, "the Federal system is itself our greatest political achievement. It is the very foundation of our greatness."

Mr. Goldwater arrived in Chicago this morning and told a few hundred persons at the airport that Illinois was one of the four states "we have to take and will take" to win the November election. The other pivotal states, he said, are California, Texas and Ohio.

Mr. Goldwater then drove to the Polish area on Chicago's north side to visit the Polish-American Museum in the Polish Roman-Catholic Union Building.

Because of white backlash, which is said to be especially strong among some Polish-Americans, Mr. Goldwater may do well within that ethnic group. However, he said nothing partisan as he toured the museum, looking at mementos of such figures as Paderewski, Pulaski, Kosciusko and Mme. Curie.

This afternoon, Mr. Goldwater and his wife Margaret attended a reception for Republican financial contributors at the Buckingham Court of the Essex House Hotel.

On Dec. 2, 1962, 70 conservatives met there without Mr. Goldwater's approval to begin the "draft Goldwater" movement. A bronze plaque commemorating that meeting was hung in the room.

Mr. Goldwater's speech to the American Political Science Association was a chance for him to perform for a tough audience. Although the Senator has a number of conservative intellectual advisers, he is opposed by much of the academic community.

Mr. Goldwater told the political scientists that the American tradition was one "of legitimacy combined with limited government."

The Senator contended that some persons "worship" strong Presidents simply because they approve of the results and goals achieved by a powerful figure in the White House.

Political Heroes Cited

"This," he argues, "is nothing less than the totalitarian philosophy that the end justifies the means; or, put in culinary terms, that you have to break some eggs to make an omelet."

His political heroes, he said, are those who "refrained from using power when they doubted the legitimacy of its exercise."

As examples Mr. Goldwater cited the Republican Senators who voted to acquit President Andrew Johnson in his impeachment trial even though they "despised" him.

He also praised the Democratic Senators who voted against Franklin D. Roosevelt's "court packing plan" in 1937 even though they disliked the then conservative cast of the Supreme Court.

The city has purchased nearly $3 million worth of Duncan meters. District Attorney Frank S. Hogan is looking into charges that bribery was involved in the sale.

On Tuesday four executives connected with the meter company pleaded guilty to conspiring with Gittelson to offer a $50,000 bribe to a city official. Gittelson has denied telling the executives he paid the bribe.

Mr. Screvane disclosed on Tuesday that he had asked the District Attorney's office to start the investigation that led to Gittelson's indictment. He did so, he said, because he had heard his name being wrongly bandied about. And he revealed that he had testified before a grand jury last June 30.

Comment by Mayor

Among the developments yesterday were these:

¶Mayor Wagner said he had not had a chance to discuss the matter with Mr. Screvane, but he added that the Council President was an "honorable man" in whom he had faith.

¶Indications were that Gittelson's trial before Justice Arthur Markewich might be delayed in view of a tiring four-and-a-half-week trial that his lawyer, Joseph E. Brill, only recently completed. Assistant District Attorney Burton B. Roberts said that he was ready to prosecute and that the four meter executives who pleaded guilty Tuesday to conspiracy

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GILLIGAN SHIFTED TO AVOID PICKETS

Sent to a Secret Post After CORE Planned Protest

By DOUGLAS ROBINSON

The Police Department decided yesterday to assign Lieut. Thomas R. Gilligan to an undisclosed post on his return to duty today because of a demonstration threat by the Brooklyn chapter of the Congress of Racial Equality.

Lieutenant Gilligan, who has been on sick leave since July 16, when he fatally shot a 15-year-old Negro boy, had been scheduled to resume work today from 8 A.M. to 4 P.M. at the 92d Precinct, 263 Bedford Avenue, in the Williamsburg area of Brooklyn.

The shooting of the youth, James Powell, ignited a series of riots in Harlem and in the Bedford-Stuyvesant section of Brooklyn.

The officer was subsequently cleared of any wrongdoing by a New York County grand jury and by the Police Department's civilian complaint review board. Both decisions were protested by civil rights groups.

Yesterday the proposed dem-

Continued on Page 30, Column 6

MILLS GIVES WAY ON AGED CARE BILL

NYT - 11/12/64 - 1:2

Says He Will Let Committee Act on Health Program if President Asks Him

By MARJORIE HUNTER
Special to The New York Times

WASHINGTON, Nov. 11 — The Chairman of the House Ways and Means Committee cleared the way today for early consideration of the Administration's plan for health insurance for the aged under Social Security.

Representative Wilbur D. Mills, Democrat of Arkansas, said he was ready to bring the long-stalled measure up in committee immediately after Congress convened in January if President Johnson asked him to.

His statement was made by telephone from Arkansas.

Sources close to the President said today that the Administration had not yet decided whether to push first for health insurance or excise tax cuts. Public comments by Administration officials have left the impression that both would be at the "top of the list."

Some Administration sources predict that Congress will pass some form of health insurance for the aged next year, even if it means bypassing Mr. Mills and his committee.

Compromise Foreseen

These sources say the Democrats now have the votes in the House to force through a discharge petition that would bring the measure to the House floor.

However, sources within the Administration consider it likely that some compromise will be worked out to win Mr. Mills's approval.

Mr. Mills has long opposed the Administration plan of financing health insurance under the Social Security system. He has said that he fears that rising medical costs will ultimately jeopardize the actuarial soundness of the Social Security System.

Mr. Mills has not abandoned his opposition to the plan. However, he has said that he hopes his committee can work out

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NEWS INDEX

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Treasury to Ease Depreciation Rule On Business Taxes

By EILEEN SHANAHAN
Special to The New York Times

WASHINGTON, Nov. 11 — A tax change that could save business as much as $200 million to $300 million a year is in an advanced stage of preparation in the Treasury Department.

The new tax benefit for business will come in the form of a major revision and liberalization of the Treasury's rules concerning depreciation on all business machinery and equipment. The change would not require legislation.

[President Johnson and Secretary of the Treasury Douglas Dillon, meeting in Texas, agreed Wednesday to recommend a cut in excise taxes of at least $550 million. Page 25.]

The depreciation rules were completely rewritten and liberalized two years ago, but many businessmen have been protesting that the rules are still too strict.

Despite any difficulties, the Treasury is hoping to get its revision of the rules completed by Dec. 1. This is because it

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MINOW MAY TAKE TOP CURTIS POST

Management Team Sought by Publishing Company

By ROBERT E. BEDINGFIELD

The Curtis Publishing Company has decided to place its management in the hands of a new team of prominent executives.

Newton N. Minow, chairman of the Federal Communications Commission under President Kennedy, has been offered one top position at the rebellion-torn company and is reportedly ready to accept the job.

Another top position will be given to A. Edward Miller, who resigned yesterday as publisher of McCall's magazine.

A third high post has been offered to an unidentified executive, but his acceptance has not yet been received.

Directors of Curtis are expected to act at a meeting in Philadelphia today on the hiring of both Mr. Minow and Mr. Miller and to designate titles for them.

The two men will share the executive direction of the company.

Indications last night were that Mr. Miller would be the

Continued on Page 55, Column 1

6 RAILWAY UNIONS THREATEN STRIKE

Shopcraft Workers Prepare for Walkout This Month— National Tie-Up Looms

By JOHN D. POMFRET
Special to The New York Times

WASHINGTON, Nov. 11— Officials of six unions representing railroad shopcraft workers decided today to prepare for a national railroad strike on Nov. 20 or 23.

The six unions represent about 160,000 of the 443,000 nonoperating railroad employes. Most of their members are engaged in the repair and maintenance of railroad equipment. If they strike, other railroad workers are expected to refuse to cross their picket lines.

The dispute, over wages, involves 187 railroads and terminal and switching companies. They handle more than 90 per cent of the railroad business of the nation. The only major railroads not involved, according to industry records, are the Southern Railway System and the Florida East Coast Railroad.

The strike date will be set Friday at a meeting in Chicago of the executive council of the Railway Employes Department of the American Federation of Labor and Congress of Industrial Organizations.

Labor Clause Expiring

The council decided here today to advise the railroad general chairmen of the six unions on Monday to get ready for a walkout.

President Johnson is without means under the Railway Labor Act to prevent the strike. The statutory cooling-off period in the dispute will expire at midnight Nov. 19.

If no settlement is reached by the strike deadline, Mr. Johnson's situation would be particularly difficult because Congress is not in session.

If he wanted Congress to pass a measure blocking a strike, such as the action taken in August of 1963 when the five operating unions threatened to shut down the country's rail transportation system, Mr. Johnson would have to call a special session.

The National Mediation Board, which handles railroad labor disputes, is trying to resolve the controversy. Board mediators will meet tomorrow with representatives of the shopcraft unions and the five other unions in the nonoperating group.

The six unions involved are the International Association of

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11/12/64

MILLS GIVES WAY ON AGED CARE BILL

Continued From Page 1, Col. 2

some compromise to make hospital and other medical services available under a "prepayment program" not linked to Social Security.

"I am acutely aware of the fact that there is a problem here which must be met," he told a civic club in Little Rock, Ark., this fall.

One compromise could be a separate payroll tax—not tied to Social Security—to finance hospital and other medical costs for elderly persons.

The health insurance proposal has been the center of controversy for nearly 20 years. A plan to provide broad medical insurance under Social Security for persons of all ages was proposed in 1945 by former President Harry S. Truman.

Two months ago, the Senate passed a bill combining health insurance for the aged with increases in Social Security cash benefits. It marked the first time either house of Congress had endorsed any such proposal for medical care.

The entire bill—including cash-benefit increases earlier voted by the House—died in conference committee just before Congress adjourned Oct. 3.

What Bill Provides

The Administration health-insurance bill covered just those persons 65 years of age and over. It provided the following benefits:

¶Hospital services for either up to 90 days with the patient paying $10 a day for the first nine days; or up to 180 days with the patient paying the first two-and-one-half days of average costs; or all costs for up to 45 days. The beneficiary would be bound to whichever plan was chosen upon reaching age 65.

¶Skilled nursing home services for up to 180 days after transfer from a hospital.

¶Home nursing care for up to 240 visits.

¶Outpatient hospital diagnostic services, subject to payment of the first $20 by the patient for each diagnostic study.

¶Payment of all drugs used in hospital or nursing home.

To finance the plan, Social Security taxes would have been increased one-fourth of 1 per cent for both employe and employer and the salary base on which the tax would apply would have been increased from $4,800 to $5,200.

The first-year cost of the Administration program is estimated at $1.250 billion. About 15 million persons would become immediately eligible for aid.

A.M.A. Office Is Silent

Special to The New York Times

CHICAGO, Nov. 11 — The American Medical Association office here was silent on the outcome of last week's election, but a spokesman noted today that a previously scheduled meeting of the policy-making House of Delegates would begin on Nov. 29 at Miami Beach.

Observers expect the association to reaffirm its opposition to the Administration's medical care proposals despite an election that presumably enhanced the prospects of strong Administration efforts to pass a health care bill under the Social Security System.

Dr. Donovan F. Ward of Dubuque, Iowa, president of the A.M.A., was in Puerto Rico today and could not be reached for comment.

Part of the A.M.A.'s hesitancy to react is believed to be a waiting strategy to find out what kind of a bill the Administration will offer. In the closing days of last Congress an effort was made to get the legislation through in a compromise form.

Spokesmen for the A.M.A.'s chief opponent on the issue, the National Council of Senior Citizens, said that the association had decreased its lobby staff in Washington. The council has said that it and friends of medical care helped defeat 30 of 40 incumbent Representatives who were strongly opposed to medical care.

The council believes that the proposal has 54 sure supporters in the Senate and a majority as high as 60 in the House as a result of the election.

BLUE CROSS TELLS A DETECTIVE STORY

A man arrested in Queens last Friday and accused of checking into hospitals with stolen Blue Cross cards had fooled some authorities, but not all of them.

More than six months ago the Associated Hospital Service of New York, sponsor of Blue Cross, had alerted hospitals in the metropolitan area to watch for him. A spokesman for the agency revealed yesterday that it had rejected 11 claims involving him before he was arrested.

The man, who told the police that he was Charles Jacobs of Sag Harbor, L. I., was arrested after being admitted to the Terrace Heights Hospital, 87-37 Palermo Street, Hollis, with a stolen Blue Cross card. He aroused the suspicion of the hospital, which called the police.

Douglas A. Larsen, a vice president of the agency, said that it had "passed along information concerning him to the police in our efforts to protect our member hospitals which have picked up the tab for the bills run up by the suspect."

He made public a Blue Cross bulletin to member hospitals last June that gave some of the aliases Jacobs has used and a physical description of him.

Pilot Dies in Oklahoma Crash

FAIRVIEW, Okla., Nov. 11 (AP)—Two small planes that participated in a fly-in reunion crashed within 30 minutes today. One pilot was killed. A companion stunt flier was injured.

12/14/64

A.M.A. CONSULTS STATE SOCIETIES

Secret Session Maps New Fight on Medicare

By AUSTIN C. WEHRWEIN
Special to The New York Times

CHICAGO, Dec. 13—The leaders of the American Medical Association met today with representatives from every state medical society in a session called to build support for a last-ditch fight against medical care for the aged under Social Security.

The decision to continue the fight against medicare was set two weeks ago at a meeting of the A.M.A.'s policy-making House of Delegates in Miami Beach.

However, at that time there were protests that the headquarters here ran large "public education" campaigns costing millions of dollars without consulting component state societies.

The powerful board of trustees asked every state to send two representatives to the one-day closed-door session at the Drake Hotel today. The 13-member board, which runs the headquarters here, will hold another meeting on Jan. 9 and 10 to discuss the Kerr-Mills Act.

The A.M.A.'s Answer

The Kerr-Mills Act is the association's answer to backers of the medicare proposal, which would provide hospital and nursing home care to those over age 65.

Kerr-Mills, on the other hand, created machinery for Federal matching grants to states to aid state health programs for the poor. Doctors here today conceded there were wide discrepancies among the 38 states that accept Kerr-Mills money.

Whether a stepped-up campaign to popularize the Kerr-Mills Act as a solution to the needs of the elderly would be enough to block medicare in Congress was left undecided, one of the doctors at the meeting today said. He said that as far as he knew none of the A.M.A.'s headquarters staff produced a price tag for the new anti-medicare campaign.

One pre-Presidential election anti-medicare campaign was described at the House of Delegates meeting as having cost $2 million.

The Senior Citizens News, published by the National Council of Senior Citizens, estimated in its current issue that the new A.M.A. drive would cost $3.5 million. The publication said that "coordinate anti-medicare propaganda" would be started by "right-wing extremist radio programs and other ultra-conservative and conservative groups."

CELLER HAS DOUBTS ABOUT A U.S. JUDGE

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JOHNSON PLEDGES AGED-CARE FIGHT

Continued From Page 1, Col. 5

He has said that he views this program as a key part of his "unconditional war on poverty."

Hearings on the legislation were under way when President Kennedy was assassinated. The hearings will resume next Monday and continue for a week.

Opponents of Program

The program has been attacked repeatedly by the American Medical Association and many other groups. A number of compromise proposals, combining private insurance and Social Security financing, are pending in Congress.

From the beginning, a majority on the House Ways and Means Committee had viewed the Administration proposal skeptically. The committee chairman, Representative Wilbur O. Mills, Democrat of Arkansas, opposes the program but has promised to put the plan to a vote in committee.

A poll of the committee shows that only 10 of the 23 members are for the bill in its present form. All those for it are Democrats; with four other Democrats and all nine Republicans in opposition.

Two vacancies on the Committee occurred with the deaths recently of Representative William J. Green Jr., Democrat of Pennsylvania, and Representative Howard H. Baker, Republican of Tennessee. Mr. Green was for the bill, Mr. Baker was opposed. These vacancies have not been filled, but the appointments are expected to represent the views of the two former members.

'Errors of Fact' Charged

Special to The New York Times

CHICAGO, Jan. 15 — "Errors of fact in the President's statement indicate that his advisers are feeding him misinformation about this proposal," Dr. F. J. L. Blasingame, executive vice president of the American Medical Association, said today.

"We have always agreed that every elderly American who needs help in meeting medical expenses should get it, and we have pointed out that Congress made help available to those who need it when the Kerr-Mills Law was enacted in 1960," he added.

"We strongly disagree that it is practical, sensible, fair and just, as the President said, to increase taxes on the nation's workers to pay hospital bills for everyone over 65, hundreds of thousands of whom are much better off financially than the average wage earner," Dr. Blasingame said.

"We do not agree that it is fair or just to force the worker with a large family who earns $5,200 a year or less to pay the hospital bills for the half a million elderly who have an annual income of $10,000 and more and the 10 million others who have protected themselves with hospital insurance."

He said the statement that medicare would cost the average worker only 25 cents a week was accurate only for those who earn $50 a week.

October, Archbishop Davis and Bishop McManus joined a third prelate in signing a pastoral letter forbidding church members to vote for the Governor's Popular Democratic party.

group or person inciting racial bias.

Mr. Abram, replying to criticism of the United States draft, said: "The individual in our society has a bundle of rights, including the right to be wrong."

Dutch Urged to Curb Raises

Special to The New York Times

THE HAGUE, Jan. 15 — Prof. Hendrik Witteveen, Dutch Finance Minister, appealed to industry today to keep wage increase this year within the ten per cent limit agreed upon between labor and employers' organizations.

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Commissioner Francis
Keppel and Sargent Shriver, director of the Peace Corps.

After the talks, the educators formed into four regional sessions. Mason W. Gross, president of Rutgers, the State University of New Jersey, presided over representatives of the Northeastern and Mid-Atlantic states.

Fred Harrington, president of the University of Wisconsin, was assigned to the Midwestern meeting. Chancellor Harry Ransom of the University of Texas to the South and Southwest session, and Arthur Flemming, president of the University of Oregon, to the Western group.

U.S. Group That Defied Ban On Cuba Travel Due Tonight

American students and others who defied a State Department ban by visiting Cuba this summer are scheduled to arrive today and tomorrow at Kennedy International Airport to face whatever action Federal Government agencies may decide to take.

Sixty of the travelers are expected on an Air France flight from Paris at 8 P.M. today. Twenty-four others are due at 8 P.M. tomorrow, according to airport sources.

Later, a spokesman for the Student Committee for Travel to Cuba, sponsors of the tour, said that all the students would return tonight.

Whatever action is taken on the matter of defiance of the travel ban when the travelers present their passports will be executed by the Immigration and Naturalization Service at the airport.

A.M.A. OPPOSES PLAN FOR MEDICAL CARE

WASHINGTON, Aug. 13 (AP)—The American Medical Association asked Senators today to reject a plan for health care for the aged financed through Social Security and rely instead on a program designed to aid only indigent persons.

Dr. Edward R. Annis of Miami, a former president of the association, told the Finance Committee that the Social Security proposal contained dangers "to our free system of medicine and the quality of health care it provides."

Dr. Annis said the present program of medical cost aid to the poor was able to meet the nation's needs.

Senator Albert Gore, Democrat of Tennessee, who is sponsoring the Johnson Administration's Social Security health care proposal, disagreed.

He said that only the wealthiest states had been able to take full advantage of the present program. Those with the greatest problems cannot match a large share of the Federal aid that is available, he said.

The committee is considering a House-passed bill to increase present Social Security benefits 5 per cent and make other changes in the system. The proposal at hand would attach the health care program to that measure.

Johnson's Forecast Holds In Rights Case, Reedy Says

WASHINGTON, Aug. 13 (UPI) — President Johnson's forecast Saturday of "substantive results" shortly in the investigation of the slaying of three civil rights workers in Mississippi still stands, the White House said today.

The President's press secretary, George E. Reedy, said this when reporters asked if there had been an unanticipated delay in the results. Mr. Johnson, at a news conference Saturday, said results could be expected "in a very short period of time."

"I think the President's statement still stands," Mr. Reedy said. But he did not indicate when the results of the investigation by the Federal Bureau of Investigation would be forthcoming.

Ernest Shinwell Arrested On Stock Forgery Charge

LONDON, Friday, Aug. 14 (AP) Ernest Shinwell, son of the former Defense Minister, Emanuel Shinwell, was arrested last night and charged with issuing forgeries of 14,000 shares in the Quaker Oats Company of America.

Two other charges against Mr. Shinwell accused him of pretending that 2,000 shares in F. W. Woolworth Co. of America were valid securities and thereby fraudulently trying to obtain £10,000 ($28,000) and £3,072 ($8,600).

Mr. Shinwell, 45, was held overnight in a police cell and will appear in court today.

F.B.I. IS STUDYING G.O.P. CHARGE INVOLVING BAKER

Johnson Orders an Inquiry —McCloskey Denies Any Insurance Overpayment

By JOHN D. MORRIS
Special to The New York Times

WASHINGTON, Sept. 2—The Federal Bureau of Investigation, at President Johnson's request, has begun an inquiry into charges of a conspiracy to divert $25,000 from a public stadium contract to the 1960 Democratic campaign chest.

The charges were made in the Senate yesterday by Senator John J. Williams, Republican of Delaware. The President ordered the investigation last night, George E. Reedy, his press secretary, reported today.

Mr. Williams and other Senators endorsed the President's action. But Republicans continued to press for a separate Senate investigation. They said the bureau's inquiry must not be used as an excuse for Senate inaction.

All another investigation was sought by Walter N. Tobriner, a member of the three-man Board of Commissioners that administers the District of Columbia government.

He said he would ask the Armory Board, which operates the $20 million District of Columbia Stadium for the district government, to request an inquiry by Chester H. Gray, district corporation counsel.

Accusation by Williams

In his speech yesterday, Senator Williams accused Robert G. Baker, Matthew H. McCloskey and Dan B. Reynolds of arranging a $35,000 kickback on the contract for construction of the stadium. He said $25,000 of the money was to be channeled into "The Johnson-Kennedy campaign fund of 1960."

Mr. Baker was secretary of the Senate's Democratic majority at the time and a confidant of President Johnson, then a Senator. His resignation under fire last October was followed by a Senate investigation of his outside business affairs.

In Philadelphia today Mr. McCloskey denied in a statement that his company had overpaid Mr. Reynolds's insurance firm in connection with building the stadium. The alleged overpayment was the basis for Mr. Williams's accusation.

Mr. McCloskey was the prime contractor for construction of

A.F.L.-C.I.O. OPENS DRIVE TO ACHIEVE RIGHTS ACT GOALS

Hopes to Counter Job Fears of Whites and Consequent Support of Goldwater

By JOHN D. POMFRET
Special to The New York Times

WASHINGTON, Sept. 2—The American Federation of Labor and Congress of Industrial Organizations began today a major effort to carry out the purposes of the new Civil Rights Act.

At a meeting that emphasized politics as much as civil rights, 250 national, state and local labor leaders listened to George Meany, federation president, outline the stepped-up civil rights program.

They also heard from Roy Wilkins, executive secretary of the National Association for the Advancement of Colored People, and LeRoy Collins, director of the Community Relations Service set up under the Civil Rights Act.

Both Oppose Goldwater

Mr. Wilkins's presence was a sign that the A.F.L.-C.I.O. and the N.A.A.C.P., which have been feuding over association charges of union discrimination that the federation regarded as unfair, have entered a period of cooperation.

Their common opposition to Senator Barry Goldwater, the Republican Presidential nominee, appeared as much responsible for this as anything.

The federation's leaders hope that one immediate result of their civil rights program will be to encourage political alliances with Negro groups.

They also hope the program will counteract so-called white backlash among union members stemming from misconceptions of what the fair employment practices section of the new law does.

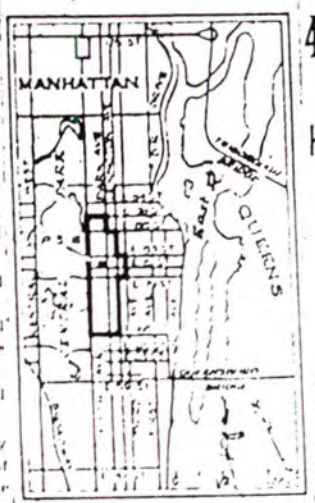
Urges Action Now

Union leaders fear that many members may vote for Senator Goldwater, who opposed the Civil Rights Act, because they think the act requires employers to displace white workers with Negroes and destroys union seniority protection.

It was disclosed today that the federation planned to distribute three million copies of a handbill headed "Civil Rights: Facts vs. Fiction." The handbill emphasizes it is untrue that a certain number of Negroes will have to be hired on every job.

PRESIDENT'S PLAN FOR CARE OF AGED VOTED BY SENATE

NYT 1:8



NEW ZONE: Area outlined has been approved by court for P.S. 6. Old zone ran from 63d St. to 94th St.

REZONING OF P.S. 6 UPHELD BY COURT

Parents Lose Fight to Block Transfer of White Pupils Out of Select School

By ROBERT E. TOMASSON

The Board of Education's plan to rezone a predominantly white public school on the East Side to make room for pupils from crowded East Harlem schools was upheld in court yesterday.

State Supreme Court Justice Vincent A. Lupiano dismissed a petition filed by three parents of pupils attending Public School 6 to overturn the board's rezoning, which is part of an effort to achieve racial balance in city schools.

P.S. 6, at 81st Street and Madison Avenue, has been known for 60 years as the best among public elementary schools.

In their suit, the parents said that the board was effecting the rezoning "solely to provide vacancies at the school for Negro and Puerto Rican children."

Sees No Discrimination

"This, they said, was in violation of the due process and equal protection clauses of the [illegible] Federal Constitutions.

49-44 ROLL-CALL

House Fight Likely— Johnson Calls Action a Victory for All

By MARJORIE HUNTER
Special to The New York Times

WASHINGTON, Sept. 2—The Senate handed President Johnson a major victory today by voting to provide health insurance for the aged under Social Security. The vote was 49 to 44.

It marked the first time either body of Congress had endorsed any such proposal for medical care, although repeated attempts had been made over the last 15 years.

President Johnson immediately hailed the action as "a victory not only for older Americans but for all Americans."

"The health of every citizen—old and young, rich and poor—is vital to our strength as a nation," he said.

Not Over Hurdles

But the Administration is not yet over the hurdles. The proposal is expected to run into strong opposition in the House.

Only President Johnson's success as a master persuader could possibly clear the way for the plan on medical care to become law, most Capitol observers believe.

The showdown, with the vote seesawing all the way through the roll-call, came in a hushed chamber in midafternoon.

Visitors in the crowded galleries could see a major campaign issue shaping up on the Senate floor.

Senator Barry Goldwater, the Republican nominee for President, flew back from Phoenix, Ariz., to vote against the proposal. He issued a statement describing the program for medical care as an insult to the intelligence of the American people.

Passage Criticized

In a two-page statement put into The Congressional Record, Senator Goldwater said:

"I face with deep foreboding the consequence of our embarking on this course." He criticized the passage of the plan

...the contract for construction ... the stadium. He said $25,000 ... money was to be chan... into "The Johnson-Ken... campaign fund of 1960."

Mr. Baker was secretary of ... Senate's Democratic major... at the time and a confidant ... President Johnson, then a ... His resignation under ... October was followed ... Senate investigation of his ... outside business affairs.

In Philadelphia today Mr. ... McCloskey denied in a state... ...t that his company ... overpaid Mr. Reynolds's ... insurance firm in connection ... with building the stadium. The ... alleged overpayment was the ... basis for Mr. Williams's accu... ...n.

Mr. McCloskey was the prime ... contractor for construction of ... the stadium. He was then na... tional finance chairman of the ... Democratic party and later ... served as Ambassador to Ire... ...d.

Mr. Reynolds, head of a Silver ... Spring, Md., insurance agency

Continued on Page 16, Column 4

...They also hope the program will counteract so-called white backlash among union members stemming from misconceptions of what the fair employment practices section of the new law does.

Urges Action Now

Union leaders fear that many members may vote for Senator Goldwater, who opposed the Civil Rights Act, because they think the act requires employers to displace white workers with Negroes and destroys union seniority protection.

It was disclosed today that the federation planned to distribute three million copies of a handbill headed "Civil Rights: Facts vs. Fiction." The handbill emphasizes it is untrue that a certain number of Negroes will have to be hired on every job, even if white workers have to be dismissed to make room for them.

It also emphasizes there is no fair housing provision in the bill — although the A.F.L.-

Continued on Page 22, Column 2

...to make room for pupils from crowded East Harlem schools was upheld in court yesterday.

State Supreme Court Justice Vincent A. Lupiano dismissed a petition filed by three parents of pupils attending Public School 6 to overturn the board's rezoning, which is part of an effort to achieve racial balance in city schools.

P.S. 6, at 81st Street and Madison Avenue, has been known for 60 years as the best among public elementary schools.

In their suit, the parents said that the board was effecting the rezoning "solely to provide vacancies at the school for Negro and Puerto Rican children."

Sees No Discrimination

This, they said, was in violation of the due process and equal protection clauses of the state and Federal Constitutions and contrary to Section 3201 of the Education Law, which prohibits admission or rejection into schools based on a pupil's race.

Neither the board nor Justice Lupiano has denied that the rezoning will specifically exclude white children from the school.

But the court discounted the charge of racial discrimination.

"It must be stressed that the rezoning affects the redistricting of only white children and [illegible] generates no basis [illegible] per se for consideration of the [illegible]

[illegible]

In studying the rezoning plan, Justice Lupiano said that the court could not say that a con-

Continued on Page 19, Column 3

...seesawing all the way through the roll-call, came in a hushed chamber in midafternoon.

Visitors in the crowded galleries could see a major campaign issue shaping up on the Senate floor.

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Passage Criticized

In a two-page statement put into The Congressional Record, Senator Goldwater said:

"I face with deep foreboding the consequence of our embarking on this course." He criticized the passage of the plan as a "most significant step" toward making the Social Security system a relief and charity organization.

Five liberal Republicans joined with 44 Democrats in voting to put health insurance into the Social Security bill. Voting against were 28 Republicans and 16 Democrats.

The Republicans supporting the move were Jacob K. Javits and Kenneth B. Keating, both of New York; Clifford P. Case of New Jersey; Margaret Chase Smith of Maine, and Thomas H. Kuchel of California.

The Republicans were on hand in full strength; all the [illegible] were Democrats.

Humphrey Votes "Yea"

Senator Hubert H. Humphrey of Minnesota, the Democratic nominee for Vice President, joined the majority of his party colleagues in voting for the plan.

Today's action was not final, for the bill to which the Administration's plan on medical care was attached is not expected to clear the Senate until later this week.

The proposal, however, is now securely nailed into the House-passed measure that would increase Social Security taxes and benefits for 20 million Americans.

As passed by the House, the bill would have provided 5 per cent across-the-board increases in [illegible] benefits for those on Social Security rolls. The tax rate would have been raised to 9.4 per cent (half of this paid by the employer, half by the employe) over a period of years, and the income base on which

Continued on Page 14, Column 4

NYT 9/3/64 1:8

CUT OFF

...ork, War Hero, Dies

The New York Times

...welcomed back to Pall Mall, ...oming a hero in World War I.

Killed 25 Germans and Captured 132 in Argonne Battle

Special to The New York Times

NASHVILLE, Sept. 2 — Alvin C. York, the [illegible] World War I infantryman who became an American legend, died this morning at Veterans Administration Hospital after a long illness. He was 76 years old.

On Oct. 8, 1918, during the final offensive of the war, the Tennessee mountaineer whose religious convictions at first kept him from fighting, singlehandedly captured or killed an entire German machine-gun battalion.

Thereafter his life became a tangle of parades, political appearances and unpaid taxes. But the sergeant's modesty and devotion to his people in the steep Cumberland hills kept him clear of the heroic life and added to the legend.

The old soldier, winner of the Medal of Honor and nearly 50 other decorations, was brought to the hospital on Saturday from his home in Pall Mall, 120 miles northeast of Nashville. His illness, the 11th in the last two years, was described as an acute internal infection.

Sergeant York had been in a coma since Sunday. His death at 10:40 A.M. today was caused, a hospital statement said, by "general debility resultant of a combination of conditions incident to his age and complicat-

Continued on Page 26, Column 1

Report on Gilligan Assailed by CORE

By DAVID HALBERSTAM

The Congress of Racial Equality yesterday sharply criticized District Attorney Frank S. Hogan's report on the clearing by a grand jury of Police Lieut. Thomas R. Gilligan in the fatal shooting of a Negro boy.

It said the report failed to emphasize "the most significant contradictions [and] the disparity of the opponents."

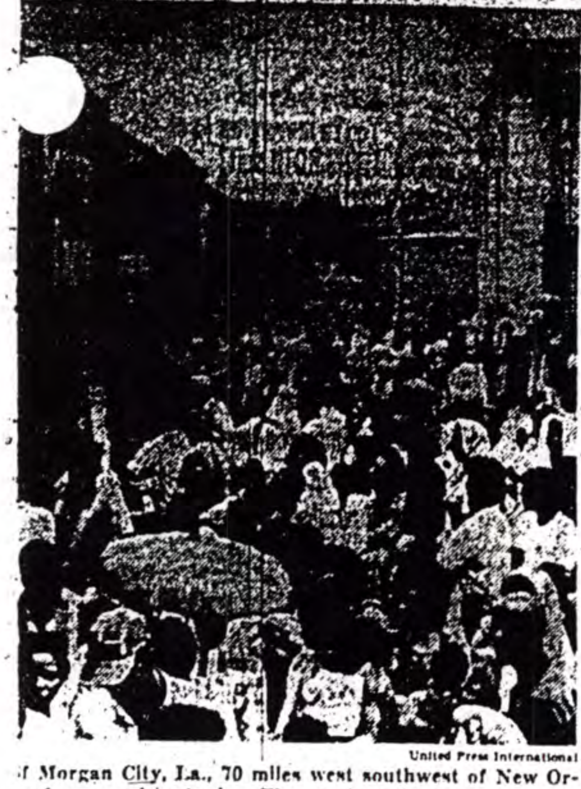
CORE's 14-page report summarized what it said was its own investigation and charged that 15-year-old James Powell had been shot "needlessly" by Lieutenant Gilligan last July.

The police officer was cleared of criminal liability in the shooting by a New York county grand jury on Tuesday. The shooting, in front of a building at 215 East 76th Street, touched off rioting in Harlem and the

Continued on Page 19, Column 5

NEWS INDEX

...to Help People Flee From Storm



United Press International

...f Morgan City, La., 70 miles west southwest of New Or-... safer ground yesterday. Thousands fled before big storm.

The New York Times Oct. 3, 1964

Hurricane Hilda (arrow), larger than New England, bears down on Louisiana.

25,000 FLEEING GULF HURRICANE

...ntinued From Page 1, Col. 4

...rived from the coastal marsh-...ds. Two special Missouri Pa-...ic trains from New Orleans ...cked 3,400 persons aboard 90 ...coars at Franklin and carted ...em north to Red Cross shel-...s at Lafayette.

Cowboys herded cattle north ...of Cameron Parish, where ...hurricane in 1957 killed 500 ...sons and 35,000 head of stock.

Gov. John J. McKeithen or-...red National Guard troops ...d civil defense forces "to ...ck and double check" to ...ke certain that Louisiana's ... areas were 100 per cent ...d before the storm

...0,000 Square Miles

The giant storm with its buf-...ing gale winds covers 70,000 ...are miles.

Red and black hurricane ...rning flags flew from the ...uth of the Mississippi River ...st to the Texas border. A

BILLION AGED CARE AND BENEFITS DIES

Final Attempt Fails to End Social Security Deadlock

By MARJORIE HUNTER

Special to The New York Times

WASHINGTON, Oct. 2 — A final attempt to break the deadlock over health insurance for the aged failed today, sending the entire Social Security bill down to defeat.

This ruled out any Congressional aid this year to the nation's elderly, either in the form of health insurance or increases in Social Security cash benefits.

The action, both a defeat and a victory for President Johnson, immediately pushed health insurance into the forefront of domestic issues in the Presidential campaign.

It was a defeat for the President—his most severe of the entire session—because he failed to get a program of health insurance for the aged.

But it was a victory, too, because the Administration succeeded in warding off attempts to raise cash benefits without including health insurance. It had feared that, for a long time to come, the rise in the Social Security tax would have made it impossible to win a further increase in the tax to pay for a medical care plan.

Legislative leaders conceded that Mr. Johnson had taken a calculated political risk in holding out for health insurance, thus ruling out proposed cash increases for some 20 million Americans on the Social Security rolls.

Senator Barry Goldwater, the Republican nominee for President, opposed the health insurance plan but said in late August that he would vote for cash increases in Social Security benefits.

In breaking off efforts to reach agreement on differing versions of the Social Security bill passed by the two houses, the Senate and House conferees stood firm today in the positions they took yesterday.

House Rejects Health Plan

The Senate conferees voted, 4 to 3, to insist on health insurance. The House conferees voted, 3 to 2, to reject the insurance feature that the Senate had added to the House-passed bill raising cash benefits.

As the conference broke up, Senator Albert Gore, suitcase in hand, hurried out of the meeting room. He had delayed a campaigning trip home to Tennessee to cast a final vote.

"This means the President will go to the people and ask for a mandate on this issue in November, and he'll get it," Mr. Gore said.

A key architect of the health insurance plan, the Democratic Senator predicted that the issue would be the most important domestic one in the Presidential campaign.

Republican conferees, who joined with two Democrats in opposing health insurance, also viewed the conference action as a major campaign issue.

Senator John J. Williams, Republican of Delaware, went immediately to the Senate floor...

CONGRESS VOTES $3.25 BILLION AID

Money Measure, Cut 8%, Is Sent to White House

By FELIX BELAIR Jr.

Special to The New York Times

WASHINGTON, Oct. 2—The House approved by a voice vote today the Senate-passed bill appropriating $3.25 billion for foreign aid and sent the measure to the White House.

The bill cut the Administration's $3.5 billion asking figure by 8 per cent, the lowest percentage cut in the 17-year history of the program.

Earlier in the day, the Senate completed Congressional action on the foreign aid authorization bill, which set a ceiling on planned aid spending that included all but a small fraction of the President's request. The House had already approved a Senate-House compromise version of the authorization measure.

In drafting the compromise authorization, the conferees deleted the Senate's rider expressing the "sense of Congress" as favoring a "reasonable" delay in court-ordered reapportionment of state legislatures.

Final action on this bill today meant that there would be no further legislative attempt this year to delay reapportionment.

There was no significance in the Senate's acceptance of the money amounts in the House-passed authorization measure. That bill merely fixed the money ceilings on various aid programs.

Its importance lay in the fact that the compromise eliminated or substantially modified most...

G.O.P. Scores Baker Case Pace, But Democrats Won't Be Rushed

By BEN A. FRANKLIN

Special to The New York Times

WASHINGTON, Oct. 2—Republicans expressed irritation today over the slow pace of the renewed investigation into the affairs of Robert G. Baker, but the Senate Rules Committee's Democratic chairman would not be hurried.

The committee devoted another five-hour day to tedious and for the most part repetitive background into a charge by Senator John J. Williams, Republican of Delaware, that Mr. Baker was instrumental in arranging a $25,000 "kickback" to the Kennedy-Johnson campaign fund of 1960 from Federal payments for the $20 million D. C. Stadium.

The second day of leisurely public hearings on the stadium connections of Mr. Baker, the former secretary to the Democratic majority in the Senate, produced a sarcastic jab at the committee from Senator Williams, who also raised the questions that led to Mr. Baker's resignation a year ago this month.

Senator Williams is not a member of the Rules Committee, but his new charges surrounding the stadium forced the committee to reopen the Baker matter yesterday.

In a Senate speech today Mr. Williams charged that the committee's Democratic majority was "acting like a group of small boys delaying a trip to the woodshed in the pious hope that something will stop them before they get there."

"Let's stop this dodging around the issue," he said, "and call the main witnesses."

Witnesses before the committee yesterday and today were officials of the District of Columbia government and the stadium board.

All of them have denied any knowledge of a "kickback." Today Senator John Sherman Cooper of Kentucky, the only Republican member of the committee at the reopening of the Baker hearings, acknowledged to reporters that "I would honestly have to say from what we have heard so far that these people knew nothing about it."

Senator Cooper also demanded today that the committee chairman, B. Everett Jordan of North Carolina, "get on with the main witnesses."

He said they were Mr. Baker, Matthew H. McCloskey, Don B. Reynolds, William N. McLeod Jr., and Senator Williams. Senator Cooper, however, was given no assurances when they would be called.

Mr. McCloskey, a former finance chairman of the Democratic National Committee, is president of McCloskey & Company, the Philadelphia construction concern that was low bidder on the $19.3 million stadium. Senator Williams has accused him of making a $35,000 overpayment to Mr. Reynolds from which the $25,000 "political contribution" is supposed to have come.

Mr. Reynolds, a Silver Spring Md., insurance man and former business associate of Mr. Baker, sold the contractor's performance bond on the stadium job.

SENATE APPROVES AID TO EDUCATION

Sends Expanded, $1.9 Billion Defense Act to Johnson

By C. P. TRUSSELL

Special to The New York Times

WASHINGTON, Oct. 2—The Senate completed legislative action today on the last of the pending education bills. Afterward, members hailed the 88th as the Congress that made the most progress in this field in a century.

The legislation will extend and expand the National Defense Education Act for three years past next June 30 at a cost estimated at $1.9 billion.

It will also continue for a year beyond June 30, 1966, the impacted area program under which Federal aid is given school districts overcrowded by the children of Government employes. This program is running at approximately $300 million a year.

A voice vote of the Senate sent the measure to the White House. Consideration of its final provisions, after conference adjustments, was interrupted repeatedly as members broke in with tributes to Senator...

The Proceedings In Washington

YESTERDAY
(Oct. 2, 1964)

THE PRESIDENT

Met with the Alaska Commission, talked with lawyers for Johnson group, attended ceremony proclaiming International Cooperation Year, saw Budget Director Kermit Gordon.

THE SENATE

Passed compromise national defense education bill; adjourned at 10:01 P.M.

Rules Committee heard testimony on the Baker case.

THE HOUSE

Passed a compromise $3.5 billion foreign aid authorization bill; joint conferees wrote off Social Security and Appalachian bills; adjourned at 8:58 P.M.

DEPARTMENTS & AGENCIES

Secretary of State Rusk addressed luncheon of business, professional and educational leaders.

SCHEDULED FOR TODAY
(Oct. 3, 1964)

President Johnson meets with college student leaders followed by buffet reception, 5 P. M.

Senate and House meet at 11 A.M.

...at Lafayette ... Cowboys herded cattle north ... of Cameron Parish, where hurricane in 1957 killed 500 ...sons and 35,000 head of stock.
...Gov. John J. McKeithen or... ...ed National Guard troops ...d civil defense forces "to ...eck and double check" to ...ke certain that Louisiana's ...tal areas were 100 per cent ...1 before the storm.

...000 Square Miles

The giant storm with its buf... ...ing gale winds covers 70,000 ...uare miles.

...ted and black hurricane-... ...rning flags flew from the ...uth of the Mississippi River ...t to the Texas border. A ...ricane watch, one step below ...urricane warning, remained ...effect from Mobile, Ala., to ...Mississippi River and along ...entire Texas coast.

...ides were expected to run ...ee to six feet during the ...ht.

...o one would predict exactly ...en or where the season's ...t powerful hurricane would ...n into shore.

...eeding and caring for the ...nting swell of refugees ...ckly became a formidable ...

...he Red Cross sent in 10,000 ...s and 20,000 blankets to the ...ke Charles and Lafayette ...as. Both the Salvation Army ...l civil defense authorities ...ssed supplies.

...n New Orleans the Levee ...rd filled 10,000 sandbags ...t held them in readiness.

...he hurricane played havoc ...h classroom work and foot... ...schedules. Tulane Univer... ...here and Nicholls State ...lege in Thibodaux suspend... ...classes. Tulane postponed in... ...nitely its Saturday night in... ...rectional football game with ...e in the Sugar Bowl.

... officials from the Of... ...Emergency Planning ... New Orleans to brief ...ense leaders on help ...ilable from the Federal Gov... ...ment.

...ir Adventist Churchmen ...ie in Air Crash in Mexico

...ERMOSILLO, Mexico, Oct. ... (AP) — The police reported ... four members of a Califor... ...Adventist Church gooodwill ...gation were killed today ...n their private plane ...shed and burned.

...he police said the plane was ...t of a six-plane air caravan ... left Los Angeles earlier ...y for the village of ...ojoa, where the Adventist ...rch operates an agricul... ...al-industrial school.

...he first five planes landed ... to refuel and took off ...out trouble. The sixth plane, ...ingle-engine Bonanza with ...ense N-9563-R, crashed on ...ling.

...uthorities said four badly ...rred bodies had been re... ...ered from the wreckage. ...ers found mentioned the ...es of three—Thor Lieder, ... Dallas White and John Beer ...ulum.

...ducation Council Elects

...AN FRANCISCO, Oct. 2— ...William C. Friday, president ...he University of North Car... ...was elected chairman ...y of the American Council ...ation. Dr. C. Easton ... president of Mills Col... ... elected vice president ...Frederick H. Burkhardt, ...ident of the American Coun... ...of Learned Societies, secre... ... The council ended its 47th ...al meeting at the Sheraton... ...ce Hotel here.

...

In drafting the compromise authorization the conferees deleted the Senate's rider expressing the "sense of Congress" as favoring a "reasonable" delay in court-ordered reapportionment of state legislatures.

Final action on this bill today meant that there would be no further legislative attempt this year to delay reapportionment.

There was no significance in the Senate's acceptance of the money amounts in the House-passed authorization measure. That bill merely fixed the money ceilings on various aid programs.

Its importance lay in the fact that the compromise eliminated or substantially modified most of the policy and operating restrictions written into the measure in the Senate.

Senator Wayne Morse, Democrat of Oregon, labeled the authorization compromise "the most unacceptable conference report to come before the Senate in my 20 years in this body."

He forced a roll-call vote on the negotiators' agreement, which was adopted, 35 to 15.

The Senator had sponsored a number of amendments to the bill, chief among them a proposal to limit the pending and future foreign aid authorizations to $3.25 billion.

This was knocked out in conference, as were Senate amendments banning any kind of aid to Indonesia and removing the President's authority to provide such aid if he found it in the interest of the United States.

More important was one that would have increased by $400 million a year the interest charges on development loans to economically dependent nations. The amendment would also have shortened the present 10-year grace period on such loans and would have cut the maturity period from 40 to 25 years.

Final action on the aid bills was a significant victory for the Administration.

It marked an end of the iron rule over foreign aid appropriations by Representative Otto E. Passman, Democrat of Louisiana. The chairman of the Appropriations Subcommittee on Foreign Operations had boasted of cutting Presidential requests an average of $800 million a year during his long tenure.

Johnson Names 2 Panels To Aid Alaska's Economy

WASHINGTON, Oct. 2 (AP) —President Johnson set up two new Federal committees for earthquake-damaged Alaska today. He said they would provide the next step forward "toward a broader and better future for the state."

The Alaska Reconstruction Commission, which Mr. Johnson established after the earthquake March 27, held its final meeting at the White House.

The President said its work had been substantially completed, with major services restored in Alaska and nearly $50 million worth of small loans approved for homeowners and businessmen.

He then established a new Federal field committee in Alaska to cooperate with a similar group named by Alaska's Governor "to prepare practical economic development."

He also set up a President's review committee, to be headed by the Secretary of Commerce, to provide general direction for the field committee.

...meeting room. He had delayed a campaigning trip home to Tennessee to cast a final vote.

"This means the President will go to the people and ask for a mandate on this issue in November, and he'll get it," Mr. Gore said.

A key architect of the health insurance plan, the Democratic Senator predicted that the issue would be the most important domestic one in the Presidential campaign.

Republican conferees, who joined with two Democrats in opposing health insurance, also viewed the conference action as a major campaign issue.

Senator John J. Williams, Republican of Delaware, went immediately to the Senate floor and denounced the Administration for what he called its "callous disregard" for the nation's needy citizens.

Representative John W. Byrnes, Republican of Wisconsin, another conferee, accused the backers of the health insurance plan of "sabotaging" the cash benefits for older Americans.

Mr. Byrnes placed the blame directly on the White House.

Another Republican conferee, Representative Thomas B. Curtis of Missouri, expressed surprise that the Senate conferees had not retreated on the insurance feature. He, too, blamed the President for stalling the cash benefits.

"Mr. Johnson, who seems to think the Executive has the job of running Congress, sent word to his minions," Mr. Curtis commented.

Paradoxically, the key figures in deadlocking the conference, thus upholding the Administration's insistence on leaving the way open for health insurance in the future, were two Southern Democrats who had vigorously opposed medical care on the Senate floor.

Provide Senate Majority

Senator Russell B. Long of Louisiana and Senator George A. Smathers of Florida joined with two health insurance backers, Senator Gore and Senator Clinton P. Anderson, Democrat of New Mexico, to provide the majority needed to uphold the Senate stand.

Voting to recede were Senator Harry F. Byrd, Democrat of Virginia, Senator Frank Carlson, Republican of Kansas, and Senator Williams.

In a separate vote of House conferees, Representative Wilbur D. Mills, Democrat of Arkansas, joined with two Republicans, Mr. Byrnes and Mr. Curtis, in rejecting the health insurance amendment.

Voting to accept the amendment were two other Democratic Representatives, Cecil R. King of California and Hale Boggs of Louisiana.

Democratic Congressional leaders were frankly disheartened over the failure of Congress to enact a health insurance program this year.

The House bill would have provided 5 per cent increases in Social Security cash benefits, amounting to about $1.5 billion a year. It would have been the first increase since 1958. The Social Security tax would have been raised to a total of 9.6 per cent, half paid by the employer and half by the employe.

The Senate virtually scrapped the House proposal and substituted increased cash benefits plus health insurance for those 65 years old and older. To finance the more costly program, the Senate proposed that the tax be raised to 10.4 per cent.

...century.

The legislation will extend and expand the National Defense Education Act for three years past next June 30 at a cost estimated at $1.9 billion.

It will also continue for a year beyond June 30, 1966, the impacted area program under which Federal aid is given school districts overcrowded by the children of Government employes. This program is running at approximately $390 million a year.

A voice vote of the Senate sent the measure to the White House. Consideration of the final provisions, after conference adjustments, was interrupted repeatedly as members broke in with tributes to Senator Wayne Morse, Democrat of Oregon, for his leadership as chairman of the education subcommittee of the Committee on Labor and Public Welfare. Mr. Morse shunted the praise to his subcommittee colleagues.

Other major educational legislation during the 88th Congress included the $1.2 billion program of Government grants and loans for classroom construction.

Although blocked several times by controversy over religion issues, this program was the first general legislation of its kind to clear Congress.

There were also several measures providing subsidies for medical and nursing school facilities, scholarship programs for needy students, $260 million a year for expansion of vocational education and Federal grants for library buildings.

In the national defense education program, which concentrates on the upgrading of instruction at all levels, the loan programs for prospective teachers would be expanded to include "students with superior academic background."

The annual limit of individual loans to graduate and professional students would increase from $1,000 to $2,500 and the aggregate from $5,000 to $10,000.

The number of graduate fellowships would rise from the present 1,500 to 3,000 for the rest of the current fiscal year, 5,000 in fiscal year 1966, which starts next July 1, and to 7,500 through 1968.

The loan limit of $800,000 for institutions would be removed. Grants for equipment for the teaching of certain subjects would rise to $90 million a year, and $10 million would be added for supervision.

The subjects, now limited to education in science, mathematics, or a modern foreign language, would be broadened to add history, civics, geography, English, or oral reading.

This provision provoked a spirited House fight yesterday. Opponents, led by Republicans, contended that the subject range was being so broadened as to threaten Federal Government control. A motion for House conferees to insist on restrictions was defeated, however.

Venezuela's 1965 Budget Filed

Special to The New York Times

CARACAS, Venezuela, Oct. 2 —The Venezuelan Government's budget for 1965 calls for expenditures of 7,260 million bolivars (about $1,670 million), the Finance Minister, Dr. German Andres, said in a message to a joint session of Congress today. He reported estimated revenue of 6,973 million bolivars ($1,544 million) with prospective borrowings for the balance. Venezuela's revenue is 70 per cent from oil, the remainder from taxes.

THE HOUSE

Passed a compromise $3.5 billion foreign aid authorization bill; joint conferees wrote off Social Security and Appalachian bills; adjourned at 8:58 P.M.

DEPARTMENTS & AGENCIES

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Senate and House meet at 11 A.M.

Flood Toll 39 in Indian Town

HYDERABAD, India, Oct. 2 (Reuters) — The Chief Minister of Andhra state, K. Brahmananda Reddi, reported tonight a toll of 39 known dead in the flooded town of Matherla, 130 miles from here. The town was deluged Sept. 28 when two irrigation reservoirs burst.

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NYT
10/3/64
12:5

MEDICARE CHRONOLOGY -- HOUSE

1964

-- Ways and Means Committee reports bill on party line vote (D: 17-0) (R: 0-8)

-- Republican Amendment to gut the bill and replace it with a voluntary program fails 191 to 236 (D: 63-226) (R:128-10)

-- House approves Medicare with strong bipartisan support, 313-115 (D: 248-42) (R: 65-73)

-- House approves conference report 307-116 with a majority of Republicans (D: 237-48) (R: 70-68)

MEDICARE CHRONOLOGY -- SENATE

1960: Sen. Clinton Anderson's Amendment Failed 44-51 (D: 43-19); (R:1-32)

1962: Sen. Clinton Anderson's Amendment Tabled 52-48 (D: 21-43); (R: 31-5)

1964: Sen. Albert Gore's Medicare Amendment Adopted 49-44 (D: 44-16); (R: 5 - 28) -- Died in Conference

1965 Medicare Adopted 68-21 (D: 55-7); (R: 13-14)

1965 Conference Report Adopted 70-24 (D:57-7); (R: 13-17)

SOCIAL SECURITY CHRONOLOGY -- HOUSE

On April 5, 1935

Ways and Means Committee reports the Social Security Act without a single Republican vote (D: 16-0; 1 absent) (R: 7 "Present")

On April 19, 1935:

House rejects motion to recommit the bill to Ways and Means (offered by Treadway - R, MA) 149-253 (D:45-252) (R:95-1)

House approves Social Security 372-33 (D:288-13) (R:77-18) (I:7-2)

On August 8, 1935

House approves conference report by voice vote

SOCIAL SECURITY CHRONOLOGY -- SENATE

On June 19, 1935

Accepted an amendment to exempt firms offering private pensions 51-35 (D:35-30) (R:16-3) -- dropped in conference

Rejected an amendment to strike old-age benefits was rejected 15-63 (D:3-54) (R:12-7)

Passed the bill 77-6 (D:60-1) (R:15-5) (I:2-0)

On August 8, 1935

Adopted Conference report by voice vote

"It was an open secret on the hill that many Republicans were not in sympathy with the measure drafted, but dared not be recorded against it for fear they would be snowed under at the next election."

-- **"G.O.P. Crushed as House Votes Pensions, 372-33."** The Washington Post. (Douglas Warrenfels, April 20, 1935, p.1).

HOMECARE

NATIONAL ASSOCIATION FOR HOME CARE
519 C STREET, N.E., STANTON PARK
WASHINGTON, D.C. 20002-5809
(202) 547-7424, FAX (202) 547-3540

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CHAIRMAN OF THE BOARD

VAL J. HALAMANDARIS
PRESIDENT

HONORABLE FRANK E. MOSS
SENIOR COUNSEL

STANLEY M. BRAND
GENERAL COUNSEL

August 5, 1994

First Lady Hillary Rodham Clinton
Old Executive Office Building, Room 100
Washington, D.C. 20500

Dear Mrs. Clinton:

Thank you again for taking time from your busy day to participate in our latest HealthRIGHT event, which took place today in the Ways and Means Committee hearing room. From all reports things went extremely well. All of the networks, plus CNN and MacNeil/Lehrer requested a copy of the video petition, which we presented. We hope that the result, once again, will be positive news coverage which will help bring about the enactment of true national health care reform.

When I returned to the office I received a rude shock. Our staff obtained a copy of the Mitchell bill and analyzed it carefully. The conclusion of our staff and members of our Government Affairs Committee is that the bill is inadequate -- marginal at best in terms of meeting the objective for which we have all worked so hard, namely universal coverage. We have even more problems with the treatment home care receives in the acute benefits provisions. Although home health is included in the standard benefits package, it can only be used when required as an alternative to institutionalization.

Even more serious from our point of view are massive cuts in Medicare, a disproportionate share of which would come from home care beneficiaries. We are still analyzing the proposal, but as we understand it, it contains the following provisions:

- A 20 percent co-payment in the Medicare home care program would be required. This provision would be particularly devastating. It would cut the home care program by approximately $26 billion over a five year period. The burden of this provision would fall squarely on the shoulders of Medicare beneficiaries. Our members are concerned that this would add billions to their administrative costs at a time when their reimbursement rates are frozen or being reduced and that it will act as a significant disincentive to the use of home care benefits resulting in the end of increased program costs as individuals are kept longer then necessary in institutions.

- A continuation is proposed of an existing freeze on Medicare payments. Under current law, Medicare costs and related limits are updated each year with automatic increases put into effect which mirror increased costs related to inflation. Costs which have been frozen for the past two years would remain frozen at the 1993 level until July 1996.

HOMECARE

- A reduction in the Medicare cost limits is proposed to 100 percent of the median. Costs limits are currently set at 112 percent of the mean. This is slated to reduce Medicare benefits by at least $4.2 billion over five years.

Unfortunately, the above information comes only one day after a report in the *Wall Street Journal* that the Clinton Administration has shifted $250 billion in future Medicare spending away from home health agencies to hospitals as a means of enlisting the support of the American Hospital Association, as one of the so called "Four Horsemen" allied to bring about health care reform.

I have been around this city long enough not to believe what I read in the newspaper, but our members are extremely alarmed. You have been gracious enough to say on several occasions that no group has worked harder in the crusade and support of the President's health care reform plan than has the hospice and the home care industry. I know this is where your heart lies. The National Association for Home Care and our allied Center for Health Care Law, Hospice Association of America and HealthRIGHT organizations have done everything possible to assist you and the President. As you know, we have spent millions of dollars in a national advertising campaign and funded HealthRIGHT as a means of bringing real people with real problems to Washington to lobby the Congress, to support the President and increase pressure for health care reform.

The measures which are now being proposed by some people in Congress, supposedly with Administration support, appear to be punitive and discriminatory to home care providers and the millions of people they serve. I hope that we are wrong and that there is some misunderstanding on our part. I would like to emphasize the gravity of this matter by telling you it threatens our very support of current health care reform legislation.

It is my fondest wish to be able to use all of our energies and resources in support of health care reform over these coming weeks. We have worked so hard to assist you and the President in pursuit of common objectives. We would be extremely reluctant now to have to oppose the legislation. I am writing to ask your advice on how to proceed. May I ask your staff to set up a meeting for us to resolve this matter at the earliest opportunity with key White House staff to discuss this matter? We are asking for similar meetings with members of Congress.

Sincerely,

Val J. Halamandaris
President

cc: Melanne Verveer