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Subject: Health

Issue: Medicare, Medicaid

Emphasis: Discuss history of federal Medicare and Medicaid programs. Analyze their successes and failures. Show that while Medicare and Medicaid are necessary programs, problems with their administration indicate a completely government-run national health insurance program is unfeasible.

Data Section:

1. Social consciousness has evolved in this country to the point where basic medical care is recognized as a right or entitlement of all citizens. Historically, Medicare/Medicaid was milestone legislation - the first national response to this consciousness - providing medical care at least to the poor, the handicapped, the disabled and the aged.

The legislation which was to become the vehicle of the Medicare and Medicaid programs, the Social Security Act, was enacted in 1935. The Social Security Administration was to be responsible for three major programs: old age insurance, unemployment insurance, and public assistance. The 1960 Amendments to the Social Security Act (Kerr-Mills Law) contained two provisions expanding the medical care features available under the public assistance program for persons aged 65 and over. This established the Medical Assistance for the Aged program, the forerunner of Medicaid.

In 1965, legislation was enacted adding to the Social Security Act two programs - Medicare (Title XVIII) and Medicaid (Title XIX). Medicare is a two-part health insurance program for the aged; a basic program of hospital and related benefits, and a voluntary supplementary medical insurance program. The Medicaid program both amalgamated and extended previous medical-care provisions under the public assistance program. It is a federal-state program which, at the option of the states, makes vendor payments to providers of medical services on behalf of recipients of cash maintenance payments and on behalf of "medically indigent" persons.

Suddenly, just five short years after the long, bitter battle for Medicare/Medicaid was won, basic medical care was viewed by the majority of the population by government, and possibly by a majority of the health professions, as a right or entitlement of all citizens alike (1), (2). The concern now is how best to realize this national goal.

2. Medicare and Medicaid are necessary programs because the elderly, the disabled and the poor have more illness, therefore higher medical costs than the average citizen, and are least able to pay for it.

In fiscal year 1972, 27% of the personal health care dollar was spent for the aged, who comprise 10% of the total population. The large medical bill reflects the following facts: The average older person has more and costlier illness than the average person under 65; he is twice as likely to have one or more chronic conditions; he is admitted to hospitals much more frequently and for longer stays; on the average, he uses physicians' services to a far greater extent (3).

There is abundant documentation, from the National Center for Health Statistics and elsewhere, of the greater incidence of illness among the poor compared to those with higher incomes. According to Louis Harris, public opinion analyst, the incidence of serious illness is reportedly two to three times higher for the poor than for the population as a whole (4).

Some 40 to 50 percent of Americans - the aged, children, dependent poor, and those with some significant chronic disability - are in categories requiring large amounts of medical care but with inadequate resources to purchase it (5).

3. Medicare and Medicaid provide benefits to millions but the cost of the programs are tremendous and the resulting inflation in health care costs is adversely affecting the health care costs of the general population.

In 1971, nearly 21 million people aged 65 and over were protected by Medicare Hospital Insurance (Part A). Nearly 20 million were voluntarily enrolled in the supplemental Medical Insurance program (Part B). About half of the enrollees received services under Part A and/or Part B for which providers were reimbursed over \$7 billion (6).

It is estimated that Medicare payments cover about one-half the total health care expenditures of the elderly. For hospital and physicians bills, the proportion is about three-fifths. Compare this with the 1968 private health insurance benefits which met only 36 percent of the total expenditures by private consumers (7).

More than 19 million persons were eligible for Medicaid benefits in 1972. Federal, state and local expenditures under the Medicaid program have increased from \$1.7 billion in fiscal year 1966, to \$6.5 billion in 1971, and to an estimated \$7 billion in 1973 (8).

Total personal health care expenditures in this country rose sharply from \$10.4 billion in 1950 to \$71.9 billion in 1972. Public funds accounted for only 20% of the expenditures in 1950 but for over 40% in 1972 (9).

4. Recent Legislative Amendments (1972) relating to Medicare and Medicaid will allow and encourage innovative approaches to delivering health care by the private sector which is a better approach to providing economical, efficient and quality care to all than further massive government intervention. (10)

DISCUSSION SECTION

Genesis of Medical Care Legislation

Possibly the first national advocacy of government health insurance in the United States was in the platform of the Socialist Party in the early 1900's. Subsequently, a plank supporting national health insurance was included in the platform of the Progressive Party founded by Theodore Roosevelt prior to the 1912 elections.

Over the years, socialized medicine has been advocated. Defined as complete ownership of all medical care facilities by the government, with medical practitioners and other staff providing the services being salaried employees of the government, socialized medicine was most openly advocated during the depression days of the 1930's. There was considerable support for this type of proposal among persons in the academic world, but widespread popular and legislative support was never forthcoming. Since the late 1930's, very little advocacy of socialized medicine has been heard publicly.

The proposals for a compulsory national health insurance program covering persons of all ages that were made during the 1940's met with little success. This was partly due to the rapid growth of various forms of private health insurance and also because of the opposition of many important and powerful organizations, such as the American Medical Association and the insurance companies.

Beginning in the early 1950's, advocates of a federally administered national health insurance program focused on the most vulnerable area - protection for a group of persons with notably high medical expenses and low incomes - namely, persons aged 65 and over. Finally, in 1965, legislation was enacted launching the program now popularly called Medicare. The same legislation contained somewhat parallel provisions.

Medicare is characterized as a federal insurance program, paid for, on an actuarially determined basis, by the prospective beneficiaries and their employers, financed through special trust funds with nationally uniform benefits, and entitlement as a matter of right, regardless of personal need. In contrast, Medicaid is a series of separate state welfare programs - 52 as of mid-1970 - paid for out of general taxes, on the basis of annual appropriations from the federal and state governments, with some federal benefit and eligibility standards but wide regional and state variations, and entitlement based on a state-administered means test. All three key variables in the Medicaid formula - means test or income limits, benefit standards, and available funds - are subject to frequent change in accordance with economic and political pressures.

No state is required to have - or to continue - a plan that qualifies under the Medicaid program, but if it does not, the federal financial support for medical care costs of a substantial proportion of the population is not available. Each state necessarily bears a substantial portion of the cost of the program that is met from federal matching, whether or not it participates therein because its citizens pay taxes to the federal government that are used for all federal expenditure purposes. Thus, in order to get its money back, there is strong pressure exerted on each state to participate in the Medicaid program.

Meanwhile, inflation of medical costs had begun in the 1950's and began to increase rapidly during the late 1960's when a large amount of "new" money became available for health care from private health insurance policies as well as Medicare and Medicaid programs. Very soon both programs were in serious financial trouble.

In 1969, the Senate Committee on Finance requested the staff to undertake an inquiry into the status and operations of the medicare and medicaid programs.

The 1970 Report was directed toward trying to make Medicare and Medicaid work, principally by building in some cost controls - "to repair rather than retrench".

Also in 1970, a Task Force was established by the Secretary of HEW and chaired by Walter J. McNerney, President of Blue Cross Association. This report considered the whole problem of health care delivery in the United States. It interpreted the recent Federal enactments as intending that access to basic medical care shall be a right or entitlement of all citizen.

Indeed, shortly after enacting Medicare, Congress reaffirmed its conviction that "fullfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person".

This was echoed from the business sector in a Statement on National Policy by the Committee for Economic Development in April 1973. "We recommend enactment of a health-insurance program that would require a basic level of protection be made available to all Americans regardless of their means, age, or other conditions. . ."

The California Medical Association in its Position Paper on National Health Insurance (2) outlines principles deemed essential to any such program. "The first is adequate coverage for all. Everyone should be able to get the health care he needs; no one should lack health care simply because he cannot afford it".

Need for Medicare/Medicaid Program

In 1970, approximately 26 million people in the United States lived below the poverty line (about \$70 a week income for a family of four) and approximately 15 million more are near-poor (\$90 a week income for a family of four). Only 13 million were covered by Medicaid in 1971. Less than 30 states, despite the availability of Federal matching money, have programs for persons who are medically needy but do

(4 1-56)

not qualify for cash assistance. Two out of three children in poor or near poor families are not included under Maternal and Child Health or Medicaid programs. Among the poor and near-poor, only a little over a third below the age 65 have private prepaid medical care or medical insurance of some sort. In total, depending on different estimates, between 30 and 45 million people under age 65 are without any health insurance. The stated objectives of Medicaid was to assure adequate health care to the nations poor and near-poor. (11)

As a group, the elderly have less opportunity than employed persons to spread costs of medical care through health insurance because of lower income. There is little question that the Medicare program has provided incalculable health services to millions of the elderly. Medicare offers for better benefits than any existing private insurance to this age group.

Medicare Eligibility, Benefits and Costs

The Hospital Insurance (HI) benefits are available to all persons aged 65 and over who are "entitled" to monthly cash benefits under either OASDI or the Railroad Retirement system. The Supplementary Medical Insurance (SMI) program with minor exceptions is available to any person aged 65 or over who elects to participate in it.

HI is provide in-hospital and post-hospital services to the beneficiaries after certain deductible and cost-sharing amounts are paid by them, rather than providing specified indemnity benefits and leaving it up to the beneficiary to pay the defference between the charges and the benefits. In this respect, HI is patterned along the lines of Blue Cross benefits, instead of those found in the more usual insurance company plans.

SMI coverage focuses on physician and related services such as home health services, diagnostic tests, x-ray, physical therapy, rental or medical equipment, etc..

SMI is patterned closely after indemnity health insurance plans of the comprehensive type.

Medicare costs to the aged themselves are relatively small. The most expensive portion, HI, is paid for by or on behalf of the beneficiary by a relatively small payroll tax, currently a maximum of \$108 per year. This financing is made possible by means of the tremendous population spread, the compulsory tax paid by the wage earner and the matching provisions by the employer. SMI is financed jointly by the covered individual, after he reaches age 65, and by the federal government through general tax funds. SMI differs here from private insurance in that the premium payment with respect to the protected person is not the actuarial equivalent of his benefit protection. That is the reason for the 50-50 matching government contribution - namely, to balance out the different risk levels involved.

Unfortunately, however, the price of all the good things achieved created a financial crisis in the program. Payroll taxes, contributions, coinsurance and deductibles have had to be repeatedly raised*until there is danger of re-creating a financial barrier to health care on the part of many of the elderly.

In fact, the failures of the Medicare program can almost be summed up in one word - "cost".

The program's contribution to the tremendous inflation in health care costs since 1965 involves both price and use of all types of services. With respect to hospitals, price is the primary culprit although there has been some rise in the average length of stay of Medicare beneficiaries. As to extended care and home health programs,

*The HI tax rate on employee and employer each went from 0.135% on \$6,600 maximum wage in 1966 to 1.0% on \$10,800 maximum wage in 1973. The SMI premium went from \$3.00 per month originally to \$5.80 currently.

both price and use have exceeded expectations. With respect to physicians' services, this is also true. Some fraud has also been revealed and widely publicized. Anne Somers, nationally known authority on health care organization and financing, believes that this is less the result of any widespread dishonesty among providers or administrative laxity than of a more basic problem - maintenance of what the Social Security Administration calls "program laxity" under a law that is virtually open-ended with respect to the use of physicians' services and all prices. The Senate Finance Committee Staff Report (1970) pointed out quite bluntly that under the law, the institutional suppliers of covered health services under Medicare (and Medicaid too, in large part) were paid whatever it cost them to provide their services. Physician bills were essentially paid as rendered. Unlike most areas in the private economy no incentives existed to produce or supply a given health service at the most economical price consistent with quality of care. As a matter of fact, hospitals and extended care facilities could, under the reimbursement rules, spend money on virtually anything and be paid for it by Government.

Medicaid Eligibility, Benefits and Costs

Title XIX eligibility standards require inclusion of all persons receiving or eligible to receive money payments under the four categorical public assistance programs (OAA, AFDC, AB and APTD). Federal matching funds for Title XIX vary from 50 to 83 depending on a state's per capita income. The states were also encouraged to include the "medically indigent", persons not on welfare but with incomes so low that they couldn't meet their medical expenses, and all children under 21 who needed medical care but couldn't afford it.

The definition of "medical indigence" was originally left to the states. But after New York and California has provided comparatively liberal income limits, Congress in 1967 set the upper limit at one and one-third times the state's AFDC limit.

The number of potential eligibles was also restricted by limiting the number of children under 21 who may be put on AFDC to the same proportion of all children in the state under 21 who were on AFDC Jn. 1, 1968. Additional pressure against a liberal definition of "medical indigence" comes from the fact that federal matching funds are available for only very limited categories of the medically indigent.

With respect to benefits, Congress has also been ambiguous. Originally, states were required to provide all beneficiaries with at least five specified basic services. Fourteen other services were also eligible for federal matching. Since the 1967 Amendments, however, the states are no longer required to provide the five basic services to any but the categorically needy. For the medically needy they may substitute any seven of the fourteen others.

Criticism of Medicaid has tended to focus on problems of cost as well as eligibility. The HEW Secretary's Task Force stated: " . . .that the cost of covering less than one-third of the indigent and medically indigent has exceeded earlier estimates of the cost of covering the whole medically deprived populations is due to a combination of factors, including inflation. It also suggests how badly the expenditures have been controlled, or how badly the program costs were estimated, or both".

Rejecting such limited cost controls as are present in an insurance program such as Medicare, where benefits and eligibility must be actuarially related to revenues, the Medicaid program is subject to constant pressures for both too rapid liberalization and politically explosive retrenchments. Relying on an unadministrable means test to determine eligibility, it provides virtually an open invitation to fraud on the part of borderline consumers. State and local governments were in no position to assume even half the burden of the Medicaid costs. At the same time they were unprepared administratively to exercise effective cost or quality controls.

The "Medicaid crisis" is incredibly involved. Aside from general problems of inflation and inadequate administrative controls, which it shares with Medicare and private insurance, the Medicaid crisis is part of the general "welfare crisis" and the "crisis in race relations". As a welfare program paid for out of general taxes, it shares the stigma accorded by most middle-class Americans to welfare programs, especially when they appear inordinately expensive. As a program serving large numbers of blacks, especially in northern urban areas, it is subject to the same sort of back-lash resentment from low-income whites that has plagued most recent efforts to upgrade Negro social services and opportunities.

Meanwhile, one of the most serious results of the rising Medicare (and Medicaid) prices and costs is that health care costs and financing for the general population has been adversely affected. The charges for adequate nongovernmental health insurance are rising to levels beyond the financial capacity of millions of Americans. Most of them probably would prefer to continue their private coverage rather than become part of a monolithic system of governmental health care. However, under foreseeable conditions, whatever choice they currently have is in danger of being removed by circumstances beyond their control.

Recent Reforms

The Committee for Economic Development concluded in 1973 that: "Medicare is the largest single health insurance plan and one of the best run in the nation. Although the plan is not without problems, the system serves its present and potential beneficiaries well, and its difficulties are susceptible of correction".

Anne Somers states: " . . . Medicare is a fully accepted part of the health care scene, generally popular with providers and beneficiaries alike".

The Senate Finance Committee Staff concluded that "Medicare is a good Federal program". However, it indicated major areas where changes in the statute itself or in the administration of the program would improve efficiency and economy while improving the quality of care rendered. In contrast, the Medicaid program had not nearly approached the congressional objectives of assuring good health care for the poor in an effective and economical fashion.

They called upon the physician and his medical society to be the key in making the programs workable and acceptable. They were persuaded that neither the Government nor its agents had the capacity for effective audit to assure that a given physician functions responsibly in dealing with the publicly financed programs. They requested prompt action by organized medicine to do what was required to monitor care provided and charges made. In the absence of such constructive effort, they feared that virtually insurmountable pressures would develop for alternative control procedures which might be arbitrary, rigid and insensitive to the legitimate needs of both the patient and his physician.

This plea related partially to the utilization review mechanism which had been written into the law in order to promote the most efficient use of the institutional facilities. In light of the shortcomings existing in the utilization review process, the 1972 Amendments to the Social Security Act provided a review mechanism through which practicing physicians will assume full responsibility for reviewing the utilization of services. Also, the Secretary is required to establish independent "professional standards review organizations" (PSRO's) throughout the country in various areas.

The Secretary's Task Force found that even after four year's experience under Medicaid and Medicare, and with parallel opportunities for expansion in the private sector,

a significant number of Americans were not adequately protected against costs of needed health services. It was a central conclusion of the Task Force that money alone would not guarantee either capacity or effectiveness of the system. Additional financing needed to be accompanied with "opportunities and encouragement of physicians, hospitals and others to provide service in ways that permitted response to sound economic and patient-care incentives, and to engage in a competition of organization and method". The Task Force strongly endorsed the Health Maintenance Organization (HMO) proposal to provide an option for Medicare and Medicaid beneficiaries to elect to receive services through a single organization providing coordinated services financed through prepaid capitation.

The advantages of the HMO concept are that they stress prevention as well as cure, and that they closely link financial functions and the delivery of health services. Financing is based on prepayment for an essential set of benefits and providers of care can be paid in accordance with fees and charges fixed in advance by agreement and related to a budget that reflects efficient organization and administration.

The 1972 Amendments permitted, after June 1973, prospective medicare payments to be made to HMO's: (1) on an incentive capitation basis, in case of an established HMO, or (2) under a "costs only" per capita rate system in the case of new HMO's. There was no need to enact comparable Medicaid legislation because sufficient authority existed in the program to permit states to arrange for medical coverage through an HMO.

Controls and incentives will not be realized without more forceful leadership and better organization within the health field. The total job to be done will take concerted efforts of both the public and private sectors.

Position

Accepting that adequate health care is the entitlement to all citizens, government's role should be one of leadership in promoting national health insurance, not in administering it. Government financial assistance should be provided to those unable to pay for care. The consumer should be allowed complete freedom of choice in choosing his own doctor and health facility. In order to provide as many choices as possible and to keep costs at a level that the nation can afford, government must encourage, assist, and evaluate innovative ways to deliver health care. It must motivate and encourage organized medicine to take an active role in peer review mechanisms to promote the effective, efficient and economical delivery of health care services and to assure quality of care.

QUOTATIONS

"It is the intention that the Federal leadership as far as possible shall guide, not direct; motivate, not demand; assist, not provide; and evaluate, not ordain". Task Force on Medicaid and Related Problems U.S. Department of Health, Education, and Welfare, (1970)

"Just turning the problem (health care dilemma) over to government, because of greater ease of financing, might be the easiest, but also the laziest and in the long run most unproductive, approach to the problem. If we are to get out of this corner, we must do some basic rethinking. This rethinking must involve all aspects of the health care equation - organization as well as financing, prevention and aftercare as well as diagnosis and treatment, consumer knowledge as well as provider skills, the doctor-patient relationship as well as science and technology of medicine". Anne R. Somers, Health Care in Transition: Directions for the Future (1971)

"After nearly a decade of mounting debate, the nation is nearing the point of taking decisive action to remedy the inadequacies of its health-care system . . . We believe the goal of providing adequate care for all will continue to elude the nation even though vastly greater financial resources are poured into the system as presently constituted. . . . This committee proposes that the system be restructured through a series of actions to be taken in both the public and the private sectors, building on strengths and potentials where these exist". Committee for Economic Development Building a National Health-care System (1973)

"Wherever people live, the rising expectations of which we hear so much have risen particularly steeply with regard to health. Of all the issues that confront Americans, this one cuts most widely across racial, political, age and income lines in every section of the country. And of all the gaps between promise and performance, this is the one that the vital center of the nation - whether because care is unavailable or impersonal and expensive - finds most deeply disappointing". Judith Randall, Syndicated newspaper Column (July 16, 1970)

"At first unsophisticated about the need for government programs to help the disadvantaged, carriers are now learning to work with government . . . Perhaps the fundamental flaw is an excess of publicly unrewarding competition among carriers vis-a-vis largely uncompetitive producers of services. Health care is involved in what often seems to be contradictory values of access, dignity, innovation, variety, and uniformity. If these values are to be properly balanced, the remedy lies in stronger internal and external disciplines for the entire industry".

Walter J. McNerney, Private Health Insurance and Medical Care (1968)

"Grant us a profession populated by men and women of competence, integrity, and a will to do their best for their people and we will give you care for the health of our nation without the need for restrictive systems, intricate controls, or massive governmental interventions".

Russell B. Roth, M.D., First address as President of the American Medical Association (1973)

"What is basically wrong with the health service system in the United States? . . . The basic fault in American health service is the discrepancy between our assertion of health care as a basic human right and our practice of treating it as a marketplace commodity. . . .We have not organized the provision or "delivery" of health care services in the way that other services deemed essential to society have been organized, such as education or protection against fire".
Milton I. Roemer, Nationalized Medicine for America (Sept. 1971)

"We need the richness and diversity of pluralism with the recognition that no fixed ideology and no single group can determine what is best for all. For these purposes, we must strengthen both the public and private sectors - and the latter is in particularly serious jeopardy. If we give up our voluntary institutions to central government, we give up the energies of individuals involved in the enlightened self-interest of providing regionally unique and self-determined services".

John Knowles, M.D., President, Rockefeller Foundation Keynote speech, APHA Convention (1973)

REFERENCES

1. U.S.: Department of Health, Education and Welfare. Report of the Task Force on Medicaid and Related Problems. Washington, D.C. 1970, p. 2.
2. California Medical Association. "Where We Stand - California Medical Association Position Papers". California Medicine. 119:42-59, December 1973, p. 53.
3. U.S. Social Security Administration, Office of Research and Statistics. The Size and Shape of the Medical Care Dollar. Chart Book/1972, Washington, D.C.
4. Harris, L. "Living Sick". Sources: A Blue Cross Report on Health Problems of the Poor. Chicago, Blue Cross.
5. Somers Anne R., Health Care in Transition: Directions for the Future. Chicago, Hospital Research and Educational Trust, 1971, p. 20.
6. U.S. Social Security Administration. Social Security Bulletin, Annual Statistical Supplement, 1971. Table 122, Table 116.
7. Somers, A. op. cit. p. 58..
8. Schultze, Charles L., Edward R. Fried, Alice M. Rivlin, and Nancy H. Teeters. Setting National Priorities, The 1973 Budget. Brookings Institution, Washington, D.C.
9. Committee for Economic Development. Building a National Health-Care System. A statement on National Policy by the Research and Policy Committee. April, 1973, New York. P. 13.
10. Commerce Clearing House, Inc. 1973 Social Security and Medicare Explained, Including Medicaid.
11. U.S. Department of Health Education and Welfare. op. cit. p. 104.

BIBLIOGRAPHY

Brian, Earl W., M.D., "The Medi-Cal Reform Law". California Health, Vol. 29-10, April 1972, pp. 1-5.

Davidson, MA, Stephen M., Ronald C. Wacker, MA, David H. Klein, MBA, "Professional Standards Review Organization, A Critique". Journal of the American Medical Association. Vol 226, No. 9, 1106-1108. November 26, 1973.

California Medical Association. "There We Stand - California Medical Association Position Papers". California Medicine, Vol. 119, No. 6, December 1973. Sec: Cost of Health Care, p. 46; Health in the United States, p. 50; Health Maintenance Organization and Prepaid Health Plans, p. 51-52; National Health Insurance, p. 53-54; Professional Standards Review Organizations, p. 57-58; Quality Medical Care, p. 58-59.

Commerce Clearing House, Inc. 1973 Social Security and Medicare Explained - Including Medicaid. Chicago, Ill., 1972. 430 pp.

Committee for Economic Development. Building a National Health-Care System. A statement on National Policy by the Research and Policy Committee. New York, N.Y. April 1973, 105 pp.

Marin, Nancy, "Surprise: An HMO That Pleases Almost Everybody". Medical Economics, October 15, 1973, pp. 180-193.

Myers, Robert J., Medicare. McCahan Foundation, Bryn Mawr, Penn. 1970, 352 pp.

Rowlands Jr. Marvin L. (Editor), "Prepaid Plans Proliferate, but Doubts Still Linger". American Medical News. (AMA), Vol. 16, No. 14, April 9, 1973.

Sheridan, Bart, "Will an HMO Grab Your Patients"? Medical Economics, September 17, 1973. pp. 220-243.

Somers, Anne R., Health Care in Transition: Directions for the Future, Chicago, Hospital Research and Educational Trust, 1971, 176 pp.

U.S. Medical Services Administration, The First Six Years of Medicaid. A Selected Annotated Bibliography, 79 pp.

U.S. Department HEW, Office of the Secretary. Report of the Task Force on Medicaid and Related Programs. 1970, Washington, D.C.

U.S. Senate, Committee on Finance. Medicare and Medicaid :Problems, Issues and Alternatives. Report of the staff to the Committee on Finance, U.S. Senate, Russell B. Long, Chairman. 91st Congress, 1st Session, February 1970.

U.S. Social Security Administration, Office of Research and Statistics. The Evaluation of Medicare ; from Idea to Law, by Peter A. Corning, Washington, D.C., 1969 (Its Research Report No. 29) 151 pp.

U.S. Social Security Administration. Office of Research and Statistics. The Impact of Medicare. An Annotated Bibliography of Selected Sources. Washington D.C., 1969, 69 pp.