PRESENTATION OF MAJOR HEALTH INSURANCE PROPOSALS

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

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PRESENTATION OF MAJOR HEALTH INSURANCE PROPOSALS

TUESDAY, JUNE 19, 1979

UNITED STATES SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 9:15 a.m. in room 2221, Dirksen Senate Office Building, Hon. Russell B. Long (chairman of the committee) presiding.

Present: Senators Long, Talmadge, Ribicoff, Byrd, Jr., of Virginia, Nelson, Bentsen, Moynihan, Baucus, Bradley, Dole, Chafee, and Durenberger.

The CHAIRMAN. This meeting was called so that Senators, as well as the administration, would have an opportunity to present their major health proposals that they would like us to consider.

Now, some people might feel that we have not held enough hearings on this subject. What I am holding here is only printed on one side of the page, but these printer's galleys are the hearings that have been held in this committee up to now.

Now, I would assume, based on what I have been told by the members of this committee, that there are others who would like to testify and to be heard, and, as chairman of the committee, I will do whatever the majority wants to do. This is my duty, and I will do it. I will try to accommodate individual Senators to see that the information that they want is available to us.

As we go along working on this health insurance proposal, we are going to run into problems where we do not know the answer. After we talk it over and have the various suggestions, we may then feel that we still do not have the best answer. We may want to hold further hearings even then, and maybe after we go aways further, we might want to have some more witnesses to come tell us some more, after we have made further decisions.

In other words, there are some people who have a vital interest in this matter who might not be satisfied that their views have been considered. It may very well be that after they see the direction that things are going, they may want to be further heard, and maybe we ought to have further hearings. There would not be anything new about that.

This committee has, on occasion, had a major bill out on the Senate floor and called hearings in the morning while the bill was being debated on the Senate floor in the afternoon just to accord a chance to be heard to everyone who had a suggestion, and we acted based on what the recommendations were that we received.

The only thing that I would like to stress is that we ought to try, in my judgment, to make progress and headway in this area.

The way that I see it, as one member of the committee, is that for at least 10 years now we have been talking about doing something in the health area. Senator Ribicoff and I have been sponsoring the catastrophic health insurance bill, for example, for more than 6 years. We have been joined by a considerable number of other Senators and, more often than not, the argument against it has not been that we should not do something like this—the argument has been that if you are going to get into the health insurance area, you ought to do a lot more.

Today we will ask everyone, the administration and all Senators who can make themselves available, to present their plans and let us have a chance to be sure we know what they are advocating.

I was thinking that we could go into executive sessions tomorrow. In fact, we had scheduled an executive session for today.

I think we ought to play it by ear. We will go ahead and hold our hearing today and we will see what the other members of our committee want to do.

Senator RIBICOFF. Mr. Chairman, respectfully, I think that we are going about this wrong. You have always been most thoughtful and considerate of all points of view.

I think that we have before us today a great opportunity to finally have a health insurance plan. Frankly, I think it is going to be along the lines originally advocated by you and myself; but, for the first time, you have the President of the United States and Senator Kennedy with their proposals, which look to me that they have basically adopted some of the philosophies that you originally advocated.

Then, of course, you have Senator Dole, with some of his Republican colleagues, who for the first time have become serious players in the national health insurance plan. What bothers me is that trying to go into a markup session tomorrow without having before us the problems would be self-defeating.

Let me lay out for the members here, and yourself, what I consider to be some of the basic problems that face any of the plans. We ought to have an understanding of this before we start discussing details.

Let me give you the general issue, as I see them, in the competing health insurance plans of Senator Long, President Carter, and Senator Kennedy.

First, we have the problem of economic impact of the different national health insurance proposals—that goes to Senator Dole's proposal, too—the comparison of the different proposals, the role of cost controls, the role of deductibles and coinsurance, projected increased demand and utilization.

The next big problem is the impact of the system's reforms in each proposal. The incentives for prepaid practice, incentives for primary care, availability of providers of service to the elderly and the poor.

Then the comparative population profile. How many people of what ages and incomes would be helped how much by the various proposals.

Then you have to have the testimony of the competing plans from the employers, insurers, and providers. This is complex.

I am sympathetic with your point of view that we should try, as soon as possible, to put in the first phase of catastrophic. The President and Senator Kennedy look to 1983.

If we are going to adopt your thinking of trying to put a piece of this in place earlier, will the insurance companies, the employers, and the employees be in a position to put anything into effect by the beginning of 1980? You are going to have to open negotiations between the employers and employees of the major companies.

Then, can the insurance companies change their plans accordingly? What do you do with the thousands upon thousands of employers who do not have general insurance coverage?

Let us take the specific issues which are going to have to be addressed even if we accept the Long-Ribicoff or the Carter general approach.

One, what should be the form, amount, and duration of employer subsidies?

Two, how should the benefits and cost controls be phased in so as to minimize harmful side effects such as inflation, overutilization, and lack of primary care providers?

Three, what cost controls are feasible and desirable beyond hospital cost controls? Should there be physician fee schedules? Should they cover more than medicare and medicaid? How should the fee schedules be arrived at?

Should there be capital construction controls? If so, what kind?

Do we need additional controls on utilization?

Fourth, what mechanisms should be used for providing improved protection for the poor: The use of the private health insurance system, a voucher system or a federally run program?

If it is a Federal program, should it be merged with medicare?

What role should the States play in the administration of claims or eligibility? How can the administration be improved through competitive bidding of services?

How should coverage for the poor be financed? What should be the formula for State contributions?

Will high-benefit States be penalized? Will States be at risk, even though they have no role in the administration of the program?

Now, the question of financing catastrophic coverage. Should it be wage-based premiums or employer-mandated coverage, what percentage should the employee be required to contribute?

We have got so many complex problems that to try to sit down here as a committee and mark up and to start moving without knowing what we are talking about, I think, would be self-defeating.

I really, truly believe that we can pass national health insurance and I think we are going to have to give the Congress and the people of this country the feeling that we have been thoughtful and careful, as we have on every major piece of legislation.

I think what you have before you today, Mr. Chairman, in many ways is the most significant social and economic piece of legislation presented in the last decade, for sure, before this Congress.

You have been a forerunner, you have been a pioneer in getting landmark legislation out of this committee. I happen to think that this committee—I can say this since I am leaving the committee after this session—is the most outstanding committee in the Congress of the United States. It is thoughtful; we work carefully; we work hard.

I do not know any chairman that knows as much about his subject matter. I know of no chairman who works harder and I know no chairman that has been more cooperative with the members of the committee.

I think we have an opportunity of putting a health insurance plan across, but I would not like to see us try to mark up a bill until we have given a full opportunity for hearings on the four basic plans: The Long plan, the Dole plan, the Carter plan, and the Kennedy plan.

My feeling is when we all get through, and if we are thoughtful and careful, as we have been in the past, we are going to be able to work out a bill that can be supported by Senator Long, Senator Dole, Senator Kennedy, and President Carter. If we do not go that way, we are going to be bogged down with a lot of sniping and fighting between the four groups and we will not get a national health insurance plan.

I say this to you respectfully. There is no man in this body whom I respect more than you, Mr. Chairman. There is no man in the Senate who is more considerate of myself and my thoughts as you have. It has been a real pleasure to work with you, to work carefully and, I think, constructively, together.

I would like to be able to do it on this piece of major legislation, too. I think it can be done.

The CHAIRMAN. Let me just say this, Senator. I think that we should all be grateful to the administration and to President Carter that he has come up with a plan and that he has recommended that we pass a bill this year, as I understand it.

So as far as the President is concerned, he has sent his recommendations down here, and I really think that the administration is satisfied to present its case here and let us vote on it.

I know as far as this Senator is concerned, I am ready. I have a brief statement I will make later, which will not take 10 minutes.

As far as I am concerned, do whatever you want to do about my suggestion. As far as I am concerned, just vote one way or the other—yes, no, or any shade of maybe.

From time to time, we have enormous tax bills. They have a lot more problems in them than this bill does. My thought is that we sometimes have had to make some decisions to see what direction we were going to head in, otherwise we would not have had any bill, and we would still be arguing about what we should do.

We will go before the public next year. If we do not act, many poor people will die in the meantime, and many middle-income people will die in a catastrophic illness situation, or their resources will be wiped out. People will say, "Well, you talked all of these years. Now, we have had 6 years of conversation about your plan to help these people. Why don't you ever do something up there?"

Any State legislature would look with scorn on the U.S. Senate's taking 6 years talking about something and never getting around to doing anything.

We have finally voted on one simple proposition here in this committee. It was a unanimous vote, that we thought to the maximum extent possible that we ought to try to use the free enterprise system rather than destroy the free enterprise system in setting up a health insurance program.

I am willing to hear, Senator Ribicoff, anything that you are willing to hear. If you will find time to hear somebody on the health area, I will find the time, too. I would hope everybody will take the same attitude.

Here are some of the scheduling problems that are going to face us. I personally am committed to give windfall tax on oil first priority when it passes the House, to move it ahead of other things. At that point, we will have to set this matter aside. I am committed to the majority leader. He has pressed me for that kind of commitment, and he has made a parallel commitment to the Speaker of the House and the House Ways and Means Committee members. When we take up the windfall profits tax, we will have to set this matter aside and go to something else and then come back to health insurance later.

The windfall tax is going to be a pretty hot issue. It will take a considerable amount of debate. Hopefully, we will get our bill together and have enough answers so that we can recommend something to the Senate. Getting it out there in time to schedule it is not going to be easy, because the SALT debate is going to be a very important debate this session. And we have all the other bills that must be considered, appropriations bills and others.

It will take some real doing for us to vote on whatever we want to do about health insurance between now and the end of this Congress. I am willing to hear witnesses. I am willing to hold more hearings. I am willing to accommodate everybody.

For the information of the Senators, I try to be available anytime anyone here has somebody he wants to have heard, to sit individually with him and his constituent and talk about the problem, see what they have to offer, insofar as I can find the hours available.

I do think the fact that we scheduled an executive session to meet on health did have something to do with moving the matter forward. I think it did put some pressure on everybody involved to get their thoughts in here, to get them in some form that we could look at and hopefully provide an answer.

I would hope that today we would just go ahead and hear what the Senators and what the administration have to offer. I hope that we would limit ourselves very drastically on questions, submit most of them in writing, but if you want to ask questions, I urge Senators to limit themselves insofar as they can so that everybody can make his presentation today.

I would like to meet with the Democrats on this committee this afternoon. I would suggest that Senator Dole, if his Republicans do not know what they want to do now, may want to hold a meeting about the same time and get their thoughts together and see what they are thinking and then by the close of business today hopefully we can know what we want to do tomorrow.

This committee has rules that to meet in executive session we have to give notice 2 days in advance, so if we just wanted to vote on whether we wanted to do anything or not to do anything about health insurance, I am limited by the 2-day notice rule. That being the case, I gave notice that today's meeting would be an executive session. When I heard from the Senator from Connecticut, and his apprehension was also shared by the Senator from New York, Mr. Moynihan, I said, let's meet here and talk about these plans today.

And I suggest that we have a meeting to talk about further procedures.

We are pleased to have Mr. Hale Champion here before us.

Senator DOLE. Mr. Chairman?

The CHAIRMAN. Senator Dole?

Senator DOLE. Just let me say that, as far as I know, the Republicans are certainly willing to accommodate anyone who wants to testify. We may have some influence on which plan passes, although the media has not noticed that yet, but they may.

There are 41 Republicans and they have also some influence on what passes the Congress.

The CHAIRMAN. Senator, if I may interrupt, you have not heard all the media. I heard the Agronsky show predicting that the "3–D" bill will be the one that becomes law, the Dole-Danforth-Domenici bill.

Senator DOLE. I certainly share the views expressed by both my colleagues. It seems to me that we have had this sort of fascination with the politics of health care. Whether it be the Kennedy plan or the Carter plan, I do not think if you put them both together, you would get 25 votes.

I think that we have to back away from all the ink and look at the programs and then determine which course we are to pursue.

I really believe Senator Ribicoff is right. It is probably going to be something along the lines that Senator Ribicoff, and Senator Long and others have been suggesting for some time. Maybe it will be some variation. Maybe it will accommodate some of Senator Kennedy's wishes and also some of the administration's. But there is a Republican position. There is a Republican proposal, the 3–D proposal by myself, Senators Danforth and Domenici.

We are certainly willing to hear more witnesses. I think calling the executive session has focused the concern of this committee on a very important problem. It is not a partisan concern. It should be a matter that should be addressed.

In addition to the things that the chairman mentioned, we still have cost containment to deal with—maybe we can do that this week—plus the trade legislation—so we will have a very busy year.

I believe that you will find the majority of Republicans willing to support a limited program, we are concerned about health care; however, it is also a question of costs, a question of how comprehensive it should be, whether we are prepared to disturb the position of the patient relationship and in effect ration health care. I do not think that Republicans will pursue that line. However, we certainly want to accommodate the chairman and others on the committee to the extent possible.

The CHAIRMAN. Let me talk about this pride of authorship question. I would be ashamed if a single person in this country had to die without being cared for in this country because any Senator, including this one, was so anxious that his plan should become law that he would not let us vote on somebody else's plan.

I would think that this matter of posturing, an individual's claiming authorship, and all of that should be a very, very poor second to trying to look after the Nation's interests and the people's interests.

When we talk about authorship, about whose bill will become law, it makes me think about my definition of tax reform. Sometimes I

have been asked what my definition of tax reform is. I say, anything that can muster 51 votes out on that Senate floor is tax reform, because if you can muster enough votes to pass it, you can muster enough votes to put the title of "tax reform" on the front of the bill. If the President signs it and it becomes law, it is tax reform because the law says so. That is what will happen in health insurance if we are able to pass anything, anything that 51 Senators, at a minimum, think we should pass.

We are very pleased to have Mr. Hale Champion here. Secretary Califano had scheduled a trip months in advance which he had to take, but he is well represented here by Under Secretary Hale Champion.

We will be very pleased to hear your presentation for the administration plan, Mr. Secretary.

STATEMENT OF HALE CHAMPION, UNDER SECRETARY OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. CHAMPION. Thank you very much, Senator.

I thought that the best thing that I could do would be to run through the fundamentals and the structure of this plan, the basic benefits and costs. Obviously, there are a great number of details, and we have tried to provide you individually with more information—fact sheets describing not only what we are asking in this Congress, but what long-term results we look to achieve.

I think I might begin by summarizing—although the chairman and several of the members have really pretty much accomplished this—why we are, at this point in the history of this country, considering an important, large, and, at least initially, costly proposal for the health of the American people.

There are, in fact, basic reasons why we think that this area has captured the interest of a very large number of the citizens of this country.

NATIONAL HEALTH PLAN: THE BASIC APPROACH

Describes Ultimate Goal: Universal and Comprehensive Plan that —

- Provides Basic Health Care to All Americans
- Systematically Contains Health Cost Inflation

Proposes Phase I Legislation that:

- Lays Foundation for Long-Term Plan
- Improves Coverage for Those Most in Need: Poor, Aged and Disabled
- Provides All Americans with Protection against Cost of Major Illness
- Initiates Key Cost Containment and Other Health System Reforms

NATIONAL HEALTH PLAN: PROBLEMS WITH THE CURRENT SYSTEM

Inadequate Coverage

- 18 Million Americans with No Health Insurance
- 19 Million Americans with Inadequate Basic Health Insurance (Hospital, Physician and Diagnostic Services)
- An Additonal 46 Miilion Americans with Inadequate Catastrophic Health Insurance

Escalating Costs

- Health Costs Are 9.1 Percent of GNP ($206 Billion), Federal Health Costs 12.7 Percent of the Federal Budget ($62 Billion) — and Rising Steeply
- Total Health Costs Will Jump to $368 Billion in 1984 without Hospital Cost Containment

Other Health System Failures

- Lack of Competition: Only 4 Percent of Population in HMOs
- Insufficient Emphasis on Prevention: Often Not Covered by Insurance
- 51 Million Live in Underserved Areas

We have many existing problems. We have inadequate coverage. We have 18 million Americans who have no health insurance. We have 19 million Americans who have inadequate, substandard health insurance. We have an additional 46 million Americans—that is, additional because they do not have adequate catastrophic coverage, either, with inadequate catastrophic health insurance.

At the same time, we have a system whose costs are running out of control—costs that have to be dealt with in some fashion. It is as important at this point, to help delivery systems in this country, that we do something about costs as it is that we provide adequate benefits to the people in this country.

Health costs are now 9.1 percent of the gross national product, $206 billion. Federal health costs are 12.7 percent of the Federal budget, $62 billion. They are rising steeply.

Generally it is true that health costs in this country, without changing current law, without changing current public obligations, are doubling every 5 years.

We are not talking about an option of not having health costs go up. We clearly are going to have health costs go up very sharply in the next 5 years. The question is, What do we get for the money that we spend?

Total health costs will jump to $368 billion in 1984 without hospital cost containment, for instance. As a matter of fact, our projection for 1990 under current law, subject to such kinds of problems that projections have, is that if we do not do anything about costs, in 1990 almost 20 percent of Federal budget dollars will go for health care. And that is without changing current law.

Finally, we have some failures in the system. Everyone knows there is not enough competition in this system, not enough tension in the system. We do not have enough people in HMO's or served by other

competitive providers, and many of the arrangements in the health care system are anticompetitive.

There is insufficient emphasis on prevention. It is usually not covered by insurance, even though, in almost every kind of statistical analysis, nothing would do more to improve the health of the American people than to provide early prevention in a variety of areas.

We put very few resources in that area.

Finally, whatever systems we have, we have to remember that there are more than 50 million people who live in areas in which there are inadequate health facilities and professionals. When we consider changing the system, we have to deal with those problems as well as the problems of providing benefits.

PHASE I: GOALS

Expand Coverage to Achieve —

Universality In:

- CATASTROPHIC PROTECTION: $2500 Limit on Out-of-Pocket Expenses for Major Illness Available to All Americans
- PREVENTION SERVICES: Prenatal, Delivery and 1st Year Services Available for All Mothers and Children without Cost Sharing

Equity:

Expanded Comprehensive Coverage for Aged, Disabled, Poor and Near Poor

Hold Down Costs

- Hospital Cost Containment
- Physician Reimbursement Reforms
- Limits on Capital Expenditures

Reform the Health Care System

- Enhance Competition among Insurers, Physicians, Suppliers
- Provide Care in Underserved Areas
- Improve Management of Public Programs

Major Step Toward Universal, Comprehensive National Health Plan

Our phase 1 of a national health plan calls for these specific goals:

One, catastrophic protection. A $2,500 limit on out-of-pocket expenses for major illnesses available to all Americans.

Second, we would call for the beginning of a prevention system, a prenatal, delivery, and first-year service, available to all mothers and children without cost sharing. Building on some of the experience we had from Senator Ribicoff's efforts in this area, and other experience, we think that now is the time to make that a universal benefit.

We also need to improve the equity of our present system. We need to expand the comprehensive coverage, not only for the people who are in the private sector, but also for the aged, the disabled, the poor, and the near-poor.

So we are not just treating one section of the population. We are trying to serve a cross section, and provide a balance of care, in this first phase.

Another major goal is to hold down costs. This committee has heard a good deal about hospital cost containment. We would oppose, at

least in the early years of this plan, the cost containment bill that is currently before you.

We are also suggesting annual limits on capital expenditures, to deal with the overinvestment in hospital beds.

Physician reimbursement reforms must also be considered—I will get to that in a minute.

Finally, we will have the goal of reforming the health care system to enhance competition among insurers, physicians, among the suppliers, to provide care in underserved areas and, very importantly at this point in history, improve the management of the public programs, to put more money into the public programs as they now exist, which will in some cases result in an excessive cost.

PHASE I: STRUCTURE

HealthCare

— The Umbrella Federal Insurance Program for Aged, Disabled, Poor, Near Poor, Small and High Risk Businesses and Others Not Served by Private Insurance

Employer Guarantee

— All Employers Must Provide Insurance against Major Medical Expenses for Full-Time Workers (25 Hours Per Week, 10 Weeks) and Their Families

System Reforms

— Capital Controls, HMOs, Competition, Reimbursement Reform, Voluntary Reinsurance Fund

This is the structure of the plan as we propose it.

There are three major elements. The first is health-care, which is the name we have given an umbrella Federal insurance program for the aged, the disabled, the poor, the near-poor, small and high-risk businesses and others not now adequately served at an affordable price by private insurance.

The second is the employer-guaranteed part of the program, in which we would require employers to provide insurance against major medical expenses for full-time workers and their families, 25 hours a week for 10 weeks is our definition.

And finally, there are the systems reforms—trying to make these administrative and financial mechanisms work.

I would like to describe the benefits over the first phase. First, we would make improvements over the present level of benefits in our programs for the aged and disabled. To improve coverage for all 24 million nonpoor aged and disabled, we would limit their cost-sharing to $1,250 per person, $2,500 per couple.

PHASE I:
BENEFITS FOR THE AGED AND DISABLED

Improve Coverage for All 24 Million Non-Poor Aged and Disabled

- Limit Cost-Sharing to $1250 Per Person ($2500 Per Couple)
- Physicians Can only Charge Publicly Set Fee — Aged and Disabled Won't Face Extra Bills
- Remove Limit on Fully Subsidized Hospital Days
- Ambulatory Mental Health Coverage Increased from $500 to $1000 Annually

Provide Fully Subsidized Care for an Additional 1.2 Million Poor Aged and Disabled

- A Total of 5.2 Million Poor Aged and Disabled Will Be Covered under HealthCare

In the employer-mandated coverage area, we are talking about a $2,500 family deductible.

For the aged, there is this additional matter of limiting the individual to $1,250. We would require a schedule of preset fees for physician's services to this population and we would not permit physicians to collect anything beyond those fees, which they would be assigned.

We would remove the limit on fully hospitalized fully subsidized hospital beds to the present limits of medicare and we would increase the ambulatory mental health coverage from $500 to $1,000 annually.

In addition to that, we would increase by $1.2 million the number of poor, aged, and disabled who would have fully subsidized care. There are about 4 million such families and individuals now. This would raise that number to 5.2 million.

PHASE I:
BENEFITS FOR THE POOR AND THE NEAR POOR

Provide Fully Subsidized Coverage for an Additional 14.5 Million Poor

- Those under 55 Percent of Poverty Standard not Covered by Medicaid Now: 10.5 Million
- Those Who "Spend-Down" to 55 Percent of Poverty: 4 Million

Improve Care for 30.2 Million Covered Poor — Including 15.7 Million Currently on Medicaid

- Unlimited Hospital and Physician Services
- Complete Coverage for Prenatal, Delivery and 1st Year of Care
- Physician Participation Increased

For the poor and the near-poor, this program would provide fully subsidized coverage for an additional 14.5 million poor people. Around 10½ million are those who are under 55 percent of the poverty standard not now covered by medicaid; the categorical programs.

There are—because our present programs are basically categorical programs in the welfare area—a very large number of the very poorest people in this country who have no basic public health insurance or support. That is, 10.5 million of those people.

In addition, there are about 11 million people in this country in a band that exists $3,000 above the poverty level, which in 1980 would be $4,100.

We figure about 4 million of them, annually, would spend down within that band to fully subsidized coverage, depending on where the income was, some amount of money less than the $2,500 would spend them down to the 55-percent line, and that would mean coverage for 4 million more people, for a total of 14.5 million.

In addition, because of the uneven character of the medicaid program across this country, there would be in almost all States for almost all of the population in our standard programs some improvement for people who are already covered. We would thus, in fact, improve care overall for 30.2 million covered poor, including 15.7 million currently on medicaid.

We would hope this increased coverage together with the proposed provision of pre-natal, delivery, and the first year care, would improve the rates of infant mortality in this country.

Finally, we would hope to increase physician participation in this country, which has gotten lower and lower, by bringing the rates for physicians paid under the medicaid program up to national standards, working basically toward the medicare standard, to raise the standard of physician participation, to eliminate the two-class system that has developed in parts of our country.

Senator DOLE. What is the percentage now?

Mr. CHAMPION. About 40 percent participate in medicaid, I believe. It varies from State to State. Whereas medicare, on at least some basis or other, runs close to 90 percent.

In our phase 1 benefits for the full-time employed, we would mandate the coverage of 156 million full-time employees and families under private group plans.

One essential improvement for these workers and their families would limit their costs to $2,500 before their major medical or catastrophic would take effect.

Senator CHAFEE. For how long?

Mr. CHAMPION. Annually.

Then there would be pre-natal and first-year care with no cost sharing.

It would mandate some other important standards in a basic benefit package of hospital, physician, lab and X-ray, preventive and mental health services, with full coverage after $2,500.

It would provide for a 90-day continuation of insurance after termination of employment, to try to get rid of one of the major problems in the system of frictional unemployment, to provide a period of time as people pass from one job to another when their coverage persists under their own program.

Another element of this first phase proposal would require no exclusion of preexisting conditions. That is not an inconsiderable matter.

Our plan would also require the employer to pay at least 75 percent of the premium. Employees could bargain for a higher percentage, but the employer would be committed to at least 75 percent.

We would provide subsidies for low-income workers, using the earned income tax credit, where the premium gets costly for them. We would also limit the exposure of small employers, some of whom do not now have any health insurance, to 5 percent of payroll.

If they could not get private insurance at that level, we would admit them into the public plan once their costs are over 5 percent. That would be used, I think, largely by some small businesses and some high risk enterprises, who might want to take advantage of that option. We make it available to them.

Senator NELSON. That line, mandated coverage for 156 million full-time employees and families is a bit confusing. I am assuming you are saying the full-time employees, including their families, amount to 156 million.

How many of them are employees? Out of that 156 million, how many are full-time employees?

Mr. CHAMPION. 73 million.

Senator NELSON. Then how many of the 73 million have health insurance now? Do you have a breakdown of how many have health insurance? How many have plans that at least have the coverage provided in this plan?

Mr. CHAMPION. About 10 million have no insurance, no employee coverage.

Senator NELSON. $10 million?

Mr. CHAMPION. 10 million of the 156 million population are not covered by insurance, neither employees nor their families. 127 million—and again speaking of the family populations—have group insurance. About 13 million have individual insurance. Those policies, however, vary widely in the quality of coverage.

Senator NELSON. Do you have a breakdown on those?

How many employees, full-time, are covered by a plan that meets at least the minimum standards established in the administration plan? Is there such a statistic?

Mr. CHAMPION. We have made some estimates, but they are very suspect in terms of our present knowledge of the coverage for each of the individual plans. But we would be glad to provide our best information to you, if we could.

Senator NELSON. What I was trying to identify is how many of these full-time employees have some coverage? How many of these are paid for now totally by the employer? What are we looking at in this 73 million full-time empoyee popuation in terms of how many people already are covered with everything that the administration is proposing here. How many are partially covered? To get some idea of how much is being spent, what is the net increase, so to speak?

Mr. CHAMPION. Senator, I think the best way to do that is for us to give material to this committee in some detail. It would basically come out of our attempts to structure how much it would cost the employer for this plan.

We estimate, out of $6 billion, that uses our best estimates as to what would have to be done in order to bring these plans to the standards that we set here.

We would be glad to provide those figures.[1]

Senator NELSON. I assume that there are quite a few employers who are already—who are not going to have to pay an additional thing?

Mr. CHAMPION. A very large number, Senator.

Many plans in the country, particularly in large firms, will have not only this kind of coverage but have 100 percent employer payment.

Mr. DURENBERGER. Could you, in that regard, also give us some figures on the duplicate coverage?

Mr. CHAMPION. We will try to give you our best figures on that.

In many of these cases, where there are different kinds of insurance policies with different standards, and this is probably the area we know least about, we are trying to get better and better information. I am sure, in your consideration, that others may be able to help.

There are also nonaged, nonpoor, nonunemployed who have grave difficulties with the present health care system. We cannot provide universality in terms of comprehensive, mandatory coverage situation in a phase I program. What we want to do here is to give these people access, at some reasonable cost, to the system if they choose to exercise it. This is the population that needs access sometimes.

They could buy the health care catastrophic plan with a $2,500 deductible. They could get prenatal delivery and infant care with no patient cost sharing, although there is a nominal premium for this group entering into that plan. Of course, those who are in the low-income area would be in a position to spend down into the comprehensive, full-subsidy plan.

Senator DOLE. How many are in that group?

Mr. CHAMPION. I think there are 9 million in that group.

Senator RIBICOFF. Before we get to the benefits, escalating costs, would you give us an idea of what the Kennedy proposal, the Carter proposal, the Long proposal, the Dole proposals do about cost containment?

Mr. CHAMPION. I have not prepared a comparison. I will not run through this chart in detail. What it does is to take the population coverage to show where there are improvements, where the population is the aged, disabled—24 million get the limit on cost sharing; 5 million receive full subsidy coverage; 47 million low income will have some improvement in their situation; 156 million are covered through employer mandate, together with the new prevention item; and 9 million get access to the health care plan.

Some of those are already self-insured.

We do, with this plan, impact on or offer an opportunity that does not now exist to every American. This is not a plan that touches only this population or that population. It really offers a balanced approach to try to improve the situation for the whole of the nation.

Senator RIBICOFF. Both you and Senator Kennedy have these plans effective in 1983. The chairman of the committee is interested in trying to get the first phase of it into effect in 1980.

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[1] See p. 526.

I would support him in this objective.

What are the problems in trying to get the first phase into effect by 1980?

Mr. CHAMPION. It depends a little bit on how much public money is involved in that, and on the administration's meeting the budget responsibility, depending on the nature of that beginning catastrophic benefit.

The other set of problems, or the problems that you raised in your earlier statements, Senator, the problems of working out the arrangements with the insurance companies, of dealing with the fact that there are many existing labor contracts which already deal with some of the matters that will be covered by the law, I think would be very hard to phase in by 1980.

Mechanically, you may begin the phasing, for some period as contracts expired, and so on, but I do not think that you could bring everybody in by 1980. There are just too many other contractual, existing delivery arrangements.

One of the things that we face in constructing a plan is that we have tried to disrupt the existing system as little as possible. It is a very large, very complex system. It is the third largest industry in this country, and to turn it on a dime is not going to be possible.

The CHAIRMAN. Mr. Secretary, the insurance companies are saying they are already providing catastrophic coverage; they have major medical coverage for 75 percent already. What you are talking about is adding 25 perrent to what you already have.

Mr. CHAMPION. Mr. Chairman, to make the arrangements for those people, considering the time that it takes to rewrite those contracts or to deal with the financial arrangements of the Government, with relationship to them——

The CHAIRMAN. You are looking at it from the point of view of a bureaucrat, saying we cannot do all of this in a year. But the companies say, look, leave the bureaucrats out of this and we will do it in a year, or less than that. They say they can do it. Why do you not just let them do it?

Mr. CHAMPION. They can do it on a selling basis to those people who are ready. I think they would have great problems in forcing anybody to do it in the way in which the Congress might require in a new law.

The CHAIRMAN. My thought is, we should simply say, all right, you owe a tax in the event you do not insure your workers. Then we in effect tell the people, we want you to pool the risk—a whole bunch of you pool the risk and each of you take a share of the money and provide for it.

If we do it that way, it would seem to me that all they would need to know is how many of these people we have to take care of. We then give them their share of the money and they are off and running. They are already doing that type thing for three-quarters of America anyway. Why can they not do it for the remaining one-quarter?

Mr. CHAMPION. Mr. Chairman, I think they can do it, for some of those people. One of the things that concerns me—I will speak to it in a moment—is that I am afraid of too many people getting off and running before we know the rules by which this game is going to be played.

We have a problem now of cost data control, particularly in the public sector of health care. We have to be careful not to have some more people off and running before we have those rules set.

I think we can do a lot. I think mechanically, administratively, you can do some things earlier than 1983, but I would hope that we would not put that ahead of making sure that we knew what the costs are going to be.

Senator RIBICOFF. Along that line, until we got into the subject, I skipped asking a question concerning subsidization of small employers. What is, in your opinion, a small employer, and how do you intend to subsidize the small employer and from where?

Mr. CHAMPION. We, in effect, would include any employer whose costs to meet this plan would be more than 5 percent of payroll.

When we say "any employer," we would not set a limit on size. Our assumption is that practically all of those would be small businesses who could not handle the proposed benefits at less than 5 percent of payroll. So we did not set any arbitrary limit as to what was a small business and what was not.

The way in which we proposed to help those firms is by having the 5-percent limit. They could come into the public plan and we would subsidize any cost over their 5 percent of payroll cost.

You could select a different percentage, but it gives you a great ability to fine tune, to some of those firms you want to help, but without setting a 1-man or a 9-man or a 50-man limit in terms of what is a small firm.

Senator BENTSEN. Would that not mean you would concentrate more in the service industries where your pay may be lower and your percentage of wage costs would therefore be higher?

Mr. CHAMPION. Almost certainly, Senator; 5 percent would be around a 15-cent increase on the minimum wage.

Senator RIBICOFF. What would that take out of the budget? What would it cost the budget to do that?

Mr. CHAMPION. I have the comprehensive figures in a later chart. I would like to put them in context, if I may.

Senator DURENBERGER. Did you look at alternatives to Government subsidization, to pooling arrangements, either through a payroll tax or a premium tax, or something of that sort?

Mr. CHAMPION. Early on, we looked at the earnings-related premium, payroll tax. We have enough problems in the Government as a whole in terms of the payroll tax and its situation so that we thought that was an inadvisable way to proceed.

It is also very difficult to do a phased plan with that kind of approach, so we did not choose to propose that kind of approach.

I will try to quickly complete this and be responsive to your further questions. This next chart, I think, represents a very important proposal—that is, the creation of health care. Whatever content the Congress ultimately chooses, it seems to us that it is very important to get the public plan together.

This would establish a consolidated Federal insurance program. It would include some of the things we talked about, the continuing and improved coverage for the aged and disabled, the expanded coverage for the poor and the near poor, making available insurance as we just discussed to other individuals in small firms on an optional basis.

But most important, it would consolidate the administration of medicare and medicaid with major expansion of the private sector role.

If we put these plans together, we can look at this country as a whole in terms of claims processing, in terms of administration, in terms of reimbursement practices, and put that out competitively to the insurance and carrier industry. We think they can do an effective job across the whole range of public participation program through that kind of a relationship, if we have one true Federal kind of system.

Determination of eligibility and intake income and different ways with categorical programs, and so on—there is no reason that the Federal Government has to take on all of these roles. As a matter of fact, with medicare, most of this is now done by carriers.

We have started experiments with competitive bidding that have been extremely satisfactory, and we would like to create one Federal system called healthcare, that would let us have one set of relationships with all of the publicly supported people being served by the health system in the country.

We have discussed the impacts of this.

Senator CHAFEE. One question, if I might.

When you say consolidate administration of medicare and medicaid, it seems to me that one of the principles of medicaid is, by having the States involved, they do tend to watch costs. You may object to the rates they pay, but they are deeply involved in trying to keep costs down.

Is this, in effect, a federalization of the medicaid?

Mr. CHAMPION. No.

In terms of fiscal relief, we would intend to keep substantial State financing in this area, not increase their costs, but keep them in so they have a real interest in participating, in holding down the rates of cost care.

We are very conscious of what you are suggesting, Senator, and we think that is an essential element.

I talked substantially about the use of the private insurance system. I want to point out that under this plan, private insurers will be doing more business, both as carriers and in terms of the expanded group coverage called for. This is not a reduction in the role of the private insurance sector. It is an expansion.

This deals somewhat with Senator Chafee's point. We are still working with the States and localities to try to get the full effect and distributional effect of about $2 billion fiscal relief to States and localities.

The States would share with the Federal Government the costs of providing health care coverage for low-income eligibles. They would determine the health care eligibility for AFDC recipients.

We would set up Federal standards to help to handle the newly eligible poor under this phase. If States wished to perform that for us under our performance contract, we would be willing to enter into that performance contract.

This is on the intake side. We want to be sure that on the claims processing, reimbursement side, that we have a uniform plan operated by contract from the Federal Government to private insurers.

The way we have designed this program—I will not go into detail now—is basically to give the States the very kind of concern that you are talking about. They will stay in the program.

We will set aside under the present medicare program long-term care. Neither this program nor any other major insurance program offered by this Congress includes long-term care. It is not a problem that we have solved in this country, honestly, but we need to set it aside and treat it differently, and for the purpose of this plan, the State and Federal Government would continue in their present partnership in long-term care.

With respect to the other expenditures now under medicaid, States would be expected only to increase their share as inflation increases the cost of that share.

That gives them a very real stake in holding down those costs to a minimum level and we would continue all of the other traditional activities in certification and licensure of health personnel.

I might say one other thing about the fiscal relief question. It would be very important in some cities and counties where large city hospitals care for an uninsured population to have a difficult time staying alive. They are supported, in part, by city and county local property tax, and so on, and more than $1 billion of this relief would deal directly with this.

Those hospitals would then be paid for the care, and it would relieve local and county support for those hospitals which serve indigent populations.

With regard to payments to providers, we have already talked at great length about the administration's hospital cost containment program; I shall not repeat it here. The basic change in physician reimbursement is the one I spoke of with respect to the aged. That is in the public program.

We would negotiate a schedule of fees to be paid, and that would be the full payment of the physician. He could not make an additional billing. We would not carry that over into the private sector.

Our first problem is going to be straightening out the imbalances and difficulties in medicare-medicaid while we examine the question of how to get full equity across the private and public sectors. We do not think we are ready to move to the private sector at this time, or, indeed, how it will be done.

It is clear that the worst problem in terms of quality care is in the medicaid program, where there is such low physician participation. This plan would propose to deal with that, but it would also propose to deal with the problem that many aged face, which is they think they understand how much they are supposed to pay for something and then they get an additional charge from the physician. There is no control over that at all now, and we would, under this plan, halt that practice.

We would publish a list of physicians who will accept that public plan fee, so that the private citizens, those under private plans as well, would know what those fees are, and who accepts those fees.

Senator RIBICOFF. You would have no fee schedule for the employer mandated?

Mr. CHAMPION. That is correct, Senator.

Senator RIBICOFF. The Kennedy approach would? Is that the difference?

Mr. CHAMPION. That is correct. They would mandate the same fee across the total for all physicians.

Senator DOLE. You expect sort of the same result, though, by publishing the names?

Mr. CHAMPION. We would hope that at least it would make it a competitive matter if people really wanted to know in advance what their costs were going to be. Getting the schedules and fees known out there, the public fee, sets a kind of a standard against which citizens have to pay in the other market.

Whether it will have that result or not, I could not predict.

The CHAIRMAN. Let me make this point, Mr. Champion. It seems to me that when we get into catastrophic insurance, that doctors have historically, going back to the old practice of medicine, the way it was when I was a very young man, doctors were expected to do a considerable amount for the poor without being paid at all. They would just take their chances that they might get paid, or they might not. They thought that it was their duty to take care of the poor, even if the people could not pay.

So I think that doctors should be willing to help in these catastrophic situations for a somewhat lesser charge than they would charge in cases where the person was well able to pay it.

It would seem to me that you could expect the doctors to make their fees as reasonable as they can, less than what they would ordinarily charge, in these catastrophic situations which ordinarily they would be doing anyway if the Government were not involved in it. Then if a doctor wants to take care of people only while they are in good health and need no help of any sort, but if that develops into a catastrophic situation, where the patient is going to have a long-term illness, the doctor does not want to have anything to do with him, he should be known as a doctor who is a fair weather doctor. He is available to you when you are in good shape, but if the situation gets desperate, he is going to walk out and leave you.

If that is the case, I think that the public would want to go to another doctor. The doctor could have it either way. He either participates, or he does not.

The doctors understand insurance company procedures. They are not at war with the insurance companies. They get along pretty well. They have good doctors on the boards telling the insurance companies how they should operate their businesses.

I think we should do business on the basis that most of these patients would have some basic insurance, and if the doctors wanted to participate, they would be expected to see this patient all the way through.

That being the case, I would think that we ought to be able to get the doctors' services in the extreme cases for a somewhat lesser fee than they would expect during the time when the patient has a complete option to go to anybody that he wants to go to.

Mr. CHAMPION. Mr. Chairman, I want to make sure that I understand what you are suggesting. I think it is a very interesting suggestion. That is, that for catastrophic illnesses, fees arrived at through

some process of negotiation would apply, and would be the extent of the fee, not only in the public plan, but for the catastrophic portion of the private plan.

The CHAIRMAN. My thought is that you proceed on the basis that if you are going to spend a certain amount of money to provide these services, then it is up to the insurance companies to find the doctors who would be willing to cooperate to help bring that about.

I would hope that the doctors do not expect to be paid as much, hour for hour, working on these catastrophic cases such as in the case of terminal cancer, when all they are doing is visiting that person. There is no way they can save his life.

They would not expect to be paid as much in that situation as they do in the case of a person who has a week's illness and after that he is on his feet, going about his business.

Mr. CHAMPION. We would like to support that. That sounds very good.

Senator BENTSEN. From personal experience and what I have just seen in a letter about a relatively poor family who just lost a child to cancer over a long period of time. I have not seen that to be the case. I have not seen doctors moderating their fees at all in terminal cases.

Senator RIBICOFF. You see, this is the first time that I have heard Senator Long on this subject. That was a great question mark in my mind—what was Senator Long's thinking about this particular issue. But if I am hearing Senator Long correctly, you are not going to have much trouble putting this whole thing across, because he is pretty close to Senator Kennedy right now—he might not think so, but he is.

This has been my contention all along. The main actors involved in this program or this bill are not far apart if they will only step back and listen to one another. What Senator Long has just suggested has great significance for early passage of this bill.

The CHAIRMAN. Let us look at the history of this. My family doctor for many years was a man who was the head of the Medical Society in the State that I represent. He came from the old tradition and he said that his father, who was also a doctor, taught him that when the poor people who come to you cannot pay you, treat them. It is your duty as a human being. You just do not get paid. They might owe you something, but do not count on ever being paid by them and just forget about it. You are not going to be paid for that.

Also, you do not charge your relatives.

Mr. CHAMPION. Or other physicians, Mr. Chairman.

The CHAIRMAN. I got a lot of free medical services out of that doctor, by the way. He is a relative. Not a very close relative, but close to give me free medical service.

On what is left, the people who can afford to pay and who are not relatives, you ought to make enough money that you can live a decent life.

Now, when we enacted medicare and medicaid, especially medicare, we were moving something through that the medical association was opposing. Their attitude is, if the Federal Government is going to do this, they can blessed well pay the whole price.

So they raised their fees, and we were shocked to see what we were paying.

The first year, the cost exceeded the estimate by 50 percent. The estimate had 20 percent built in for contingency. We are paying a lot of money that we were not planning on paying.

Their attitude was, when we said, do you not think that that fee is very high, that they did not want this business anyhow. If we insisted on enacting the program, then they were going to charge the full fee for services.

So they were charging for all of their relatives, charging for all the poor people, and getting the full amount.

I would hope that when we pass this bill we will do it in a way that they think is appropriate and if we are doing it in a way that they think is appropriate, at least to some extent, they ought to look at what their previous practice was.

Poor people had difficulty paying and they did not expect to collect the fees. They took what they get, and settled for that.

I would hope that they would be willing to look upon this as something where they ought not to be paid quite as much as if it were a solvent person incurring that debt.

This is something which, on a per unit basis, does not receive as much pay as it does with those patients who traditionally have always been well able to pay.

Mr. CHAMPION. Mr. Chairman, I think that is a very valid concept to explore. As a matter of fact, when I was director of finance in California, before we had the massive Federal programs, we negotiated with the medical society, with the other providers, annually for the care of those who could not afford to pay. It was a collective bargaining session every year. They took less than their normal fees as the solution to that problem. They provided the care on that kind of a basis.

I think that can be negotiated with the medical profession and I think it is well worth exploring.

These are, quickly, the system reforms that we think are important to keep in all phases of the plan as we proceed. I mentioned most of them before.

The prevention emphasis the competitive emphasis; the limitation of capital expenditures; and a device we call a voluntary reinsurance fund that will help those small firms. Increasingly firms have found self-insurance in this area to be a very effective device.

Also, HMO's have problems in some cases with adverse selection, and we propose a voluntary reinsurance fund which, in effect, is a noncost profitless kind of reinsurance umbrella for that kind of operation which, once again, we think would enhance competition.

Senator CHAFEE. The capital expenditure limits, reducing excess hospital capacity, is that in this program, or your hospital cost containment bill, or are you considering them as a unit?

Mr. CHAMPION. We are proposing in this session—I do not know if the bill is yet before this committee, a separate bill, that would be a capital control bill. It is a $3 billion annual limit on new expenditures in any given year.

Senator CHAFEE. Not in this?

Mr. CHAMPION. It would be incorporated in this plan, Senator.

Senator CHAFEE. I see.

Mr. CHAMPION. Just as the hospital cost containment plan's intended to be a part of this overall plan.

Senator RIBICOFF. The voluntary reinsurance fund, is that a Government fund or a fund set up by the insurance companies themselves?

Mr. CHAMPION. We propose it as a Government proposal.

Senator RIBICOFF. Will the contributions be made by the insurance companies to that fund, or will this come out of the Federal budget?

Mr. CHAMPION. The funds to support that will come from the people who want to insure through that fund, and we would run it as a cost-free enterprise. It would save them some of the Lloyd's-type costs involved in insurance type umbrellas now.

Senator BYRD. What is a cost-free enterprise?

Mr. CHAMPION. We would run it at the cost of doing business, maintaining that fund for those firms, so they would have to pay into it whatever it took to keep their insurance.

Senator BYRD. Do you mean the Government? What do you mean by "we?"

Mr. CHAMPION. Small businesses which wanted to self-insure, we would give them a device. These are other administration initiatives that we hope would go forward. We do not think any of the things that we have proposed should be held for inclusion here, but we think we need to move forward on all of these things as we have proposed, if the system keeps improving, particularly with respect to underserved areas. We have a long way to go there.

Finally, here are the costs of each of these elements, including the improved benefits for the aged and disabled. These are 1983 costs in 1980 dollars.

If the program were in effect in 1980, $3.9 billion would be added for aged and disabled; $10.7 billion for the lower income nonaged; and the employer costs for the employer guarantee would be $6.1 billion.

There is a $90 million subsidy for the low-income worker for the moderate part of the premium cost if he is sufficiently low-income.

The employer subsidy, the 5 percent of payroll limit for the mandated coverage, has a $700 million cost.

Part of those costs are increased by the prevention prenatal and delivery system.

The final total is $18.2 billion in the Federal budget and $6.1 billion in employer budgets.

Senator BYRD. If you would yield at that point, why would the cost of administration, which you did not mention be $2.1 billion? This seems to me to be a very high administrative cost.

Mr. CHAMPION. Senator, it is not. Part of it is the creation of the health care, the turning of those two programs together, creating a new program that initially will have somewhat higher costs.

Even at these costs the costs go out into the private sector. They will go out to the private insurance industry for their low-cost processing thing. While that is the Federal budget cost, it goes out through the processing in the public plans, a very large part of it to the insurance companies.

As a matter of fact, because of a lot of the factors, it is not a one-sided story. The cost of processing in the Federal system as we now

do it is less, actually, than the private insurance costs. If you look at it as an overall cost in the terms of claims processing, it is somewhat higher.

The only other thing I would like to say about that administrative cost is that over time as we get rid of the present, ineffective system, we would hope to get very substantial, long-term savings by getting this into one system and basically putting most of its regular administration into the private sector.

Senator BENTSEN. Mr. Champion, let me ask you again for clarification on those numbers that you have presented. Do I understand that those are in addition to what private firms are now paying on premiums for hospitalization policies, both by the individual and the employer?

Mr. CHAMPION. That is correct, Senator. There will be an additional employer cost of $6.1 billion.

Let me make two or three general observations finally. We have tried to construct this phase 1 as a unified whole. It is not final, universal, or comprehensive, but it is much more than a beginning.

We think that it does those things which most urgently need to be done, both in terms of benefits and cost controls.

Secondly, obviously there are many other ways to deal with these problems, both substantively and procedurally, and there certainly will be, I think, improvements and changes that can be worked through.

But the key concept in working those through, I think, is balance: Balance between providing prevention and dealing with catastrophic illness, balance between the cost and the benefits, and balance between controls and competition in the reform of the health system.

To simply put more money in the high-cost, high-technology hospital sector of the system will help individuals but will accentuate all that is already wrong with the system.

We need to do both. We need to put resources into prevention, into outpatient, into primary care, and keep people out of that high-cost sector, which is so painful, both personally and financially.

Finally, I would again want to emphasize how important I think it is at this stage to establish what we call health care, a single public entity, responsible for ending the inequity, fraud, abuse, and error that have marred the history of many public programs, especially medicaid.

Such an organization can use the private sector to handle the reimbursement and claims processing simply by expanding their present operations.

To proceed further without reforming the public programs, especially medicaid, would risk more of the same kinds of problems with which this committee is already very familiar.

Thank you very much, Senator.

[The remainder of the charts follow:]

PHASE I:
BENEFITS FOR THE FULL-TIME EMPLOYED

Mandate Coverage of 156 Million Full-Time Employees and Families under Private Group Plans

Essential Improvements for Workers and Their Families

- Limits Out-of-Pocket Expenses to $2500
- Mandates Prenatal, Delivery, and 1st Year Care with No Patient Cost-Sharing
- Mandates Other Important Standards: e.g.,
  - Basic Benefit Package (Hospital, Physician, Lab and X-Ray, Preventive and Mental Health Services) *and* Full Coverage After $2500
  - 90-Day Insurance after Termination of Employment
  - No Exclusion of Pre-Existing Conditions
- Requires Employer to Pay at Least 75 Percent of Premium
- Provides Subsidies for Low-Income Workers and Small Employers

Result

Catastrophic Coverage for 56 Million with Inadequate Protection

Better Basic Coverage for These and Tens of Millions More

PHASE I:
BENEFITS FOR OTHERS

Makes HealthCare *Available* for Those Non-Aged, Non-Poor, Non-Employed Who Often *Cannot Obtain Individual Insurance*

- Can Buy HealthCare Catastrophic Plan: $2500 Deductible
- Prenatal, Delivery, and Infant Care with No Patient Cost Sharing
- Can Spend-Down into Comprehensive Full Subsidy Plan

PHASE I: BENEFITS SUMMARIZED

	Phase I Coverage	Improvement Over Present
Aged/ Disabled	24 Million Non-Poor Get Limit on Cost Sharing 5 Million Poor Aged Receive Full Subsidy Coverage	– New Catastrophic Protection for 24 Million Non-Poor – Additional 1.2 Million Poor Aged Get Full Subsidy Coverage
Low-Income	37 Million Receive Full Subsidy Coverage or Eligible for Spend-Down	– 14.5 Million Additional Poor Get Full Subsidy Protection
Employed	156 Million Covered through Employer Mandate	– 56 Million Get New, Adequate Catastrophic Protection – 10s of Millions Get Improved Basic Coverage
Others	9 Million (7.5 Million Already Self Insure) – 1.5 Million Can Buy HealthCare Catastrophic	– 1.5 Million Hard to Insure Have Major Medical Protection Available
U.S. Population (1980)	231 Million Total	**Reaches All Americans**

PHASE I: HEALTHCARE

Establishes a New Consolidated Federal Insurance Program

- Continues and Improves Coverage for the Aged and Disabled
- Expanded Coverage for the Poor/Near Poor
- Makes Insurance Available to Other Individuals and Small Firms on an Optional Basis
- Consolidates Administration of Medicare/Medicaid with Major Expansion of Private Sector Role – Especially in Billing and Collection

Impact

- Makes Protection against Cost of Major Illness Universal
- Uniformity in Eligibility, Benefits, and Reimbursement for Poor
- Increased Program Accountability
- Efficiency and Economy of Operation: Reduction of Fraud, Abuse and Error

PHASE I: THE ROLE FOR PRIVATE INSURANCE

- **Continue Underwriting and Marketing Private Coverage to Employed Groups and Individuals**
- **Expand Private Group Coverage of 56 Million Employees and Their Families**
- **Compete for Claims Processing under HealthCare**

PHASE I:
STATE ROLE AND FISCAL RELIEF

Under Phase I State Governments Will:

- Share with the Federal Government the Cost of Providing HealthCare Coverage for Low Income Eligibles
- Determine HealthCare Low Income Eligibility for
  - AFDC Recipients (Mandatory)
  - Newly-Eligible Poor (Optional under Performance Contracts)
- Continue Traditional State Activities in Certification and Licensure of Health Personnel and Facilities, and in Regulation of Private Health Insurance

Phase I Will Provide: About $2 Billion in Fiscal Relief to States and Localities in Initial Years

PHASE I:
PAYMENT TO PROVIDERS

HealthCare

- Hospitals Will Be Reimbursed under the Administration's Hospital Cost Containment Program
- Physicians Will Be Paid According to a Schedule Based on Average Medicare Fees in Area; Physicians Cannot Charge Extra

Employer Mandate Plans

- Hospitals Will Be Reimbursed under the Administration's Hospital Cost Containment Program
- The Names of Physicians Who Agree to HealthCare Fee Schedule Will Be Published for Consumer Use

PHASE I: SYSTEM REFORM

Elements in the Plan

- **Preventive Services for Pregnant Women and Young Children**
  - Shift Emphasis from Curing to Caring
- **Enhance Competition**
  - Incentives for HMO Enrollment
  - Greater Consumer Choice
- **Capital Expenditure Limits**
  - Reduce Excess Hospital Capacity and Curb Proliferation of Equipment
- **Voluntary Reinsurance Fund**

Elements in Other Administration Initiatives

- **Increase Technology Assessment and PSRO Review**
  - Ensure Effectiveness and Productivity
- **Redirect Manpower Incentives**
  - Improve Geographical and Specialty Distribution
- **Provide Access to Care in Underserved Areas**
- **Mental Health and Health Education Programs**
  - Avoid Illness: Promote Appropriate Use of Care

PHASE I: NET NEW COSTS (1980 Population and Dollars)

		Federal	Employer
Aged and Disabled		$3.9 Billion	
• Improved Catastrophic	(1.8)		
• Improved Subsidy for Poor and Near Poor	(2.1)		
Low Income (Non-Aged)		10.7	
• Full Coverage	(6.9)		
• Spend Down Protection	(3.8)		
Employed			
• Employer Guarantee			$6.1 Billion
• Low Income Worker Premium Subsidy		0.9	
• Employer Premium Subsidy (For Mandated Coverage)		0.7	
All Others		0.5	
• HealthCare Buy-In	(0.3)		
• Prevention	(0.2)		
Administration		2.1	
Tax Effects		−0.6	
	Total	$18.2 Billion	$6.1 Billion

THE NATIONAL HEALTH PLAN: STEPS BEYOND PHASE I

Aged/Disabled

- Reduce Cost-Sharing from $2500 to $1500 for Non-Poor Family ($750 Per Person)
- Add Drug Benefit

Poor

- Raise Low-Income Standard from 55% to 100% of Poverty Line
- Increase Poor Receiving Full-Subsidy Coverage from 30 Million to 37 Million

Employed

- Include Part-Time Employed, Increasing Workers and Their Family Members Covered by Employer Guarantee from 156 Million to 160 Million
- Provide Comprehensive Coverage with 25% Coinsurance and Maximum Cost Sharing of $1500 Per Family

All Others

- Require All to Purchase Comprehensive Coverage
- Subsidized Premiums and Cost-Sharing for Near Poor

Results: — Universal, Comprehensive Plan
— Total Costs Less Than Growth of Present System Due to Cost Containment

The CHAIRMAN. Mr. Champion, thank you for a very useful statement.

I am going to ask each Senator to be limited to 5 minutes because I hope we can get to the other witnesses.

I do find myself somewhat shocked to see that according to your estimates the Long-Ribicoff plan, which is supposed to have been the low-cost plan, costs $6 billion more in the first year than your plan would and apparently it would even cost more in 1985 than your plan would.

I am told by our staff the reason that estimate is higher is because the Long-Ribicoff plan would do more for the poor than your plan would do.

Are you aware of that?

Mr. CHAMPION. That is possible, Senator. We tried to distribute the benefits across the board.

The CHAIRMAN. I just think that a lot of your liberal friends do not know that this Long-Ribicoff bill does more for the poor than does the administration bill. I hope you will tell your liberal friends down there that, let them know about it.

Yours is a low-cost estimate. The Long-Ribicoff people are not the pennypinchers that some people in your Department may think.

Senator MOYNIHAN. We are reliably informed that there are no more liberal friends down there.

Senator RIBICOFF. I think that the liberals have been too quick to read Senator Long out of the liberal ranks. You would find a lot of programs to help the poor and the disadvantaged passed out of this committee and have been at the initiative of Chairman Long.

The CHAIRMAN. I came here as an old share-the-wealth man, dedicated to expanding the free lunch program. I did not have in mind increasing it quite as high as it has gone.

In any event, we are pretty liberal, with what Senator Ribicoff and I and Senator Talmadge have been suggesting.

Mr. CHAMPION. Mr. Chairman, I tried to make that figure as widely available as I could.

The CHAIRMAN. Now, one other thought occurs to me. I am not speaking of what the advice of the insurance company is at this point; I am just thinking of how to meet a problem.

It seems to me rather than having a small employer tagged with a 5-percent-of-payroll cost and a large employer paying only about three-quarters of 1 percent, that we would be better off to take the principle of group insurance to its logical conclusion—that is, simply to say that if the companies want to participate, that they will participate in the whole thing, and we will look at all of working America and its dependents as being the group that you are insuring.

I was hoping that we could get by with 1 percent of payroll as the cost, and we would put a tax on to collect the amount of money we think it is going to take us to do the overall job. Having done so, give a credit against the tax paid back to the company. That is step 1.

Step 2 is to put a 100-percent tax on the company for the same income unless they pay into the pool, so the money then goes into the pool, in which all the companies participate. Then they pay back out of the pool to each company what they estimate it is going to take to provide for the risk that each company would take.

I assume, in a State like New York, where the charges are high compared to Louisiana, they would pay more than to those in Louisiana, because they have a higher income on a per capita basis and have higher charges.

If you use that approach, it does not seem to me you are going to have to go around subsidizing all these private employers.

Mr. CHAMPION. That is another approach to that. There is a concern about that approach; that is, we do not want to be in a situation where we subsidize inefficiency, where we want all of those firms looking at ways to do this job as economically as possible. If we were to go to pools, we would want some sort of experience rated, compensatory factor in there to be sure that we were not saying someone else is going to pay for it no matter how you handle it.

The CHAIRMAN. You can get to the second point by saying that for the number of people that a company has to protect, we will pay x number of dollars, and that will have to vary because some States have costs a great deal higher than others.

Your department knows how to handle that, and I think our staff knows how to handle that, and I think the companies know how to handle that, so they collect on 1 percent of payroll.

They pool the risks. They then pay it back out into the areas, according to what the costs are in those areas to provide the services.

In doing that, you have the principle of group insurance applying to the entire group, which is all of working America. When you get the money back on so much per capita—which is not the same amount that you paid in at all—what you are getting back is what we estimate it would take to provide for those people on a catastrophic basis.

If somebody wants to come in with an HMO and hire as many people as he can sign up, they get that much money paid to them. He

might be in a position to hand everybody a cash rebate right then and there.

If you use that approach, it seems to me that you can avoid having to fool around with trying to subsidize each individual payroll or each self-employed person—just tell them that they have to pay you 1 percent of payroll. Take that money and provide the service. Otherwise, you are going to have to do all kinds of subsidizing.

Of course, let's face it, what I am talking about is a subsidy, but a subsidy that is implicit in group insurance anyway. The reason I am suggesting that to you is that I have been struggling with this problem for the past 24 hours and the thought finally occurred to me when I woke up in the middle of the night that this would be the logical way to handle the matter. We want your help in saying how we can do it.

It seems to me that this approach is more logical than trying to subsidize these private employers after they have paid a very high fee to begin with. It is a lot easier to charge them all 1 percent than to have some little fellow paying 6 percent and come in trying to say he has to get the 6 percent back. We will be hearing about the bureaucracy, not only in your department, but in IRS as well.

I will hope we might be able to follow that principle.

Mr. CHAMPION. We will be glad to examine that and try to trace that through and see what the effects might be.

The CHAIRMAN. Senator Dole?

Senator DOLE. I do not want to take any additional time. I know that Sentor Hart has been waiting for some time.

Briefly, we are moving the debate from the media to the Congress, which is not a bad place to decide what we will finally have. They may have their own views, but I guess they do not have the votes.

It is my understanding that the administration—let us say if we just passed some catastrophic health insurance plan, some compromise that we work out together—would not support that in itself. Is that correct?

Mr. CHAMPION. That is correct, Senator. We do not believe that catastrophic only is an appropriate thing to do. We think it does too much damage to the system, although we recognize the needs and concerns of those people.

Senator DOLE. I think it is the first part of your plan, catastrophic.

Mr. CHAMPION. A very important part.

Senator DOLE. It does have some priority. The argument is that we might shift the high cost, the expense, of the high-cost illnesses and not address the others. Is that essentially correct?

Mr. CHAMPION. Yes.

Whatever resources you decide at this time, there is at least as much benefit, both personally and in terms of changing the system, at the preventive end of the scale and that we ought to take those resources and spread them across, not put them in, because that would further skew the system where it would accentuate what is already a major problem for the system in hospital treatment. There is very little money spent at the point where you can get prevention or primary care.

Senator DOLE. What about long-term care? Do you address the additional benefits of long-term care?

There is a lot of interest in the hospice movement. In fact, members of this committee have expressed interest in that. Does the administration's plan address this issue?

Mr. CHAMPION. No; we would hope to deal with the long-term care problem separately for the time being. We would divide long-term care that piece of medicaid, and maintain the same Federal-State relationship.

We have two major concerns. One is that title XX services, social services, are as important in long-term care, particularly outside institutions, as is health care, and we need to have those services integrated, and that can be done really only effectively at the State and local level.

Second, while we are great believers in the importance of home health care, we have real problems in terms of controlling both the quantity and the quality of that. We need better constraints on that system, again, which we think can be done in a local situation, where the nature of that function is understood and the people who are involved can report back on the long-term care.

We have said we do not know enough about long-term care. That ought to be a separable program.

Senator DOLE. You touched on home health care also. There is considerable interest—I know Senator Packwood, Senator Danforth, and Senator Domenici, at least, on the Republican side have indicated a great deal of interest in improving home health care benefits. I guess control would be a factor that would cause some concern when you get into cost.

Mr. CHAMPION. The cost, in a few years without any major changes in the program, has gone from $300 million to close to $900 million without any changes, basically not controlled, not planned, not part of the scheme of long-term care.

As a matter of fact—in another committee, I did promise Senators that we would try to bring to them better, more useful information in terms of their approach to this in September. That will be forthcoming.

We are not dealing with that in this program.

Senator DOLE. I am not certain who supports the administration plan. I assume there are a lot of people who may oppose because you do get into physicians' fees and they do seem to have some influence in legislation.

Will there be an effort to enlist the support of the medical associations and other providers for the Carter approach, the administration approach?

Mr. CHAMPION. We certainly want to get all the support we can. We have had discussions with all these groups before we made this proposal. Obviously, they disagreed with some things and agreed with others.

I think you can see some influence in terms of our relationship with them and the final proposal we made with respect to physicians' fees as a moderate approach.

The CHAIRMAN. Senator Durenberger?

Senator DURENBERGER. Mr. Champion, a couple of questions dealing with the 75-percent maximum contribution.

Did you look at the alternative, or would it be feasible to look at the alternative of limiting the maximum employer contribution for any plan to something like the median cost of qualified HMO's, as an additional way to tie in the alternatives into the system?

Mr. CHAMPION. We did not, but we are interested in finding ways to make it advantageous to use prepaid cost-effective systems and we would be glad to look at that. The 75 percent was an attempt, really, to look at the present pattern. It is very important, in making changes of the magnitude we are discussing, that we not disrupt too many existing patterns at any one time and we were looking basically at the general character of the employer relationship to the cost of insurance.

We could certainly do that.

We did plan some internal kinds of devices to make it attractive for people to save money by using HMO's in a competitive fashion.

Senator DURENBERGER. Let me ask you how you propose to accomplish the mandating of the requirements on the employer? Do you use the tax system in some way if you do not provide the standard or basic benefit package with catastrophic on top of it?

Do you lose the deductibility for your insurance premiums?

Mr. CHAMPION. The device is the tax code. Apparently, there are some details to be resolved in respect to that, but basically through the tax code.

Senator DURENBERGER. Do you know whether the tax code's implications for the employer or the employee—do you know which it is, which direction you are going?

Mr. HEINEMAN. We would just have to say that we are looking at the whole sanctions question. When we send the specifications up very shortly, we will address that.

Mr. CHAMPION. The last one I looked at was the employer.

Senator DURENBERGER. I think you covered the issue. I am glad the chairman got you to look at the issue of the small employer and the farmers and all the rest of those folks in reviewing private alternatives, particularly from the viewpoint of Government subsidization.

Could you briefly go through, describe for us what happens to people? Is this the continuity of coverage issue? What happens to people after a certain period of time, following termination of employment?

What happens to people after the death of the single wage earner in the family? What happens to people at the end of a marriage?

How does this health care system of yours provide coverage for people who would not be covered because of the death of an employed worker?

Mr. CHAMPION. In addition to having provided that coverage, it will be maintained for 90 days after termination of employment, to catch that frictional period for employed people. There is this group that we refer to, the nonaged, nonpoor, nonemployed, and what we have been able fundamentally to provide in that area basically is an ability to buy a $2,500 deductible, or if your income is down in that band above the fully subsidized level, 55 percent of poverty, if you have spent down $2,500 or less to get to that level, that you would then be fully covered by the public plan.

We do not cover those people automatically. We offer them an opportunity to buy that coverage in the public plan at a price which

individuals would have a hard time buying on the public market. We do not have, at this point, a universal plan. We have universal access, but you cannot go that far on this number of dollars.

Senator DURENBERGER. Have you explored, either in this phase or in the second phase of this program mandating several employer options? As I understand it, in phase I you are just mandating a set of standard benefits. How about mandating——

Mr. CHAMPION. We would propose, Senator, at the third and fourth level, in a plan as complex as this, we have always anticipated that would include mandated offering of various options, all offerings in terms of HMO's, not just one HMO, but any prepaid system must be offered to employees for use.

Senator DURENBERGER. Thank you.

The CHAIRMAN. Senator Bradley?

Senator BRADLEY. I have no questions, Mr. Chairman.

The CHAIRMAN. Mr. Chafee?

Senator CHAFEE. When the employer has the insurance program in force, as I understand it, there would be every incentive for him to keep his people healthy, encourage them to remain healthy, because he would, in separate negotiations with his insurers, be able to get lowers rates.

Is that not so?

Mr. CHAMPION. That is correct. That was my concern with the chairman's proposal.

Senator CHAFEE. It seems to me that that presents problems, because the incentive for the employer to keep his people healthy, I think might be diminished unless he is going to get some rebate, lower rates.

Mr. CHAMPION. There could be a way, within Senator Long's proposal, to experience rate in terms of how you handle the pooling arrangement.

It does not make it impossible. It just adds that second level of computation in order to do it.

Senator CHAFEE. Under this health care plan, where you are talking with Senator Durenberger, the nonaged, nondisabled, and so forth, that would apply to a self-employed person? He would be able, if he could not get in as an individual—say he has a couple of people working and could not qualify under an existing private insurance plan that would pick him up in some way—he could then buy coverage under your health care program, is that right?

Mr. CHAMPION. The self-employed would have to have a mandated coverage. If it is only one employee, we would require the mandated coverage. The limit would be 5 percent of payroll.

Senator CHAFEE. Who is going to provide it for him? Who is going to provide the insurance? Suppose he cannot get it?

Mr. CHAMPION. The public plan.

Senator CHAFEE. The public plan is available to the self-employed?

Mr. CHAMPION. That is correct.

Senator RIBICOFF. If the Senator would yield, I do not understand. If you had an engineer, an architect, a lawyer or a doctor, a one-man operation earning $100,000 a year, he is going to come in and be subsidized? Cannot the pool be opened up by the private insurance companies where an employer has its insurance, under the Long-Ribicoff plan, to let him in and pay the full premium that he should pay?

I do not think that we are going to want to subsidize that kind of individual.

Mr. CHAMPION. Well, Dr. Mongan tells me he believes that that would not happen because 5 percent would be more than that cost would be to such a person. However, if it were greater, he would be eligible to come in.

Senator RIBICOFF. To take a person in that category and subsidize him is something that certainly we would have to avoid.

Mr. CHAMPION. We looked at some law firms in that connection and their costs were much lower than that, so we did not think we had that problem. But a proviso saying that would not happen would protect against it.

Senator CHAFEE. I am not necessarily thinking of the $100,000 a year lawyer. I am thinking of the self-employed handyman. He might be making $12,000. It is not always so easy to get into a group plan. They are only open for certain times. You have to have a group, and all of that. Your health care thing would thus be available?

Mr. CHAMPION. That is correct.

Senator CHAFEE. Why are you so modest in your approach to preventive measures? It seems to me the only preventive measure I see here listed is for prenatal and obstetric service and so forth, just dealing with small children. The total cost out of this $18 billion program is $200 million. Is that the best you can do?

Mr. CHAMPION. Senator, the cost is much greater, because, in each of those sectors, the cost of that preventive work is included in those larger figures. I do not know if we have the total cost of that prevention measure, but I think——

Senator CHAFEE. Essentially the preventive measures here come by the fact, presumably, that whoever covers these people would encourage them to keep well but there is no other positive preventive measure, except as I read the thing, except for the prenatal delivery and first-year services.

Mr. CHAMPION. That is right.

By the way, as near as we can estimate, a total of about $1.5 billion in this plan is included in that one preventive piece, if you pull it out of all the group figures we gave you.

The encouragement of systems reform, HMO's and so on, is also intended to help prevention. We did price out the Institute of Medicine's proposal for a lifetime examination system and that would cost—my recollection is it is about $2 billion, so it is a matter of cost.

We thought it was very important to build a preventive element into the insurance part of the system. We are doing a great deal, and we hope to do more, in prevention, in the part of the health reform, and the rest of the department, the kinds of activities now being carried forward by the public health system. There is, incorporated into this proposal, for instance the proposal of Senator Ribicoff that takes care of certain children to the age of 18.

There are many other preventive elements being supported by the Federal Government which presumably will be enhanced whenever we see an opportunity to do it, hypertension or whatever.

Senator CHAFEE. Thank you. I have no further questions.

The CHAIRMAN. Senator Heinz?

Senator HEINZ. Thank you, Mr. Chairman.

I have a couple of questions first, Mr. Champion.

With respect to the cost of the plan, you have a figure of $6.1 billion to the employer. Does that include both the cost of the increased coverage and the cost of the increased percentage of the premium that the employer would get?

Mr. CHAMPION. Yes; this is an attempt to estimate his total increased cost.

Senator HEINZ. In your overall estimates, do you calculate in the tax loss of the increased deductibility of that $6.1 billion?

Mr. CHAMPION. Yes, we do, on a somewhat different basis.

Senator HEINZ. Where is that shown?

Mr. CHAMPION. I could have Dr. Davis run throught it.

Ms. DAVIS. There is a net effect of the impact on tax receipts from the increased employer contributions and also reductions for medical expenses.

Senator HEINZ. Could you supply more detailed calculations for the record, please?

Ms. DAVIS. Yes.[1]

Senator HEINZ. One other rather detailed question that I apologize for. Maybe it is somewhere in the materials.

Just looking at catastrophic coverage for a moment, you will have a limit of $2,500 a couple, is that right?

Mr. CHAMPION. Per family, individual or family.

Senator HEINZ. Individual or family. So that an individual has to bear in a sense, a proportionately higher cost?

Mr. CHAMPION. Except for the aged where we made a special provision of $1,200.

Senator HEINZ. Is that provision the same if there are two people working in the family or three people working in the family?

Mr. CHAMPION. I will ask Dr. Mongan.

Senator HEINZ. How do you rationalize this?

Dr. MONGAN. Basically it would be handled in a fashion similar to present law in arrangements whereby if two family members are employed, they can pick the coverage. In other words, they would not both have to have coverage. They would have to show that one of the family members was covered.

Senator HEINZ. Suppose one of them chooses not to be covered? Suppose they say, I do not want to participate in the employer's plan?

Dr. MONGAN. Yes, if they can show that the other family member is covered.

Senator HEINZ. Therefore, it is possible that a family of six or seven people could be covered by the catastrophic ceiling at $2,500, and being paid relatively little over total family income, a small proportion of their family income, if there were two or three people employed, and the individual who has no working wife, working children and might just be by himself is paying a much higher portion of his or her income to obtain a benefit that proportionately is not as good. Is that right?

Dr. MONGAN. There can be variations in the payment as a percent of income. That can be due to multiple earnings of the family or due to different income levels.

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[1] See p. 526.

Senator HEINZ. It seems to me grossly unfair that two or three wage earners in that family conceivably—this may be an exceptional circumstance—could decide to opt out and ride on the coattails of some particular individual, single employee or employer program?

Dr. MONGAN. Basically, that is how private insurance operates now. If you and your spouse are both employed, rather than carry double coverage, one of you picks whichever coverage is the most advantageous to you. This would continue in the first phase, that practice.

Mr. CHAMPION. The question you raise is an important question. We all need, I think, to address it. This is not in this portion, the needs-tested or income-based program. It is not intended as such, and it is not designed as such.

Senator HEINZ. My time is up but I just want to say, you say it operates like the present system, but one of the things it does not operate like is the social security system where everybody in a sense who is going to get the benefits of social security has to pay in it. There are other models besides the present system, and I hope we have time to return to some of the issues involved here.

Thank you.

The CHAIRMAN. Senator Bentsen:

Senator BENTSEN. Mr. Chairman, I have no questions. I do have a comment.

Mr. Champion, you presented your case with a great deal of clarity and persuasion this morning and I will compliment you on it and say how much I personally regret your leaving the Federal service. I think you have done an excellent job.

Mr. CHAMPION. Thank you very much, Senator.

The CHAIRMAN. Senator Ribicoff?

Senator RIBICOFF. I have taken more than my allotted time during the presentation and I will not ask any more questions.

The CHAIRMAN. Thank you very much.

Senator Hart is now here. Senator, we would be delighted to have you take the witness stand.

Senator CHAFEE. Is this going to be the last we are going to see of Mr. Champion?

The CHAIRMAN. You are not going to see the last of Mr. Champion until he goes home from Washington. I would assume that either he or Secretary Califano or one of his able assistants sitting here with him will be around with us until we report a bill out.

Senator CHAFEE. I was more interested in joining with Senator Bentsen in bidding farwell to Mr. Champion.

The CHAIRMAN. Are you leaving?

Mr. CHAMPION. I will be here until the 30th. I understand we have several more sessions.

The CHAIRMAN. I hope I am not saying goodbye to you today.

Mr. CHAMPION. No, you are not.

Senator CHAFEE. You are leaving the city in June, are you not?

Mr. CHAMPION. That is correct.

Senator CHAFEE. That is pretty close.

Senator RIBICOFF. I thought we took care of you with the revised ethics bill that we put through here.

Mr. CHAMPION. Senator, I think that was very well done and it would have met any problems I had with the ethics bill. I had other problems that were not met by that.

Thank you.

Senator RIBICOFF. You are the example that was presented to me as to why we had to revise that bill.

Mr. CHAMPION. I assure you I was not alone, Senator. You saved a lot of people's participation.

The CHAIRMAN. I do not believe we are saying goodby to you today. I hope we are going to have you around here at least until the 30th, and I hope you will be around these sessions to help comment to the Department on these various suggestions that are going to be thrown out here.

Mr. CHAMPION. Mr. Chairman, I will be here officially until June 30. I will be at your disposal at any other time.

Senator HEINZ. Before Mr. Champion leaves, let me ask a question We do not have a bill from the administration yet; is that correct?

Mr. CHAMPION. We are drafting the bill according to the specifications. It is not a piece of legislation before the committee.

Senator HEINZ. The fact that we have had to ask some fairly detailed, elementary questions today indicates that, at least to me, that we have just scratched the surface on this particular, single approach to health insurance—the administration approach.

I would hope, Mr. Chairman, that we would be able to get into this in substantially more substance than we have been able to get into it today. It is very hard to get into the substance of something without a bill.

I do not mean to criticize the administration, or anybody else for not having a bill, but the fact is, I just do not see how we can legislate wisely until the administration sends us something to look at.

I loved your charts, Mr. Champion. They are very good. They indicate all kinds of things. But they do not tell me how we go about doing all these things.

The CHAIRMAN. We have some language for you, Senator. You just look at the Long-Ribicoff bill. The Long-Ribicoff bill is all written up and printed up for you. The 3–D bill is all in print, the Dole bill.

Senator HEINZ. Mr. Chairman, I thought you were for competition in health insurance. There are a lot of people who want competition among these plans. I think there should be competition right here in the Senate Finance Committee among the Long plan, the Ribicoff plan, the Dole-Danforth-Domenici. We ought to see this stuff in 3–D, all right, and include the administration plan.

The CHAIRMAN. I will promise this committee that we will not report out the administration bill unless they themselves write it up at some point.

[The material submitted by the administration follows:]

Office of the White House Press Secretary

THE WHITE HOUSE

TO THE CONGRESS OF THE UNITED STATES:

Today I am proposing to the Congress a National Health Plan. This major new initiative will improve health care for millions of Americans and protect all our people against the overwhelming financial burdens of serious illness.

It has been 30 years since President Truman challenged Congress to secure for all Americans access to quality health care as a matter of right. It has been nearly 15 years since the Congress, responding to the leadership of Presidents Kennedy and Johnson, finally enacted Medicare and Medicaid. Now, after a decade and a half of inaction, it is time to move forward once again.

I have consulted with the Congress, with consumers, with leaders of labor, management, and the health care industry, and have carefully weighed every option. My proposal is practical, premised on effective cost controls, and consistent with sound budget practices. It will:

-- protect all Americans from the cost of catastrophic illness or accident

-- extend comprehensive health coverage to almost 16 million low-income Americans

-- provide coverage for prenatal, delivery, postnatal, and infant care, without cost-sharing

-- establish Healthcare, which will provide more efficient Federal administration of health coverage for the poor and the elderly

-- reform the health care system to promote competition and contain costs

-- create both the framework and the momentum for a universal, comprehensive national health plan.

Protection from Catastrophic Expenses

No American should live in fear that a serious illness or accident will mean bankruptcy or a lifetime of debt. Yet today over 80 million Americans are unprotected against devastating medical costs, and millions more can lose the protection they now have because of unemployment or the death of a working spouse.

This National Health Plan will protect every American from the serious financial burden caused by major illness and injury. All employers will provide catastrophic coverage for full-time employees and their families, with subsidies to ease the burden on small businesses. No family will be required to pay more than $2500 for medical expenses in a single year. Americans who are not covered elsewhere can obtain affordable catastrophic coverage from a special Federal program. Under this special program, no one will be denied coverage because he or she is labelled a "bad medical risk."

Expanded Benefits for the Elderly

The cost of health care falls most cruelly on America's older citizens who, with reduced incomes, have the highest medical expenses. Because Medicare places limits on hospital days and places no ceiling on out-of-pocket expenses, serious illness threatens senior citizens with loss of their homes and their life savings. Under the National Health Plan, the elderly will have unlimited hospital coverage and will be required to pay no more than $1250 for medical expenses in a single year.

Today, the elderly also face heavy financial burdens because physicians increasingly charge more than the Medicare fee. Under the National Health Plan, physicians would be prohibited from charging elderly patients more than the allowable fee.

Improved Program for the Poor

The National Health Plan also provides expanded benefits for the poor. The Plan will extend comprehensive coverage -- full physician, hospital and related services -- to all Americans with incomes below 55% of poverty ($4200 for a family of four). In addition, persons with incomes above 55% of poverty will be able to "spend-down" into comprehensive coverage if their medical expenses in a given year reduce their income to the eligibility level. A family of four with an income of $4500, for example, will be covered after $300 of medical expenses. Under these provisions, 15.7 million poor people, including 1.2 million elderly, will receive comprehensive coverage for the first time.

Today the existence of 53 separate State and territorial Medicaid programs impedes efficient management. Under the National Health Plan, the administration of programs for the poor and the elderly will be significantly upgraded by the creation of a single new Federal program -- Healthcare. Healthcare will improve claims processing, reduce error rates in eligibility determination, and facilitate detection of fraud and abuse.

Health Services for Mothers and Infants

Prevention is the best way to eliminate the suffering and cost of illness, and one of the most effective preventive health measures we can take is to assure health care for expectant mothers and infants. We have been far too slow to learn this lesson. Our infant mortality rates are higher than those of eleven other nations. This inexcusable record can and will be corrected.

Under the National Health Plan, employers will provide employees and their families with coverage for prenatal care, delivery, and infant care to age one, without any cost-sharing. A high priority in future years must be to expand this coverage to include children up to age six. The employer provisions of the Plan, combined with the Child Health Assurance Plan I have already proposed for low-income expectant mothers and children, will assure that no newborn child in this country will be denied the chance for a full and productive life by the high costs of health care.

more

Extended Insurance Coverage

Today, many employees and their families suddenly lose all health coverage when the employee is laid off or is between jobs. Under the National Health Plan, employer-based insurance policies will be required to maintain coverage for 90 days after employment ends. In addition, employer-based policies will be required to maintain family coverage for 90 days after an employee's death, and to cover dependents until age 26.

Cost Containment

A renewed emphasis on cost containment must accompany new health benefits. The American people now spend over 9% of the Gross National Product on health services -- $200 billion a year. Hospital costs in America are rising $1 million an hour, 24 hours a day. It is time to draw the line.

The National Health Plan is premised on passage of strong hospital cost containment legislation, which will save the American people $53 billion over the next five years, including $28 billion in Federal, State, and local expenditures. The Nation cannot afford expanded coverage without hospital cost containment legislation. In addition, my National Health Plan proposes a $3 billion annual limit on hospital capital expenditures. This Nation cannot support more duplicative facilities and more unnecessary equipment. We must not add to the 130,000 excess hospital beds we now have. We must and we will insure that needed extensions in coverage do not become the excuse for further waste.

This Plan will also provide for a mandatory fee schedule for physicians who serve Healthcare patients. The fee schedule will curb excessive inflation in physician fees and will reduce the disparities in fees paid to rural physicians as compared to urban physicians, and primary care physicians as compared to specialists. Over time, the new fee schedule will help produce a better geographic distribution of physicians and increase the availability of primary care services.

The Healthcare fee schedule will provide a model for private health insurance plans. Private plans will publish the names of physicians who agree to adhere to the Healthcare fee schedule for all their patients. To assure that Blue Shield and similar organizations reexamine their physician reimbursement policies, the Plan will prohibit physician domination of the governing boards of these organizations.

Increased Competition

Competition has been weak in the health care industry because a very high percentage of costs are paid by third parties, and because patients generally cannot determine or shop for the services they need. In recent years, however, health maintenance organizations (HMOs) have injected important competitive forces into the health care system. The National Health Plan will encourage further competition by giving employees and Healthcare beneficiaries new financial incentives to enroll in HMOs or other cost-effective health plans.

Employers will be required to make equal contributions to the various health plans they offer their employees. Employees who choose more cost-effective plans will either pay lower premiums, receive additional compensation, or receive expanded health benefits.

The Healthcare program will pay a fixed amount on behalf of elderly beneficiaries who choose to enroll in HMOs. If the HMO can provide the standard Healthcare benefit package for less than the fixed amount, it must offer additional health benefits to the patient.

The Plan also promotes competition by requiring Healthcare to use competitive bidding to select private companies to perform claims processing and related functions. Demonstration projects by the Department of Health, Education, and Welfare have shown that this change will produce significant administrative savings.

Framework for a Comprehensive Plan

A universal, comprehensive national health insurance program is one of the major unfinished items on America's social agenda. The National Health Plan I am proposing today creates both the framework and the momentum to reach that long-sought goal. In future years, the Plan can be expanded to include all low-income persons. Employer coverage can be made more fully comprehensive, with subsidies to ease the burden on small businesses. First-dollar coverage for preventive services can be extended throughout early childhood. I am today sending to the Congress an outline of a fully comprehensive plan which builds upon the significant health care improvements that I am asking the Congress to enact this session.

Consistent with current budgetary constraints, new Federal spending for the National Health Plan will not begin until FY '83. When the Plan is fully implemented, the Federal budget cost in 1980 dollars will be 18 billion and the premium cost to employers and employees will be $8 billion. A substantial portion of these expenditures reflect reduced out-of-pocket expenses for individuals and reduced spending by State and local governments for their health programs. These expenditures are a social investment in the future of our children, the economic security of our elderly, and the well-being and peace of mind of all Americans. They are an investment in a more effective and efficient health care system. Over time, the Plan's emphasis on prevention, competition, and cost containment will reap important dividends for our Nation and its people.

I urge the Congress not to lose this precious opportunity for progress. The real needs of our people are not served by waiting and hoping for a better tomorrow. That tomorrow will never come unless we act today. The National Health Plan I propose will provide millions of our citizens with better health, greater economic security, and more productive, dignified, and hopeful lives. The American people have waited long enough. I call on the Congress to act without delay.

JIMMY CARTER

THE WHITE HOUSE,

June 12, 1979.

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JUNE 12, 1979

THE CARTER ADMINISTRATION'S OUTLINE OF A FULLY IMPLEMENTED NATIONAL HEALTH PLAN

The Carter Administration is firmly committed to a universal, comprehensive National Health Plan. This white paper provides an outline description of such a plan when fully implemented, and relates it to the Phase I legislation which the President is proposing.

I. Background

The National Health Plan, and the Phase I legislation which serves as its foundation, derive from the President's commitment to the goals of universal, comprehensive coverage.

A. Early Commitments

president Carter has been working to improve health care since his days as Governor of Georgia. During the 1976 Presidential campaign, before a group of Black medical students, he first set forth his vision of the ideal health care system, including:

-- universal, mandatory coverage;

-- the same comprehensive benefits for everyone, including preventive care;

-- a variety of financing sources;

-- strong cost and quality controls and incentives for system reform; and

-- phasing of implementation according to national priorities, dealing with the most severe unmet health care needs first.

B. Presidential Principles

In July 1978, the President reiterated his support for universal and comprehensive coverage, to be achieved through a mixture of public and private financing. He issued a set of specific principles to guide the design of a tentative plan.

These principles remain the touchstone of the proposal the Administration is presenting today. They are notable because they call for a National Health Plan much broader in scope than simple insurance improvements -- a plan that includes other steps required to address the critical problem of health cost inflation and to expand access to care for millions of underserved Americans. The principles are:

1. The plan should assure that all Americans have comprehensive health care coverage, including protection against catastrophic medical expenses.

2. The plan should make quality health care available to all Americans. It should seek to eliminate those aspects of the current health system that often cause the poor to receive substandard care.

3. The plan should assure that all Americans have freedom of choice in the selection of physicians, hospitals, and health delivery systems.

4. The plan must support our efforts to control inflation in the economy by reducing unnecessary health care spending. The plan should include aggressive cost containment measures and should also strengthen competitive forces in the health care sector.

5. The plan should be designed so that additional public and private expenditures for improved health benefits and coverage will be substantially offset by savings from greater efficiency in the health care system.

6. The plan will involve no additional federal spending until FY 1983, because of the tight fiscal constraints and the need for careful planning and implementation. Thereafter, the plan should be phased in gradually. As the plan moves from phase to phase, consideration should be given to such factors as the economic and administrative experience under prior phases. The experience of other government programs, in which expenditures far exceeded initial projections, must not be repeated.

7. The plan should be financed through multiple sources, including government funding and contributions from employers and employees. Careful consideration should be given to the other demands on government budgets, the existing tax burdens on the American people, and the ability of many consumers to share a moderate portion of the cost of their care.

8. The plan should include a significant role for the private insurance industry, with appropriate government regulation.

9. The plan should provide resources and develop payment methods to promote such major reforms in delivering health care services as substantially increasing the availability of ambulatory and preventive services, attracting personnel to underserved rural and urban areas, and encouraging the use of prepaid health plans.

10. The plan should assure consumer representation throughout its operation.

C. Consultation

At the same time that the President issued the principles, he asked that the tentative plan serve as a basis for consultation with Congress, State and local officials, interest groups and consumer representatives. He told Secretary Califano:

> "I am directing you to develop a tentative plan as soon as possible which embodies these principles and which will serve as the basis for in-depth consultation with the Congress, State and local officials, interest groups, and consumer representatives. You should then provide me with detailed recommendations so that I can make final decisions on the legislation I will submit to the Congress next year."

The President also requested analysis of options for phasing toward a fully implemented plan, as follows:

> "To respond fully to my economic and budgetary concerns, you should develop alternative methods for phased implementation of the plan."

D. Legislative Approach

The approach that emerged from the phasing analysis and the consultation process was that the President would:

-- present an outline of the full universal and comprehensive plan to the 96th Congress; but

-- ask for legislative consideration of only the first phase at this time.

As Secretary Califano said when he announced the President's decision in March of this year:

> "Since January, my colleagues and I have consulted scores of Congressional leaders, committee and subcommittee chairmen, and health industry experts. With few exceptions, the overwhelming sentiment among legislators is that the 96th Congress cannot and will not digest a complete national health plan in one bite."

Many members asked that the President send a Phase I bill to the Congress and accompany it with a description of the total plan.

II. Summary: The Fully Implemented National Health Plan

When fully implemented, the National Health Plan (NHP) will guarantee universal comprehensive health insurance for every American, using a mixture of financing sources and preserving a significant role for the private insurance industry.

General structure. The two basic structural entities established in Phase I will continue:

-- HealthCare -- a public plan providing comprehensive coverage to the aged, the disabled, the poor and the near poor, and offering comprehensive coverage to individuals and firms unable to obtain such insurance in the private sector.

-- The employer guarantee -- employers will be required to purchase qualified comprehensive plans for their employees from private insurors or HealthCare, and to pay at least 75 percent of the premium.

Eligibility. Every American will be covered by HealthCare or a qualified private plan meeting HealthCare standards. Using the estimated U.S. population in 1980 of 231 million as a base, this includes:

-- Employees and their dependents -- 160 million persons -- will be covered by the employer guarantee.

-- The aged and disabled -- 29 million persons over 65 or eligible for disability benefits -- will be fully covered by HealthCare.

-- Low income -- 37 million persons with incomes up to the federal poverty level ($7500 for a family of four in 1980 dollars) -- will be fully covered by HealthCare.

-- Others -- 5 million persons who are neither poor nor aged and who do not have salaried incomes -- will be required to purchase qualified private insurance plans or HealthCare coverage (with premium costs prorated for the near poor). This mechanism will achieve universal, mandatory coverage.

Benefits. HealthCare and all qualified private plans will be required to incorporate uniform covered services and patient cost-sharing provisions.

The comprehensive package of covered services will consist of:

-- unlimited hospital, physician and diagnostic services;

-- specific amounts of other services with annual limits:

  - 100 days of care in a skilled nursing facility*
  - 100 home health visits
  - 20 days in a mental hospital
  - $1000 in outpatient mental health care

-- cost free prenatal, delivery and both preventive and acute child health care up to the age of 6, as well as cost free preventive care for all ages, based on a lifetime health monitoring program; and

-- outpatient prescription drugs in excess of $250 per person annually.

The cost-sharing provisions will provide incentives for outpatient and preventive care and protect all Americans against large expenditures by:

-- elimination of deductibles (except for drugs);

-- an equal coinsurance rate of 25 percent across all covered services (except that there will be no coinsurance on prenatal, delivery, child health care up to the age of 6, or on other preventive care);

-- a limit on annual out-of-pocket expenses for covered services in excess of $1500 per family or $750 per individual; and

-- prohibition of cost sharing for the poor and more limited cost sharing for the near poor.

Financing. NHP will use a mixture of public and private premium financing while taking a number of steps to maximize equity:

-- Necessary subsidies for the poor, the near poor, the aged and disabled, low income workers and low wage employers will be provided through public general revenues.

-- Current Medicare payroll taxes will be retained but not increased.

-- Employers will be required to pay at least 75 percent of any mandated premium; employees, up to 25 percent.

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*This benefit is included as a transitional service to help persons with acute problems to return to their communities. Long term care will be a separate program.

-- Competition will be encouraged because private insurors will be free to price large group plans at rates reflecting actual costs. At the same time these plans will have to compete with a HealthCare premium controlled for inflation -- thus preventing exorbitant prices.

-- Every worker will be insured individually; in families with two wage earners dependents can be included in either worker's plan. This will discourage employers from seeking out "secondary" wage earners for whom they now pay no premium.

Reimbursement. Reimbursement and cost containment policies under NHP must attempt to resolve the key tension between the desire to expand coverage and the need to contain costs:

-- Hospitals will be paid by public and private insurors according to limits prescribed in the program that evolves from the Administration's hospital cost containment proposal.

-- HealthCare will pay physicians according to areawide fee schedules; physicians will have to accept the fee as payment in full and will not be allowed to bill patients for extra amounts.

-- The schedules will serve to advise privately insured patients of reasonable physician fees and to encourage them to shop for less expensive care. If private fees are not kept within reasonable limits voluntarily, consideration will be given to other measures to contain physician costs.

-- Incentives for competition will include favorable reimbursement policies for Health Maintenance Organizations (HMOs) and other organized settings.

-- Employers will be required to offer employees coverage by any qualified HMO in the area and to make equal contributions to the health plans they offer their employees. Employees will then have an incentive to choose more cost effective plans.

-- A commission will be established to determine whether physician reimbursement policies are containing costs sufficiently and achieving broad provider participation in HealthCare.

Administration. The fully implemented NHP will preserve a major role for private insurors while providing uniformity of coverage:

-- Private insurors will market and underwrite qualified insurance plans for most current beneficiaries, add new beneficiaries through the employer guarantee and increase income by bidding on claims processing for HealthCare.

-- HealthCare will consolidate Medicare and Medicaid administrative functions and standardize eligibility, benefits, and reimbursement policies.

System reform initiatives. NHP is designed as an umbrella to include non-insurance provisions addressing problems in the way the health care system operates. Some of these initiatives will be included in the Phase I legislation; others involve separate but complementary legislative or administrative steps. They include:

-- Limits on hospital capital growth.

-- Incentives for competition, primarily through HMO development and expansion and consumer information about physicians' fees.

-- Expansion of utilization review.

-- Establishment of a new process to assess and coordinate federal grant efforts in light of expanded insurance coverage, including submission of a five year plan beginning with the first year of Phase I implementation.

-- Incentives for redistribution of physicians.

-- Technology assessment.

-- Improved delivery of services: primary care in underserved areas; mental health; prevention.

-- Government-wide efforts to prevent accidents and eliminate occupational or environmental causes of disease.

Costs. When fully implemented, NHP will meet a fundamental requirement: Total health system costs, including dramatically expanded coverage and effective cost containment, will be less than those of the present health system with its inadequate coverage and lack of effective cost containment.

III. The Fully Implemented Plan Compared to Phase I

A. General Structure

The two basic structures of the fully implemented National Health Plan (NHP) -- the public plan, HealthCare, and a requirement that employers purchase qualified insurance for their employees — will be established in Phase I.

These two entities are the key to a smooth transition from Phase I to the fully implemented plan. Once they are in place, several fairly simple expansions will lead to deeper and broader coverage for all.

1. HealthCare. For HealthCare, expansion will take two forms:

   - o The most significant improvement will provide fully subsidized coverage for all of the Nation's poor -- by raising the income standard below which every person is eligible.

   - o Nearly all aged and disabled will already be enrolled; their insurance will be improved by providing greater protection against out-of-pocket expenses.

2. Employer guarantee. Expansion of the employer guarantee will also be of two types:

   - o Here the most significant improvement will be in the nature of insurance. Qualified plans will be required to incorporate uniform cost sharing provisions with greater protection against out-of-pocket expenses, thus providing comprehensive coverage to all working families.

   - o Employers will assume responsibility for part time as well as full time employees.

B. Eligibility

When fully implemented, NHP will mandate basic health insurance for all Americans. Several mechanisms will be used to move the four population groups -- the low income, the aged and disabled, the employed and others -- toward this universal comprehensive coverage.

1. Low Income. There are roughly 37 million persons at or near the federal poverty level who are not aged or disabled. Of these, 15.7 million now receive fully subsidized coverage through Medicaid. In Phase I, HealthCare will establish a national minimum low income standard at 55 percent of the

federal poverty level, regardless of family composition — thus adding 10.5 million persons to those who already have fully subsidized public coverage. The other 10.8 million persons in the low income group will be eligible to "spend down" to the 55 percent standard and obtain subsidized coverage thereafter. Roughly 4 million are expected to do so.

The fully implemented plan will raise the low income standard to full poverty level. Thus all 37 million low income persons will receive fully subsidized coverage with no "spend down" required.

2. Aged and disabled. There are roughly 29 million persons over 65 or eligible for disability assistance. About 24 million currently receive Medicare benefits; another 4 million are poor and receive fully subsidized coverage through Medicaid. Phase I will bring another 500,000 aged and disabled who are under the 55 percent of poverty standard, but not now covered, into HealthCare.

   NHP will bring in the other 400,000 aged and disabled previously excluded from Medicare, thus covering all 29 million.

3. Employed. Of the 156 million full time employees and their dependents, 128 million are currently covered by employer group plans. A total of 56 million are not adequately protected against major illness -- the 28 million without employer group coverage and 28 million more whose employer group coverage is deficient in this respect. Phase I will require all employers of full time workers to provide HealthCare or qualified private group plans, with catastrophic coverage. This will ensure that all 156 million full time workers and their dependents are covered by employer group plans and that 56 million within this group receive the protection against major illness they lacked before.

   NHP will require employers to cover part time workers and their dependents. (A part time worker is defined as one who works less than 10 weeks, 25 hours a week for the same employer.) This expansion will mean that employers are responsible for coverage of an additional 4 million persons.

4. Others. Dealing with the 9 million persons who are not categorized as low income, aged, disabled or employed full time is more complicated. Some persons without salaried incomes are covered by individual plans, which are usually very inadequate. Some are not covered at all. Phase I will allow individuals who desire to do so to purchase insurance from HealthCare that is similar to the minimum

employer guarantee plan. In addition, the "spend down" program described for the low income group will also be available to the 4 million part time employees who are not yet covered by the employer guarantee, and to others, after they use a sufficient amount of income for medical care.

With the fully implemented NHP, mandatory universal coverage will be achieved because all persons will be required to purchase qualified plans from private insurors or HealthCare (with premiums prorated for the near poor).

5. Results:

- o Every American will be fully covered by HealthCare or a qualified private plan.
- o Providers will be put on notice that no person is a poor risk because of inability to pay.

C. Benefits

The element of a health insurance plan known as "benefits" is really a combination of two features:

-- Which services are covered by the plan.

-- What out-of-pocket expenditures by individual patients for covered services are required. This is known as patient cost sharing. (It does not include premium payments, which are discussed in Section D.) Cost sharing may take the form of deductibles or coinsurance -- a consistent percentage of the cost of specified services. Total out-of-pocket spending by an individual may be limited to a specific amount.

1. Covered services. The services covered in Phase I and under the fully implemented plan will differ only slightly. Phase I will establish a lean but comprehensive package of required services for HealthCare and all qualified private plans. Physician, diagnostic and hospital services will be covered on an unlimited basis. Specific home health, skilled nursing facility and mental health services will also be covered.

Prenatal, delivery and all health care during the first year of life will be included for pregnant women and children in HealthCare or covered by the employer guarantee. Because of the importance of this benefit in preventing disease and improving health status, it will also be available to any person not otherwise covered, at a nominal premium. No cost sharing will be imposed on these maternal and infant care services.

NHP will build on Phase I by:

- o Adding outpatient prescription drug coverage. Unlike other benefits, this would operate on a $250 deductible basis for administrative ease and to target coverage on those who must take medication on a long term basis.

- o Adding complete child health care up to the age of 6, as well as preventive services for all persons, consisting of periodic checkups and counseling according to a lifetime health monitoring program. No cost sharing will be imposed on these services.

2. Cost sharing. While eligibility is the key variable in moving to a fully implemented plan for the poor, the transition from Phase I to NHP turns on cost sharing for most other persons.

   - o The poor and near poor. Poor persons eligible for HealthCare will pay no cost sharing in Phase I. Under NHP, the same full subsidy will be provided, but, as noted, to a larger number of covered poor. Near poor persons enrolled in HealthCare will face a 25 percent coinsurance rate across most covered services, but these payments will be subsidized for those just over the poverty line.

   - o The aged and disabled. In Phase I, existing cost sharing arrangements (Medicare deductibles) will apply, but no aged or disabled person will pay more than $1250 for covered services annually. Under NHP, a 25 percent coinsurance rate across all covered services except prevention will be used instead of deductibles, and the limit on out-of-pocket expenditures will be lowered to $750 per person annually.

   - o Employer guarantee. Persons included in the employer guarantee in Phase I will be protected against out-of-pocket expenses for covered services in excess of $2500 annually; the same limit will apply to families or individuals. Insurors will be able to require any form of patient cost sharing they wish as long as it does not exceed the limit. Under NHP the catastrophic limit will be lowered to $1500 per family and $750 per person. Deductibles will be eliminated (except for drugs) and cost sharing in any qualified plan will be limited to a maximum of a 25 percent coinsurance rate across all covered services except prevention.

3. Results:

- o Establishment of a precedent-setting prevention benefit for all persons, including complete health care for children up to the age of 6, designed to turn the direction of health care from curing to caring.

- o A drug benefit with a moderate deductible which will free those who must pay for medication on a long term basis from a major financial burden -- especially important for the aged living on fixed incomes.

- o Substantial protection against out-of-pocket expenditures for every American.

- o Powerful incentives for outpatient care achieved by eliminating deductibles and establishing a maximum coinsurance rate across services.

- o Phased implementation of cost sharing above the poverty standard to avoid work disincentives.

D. Financing

Financing -- who pays for the insurance policy in the first place -- affects the affordability and the equity of the plan. Both Phase I and NHP will retain the two current sources of financing in addition to some State and local revenues:

-- General revenues will be used to cover the poor; to subsidize the aged (in conjunction with current payroll taxes); to subsidize the near poor, and to offset adverse employment effects of mandated insurance.

-- Premiums paid by individuals or employers will be the predominant method of financing insurance.

1. General revenues. In the transition from Phase I to NHP, general revenue financing will expand as the number of persons with subsidized coverage increases. The aged will continue to pay 25 percent of the HealthCare premium -- an amount similar to the Part B Medicare premium -- with any part not covered by the current payroll tax subsidized by general revenues. Increased use of payroll taxes to finance improvements for the aged is undesirable because of inflationary impact and competition with other Social Security needs.

2. Premiums. Under NHP, as in Phase I, employers will pay at least 75 percent of premium costs and employees up to 25 percent. With full implementation, the premium structure will be altered in several ways. There are many advantages to retaining premiums -- among them ease of administration and minimal disruption of current patterns. However, premiums alone are not designed to vary according to ability to pay. Thus, as coverage expands and financial burdens increase it becomes more important to deal with certain problems:

   - o Competition will be encouraged because private insurors will be free to price large group plans at "experience" rates, reflecting actual costs of care. The HealthCare premium will be set at the current areawide rate for small groups and individuals -- generally higher than private large group rates.

   - o Increased premium burdens may exacerbate a tendency for firms to discriminate against the "primary" wage earner in a family, who carries insurance for himself and his dependents. Under NHP, every worker will have to be individually insured, to prevent employers seeking out "secondary" wage earners for whom they now pay no premium. Dependents will be dealt with through a premium structure that allows their coverage through either of two wage earners in a family.

   - o Larger premiums will also pose disproportionate burdens for small, low wage firms and for near-poor workers. Gradual implementation of broader benefits (and, consequently, gradual growth of premiums) will give firms time to adjust and lessen the need for subsidies in the plan's early years. The subsidies established during Phase I will be expanded as necessary.

3. Results:

   - o Continuation of employer payment of at least 75 percent of the premium.

   - o Enhanced competition among plans without subjecting employers or individuals to exorbitant premiums.

   - o Avoidance of adverse employment effects.

   - o Provision of needed premium subsidies to the poor, the near poor, the aged and disabled, and low wage firms.

E. Reimbursement

The way in which Phase I and NHP pay providers will be the keystone of an aggressive effort to contain costs and foster more efficient delivery of care. This is crucial to resolving the dilemma that stands in the way of full implementation: Expansion of coverage costs more money -- yet we need to control disproportionate growth of the health sector and to limit federal budget increases.

Ideally, NHP reimbursement and cost containment policy will bring health cost inflation in line with GNP growth and, to the maximum extent possible, finance new expansion through savings in health care costs.

The fully implemented NHP will build on three elements in Phase I:

-- Hospitals will be paid according to a single reimbursement policy for public and private insurors that is expected to evolve from the Administration's current hospital cost containment proposal.

-- Physician reimbursement reform will feature a mixture of mandatory controls for HealthCare and voluntary steps on the private side.

-- Competitive incentives to enrollment in Health Maintenance Organizations (HMOs) and other organized care settings will be established.

1. Hospital cost containment. Phase I recognizes -- as does current Administration policy -- that spiralling hospital costs are a major cause of health care inflation, requiring sustained efforts at containment. National and State limits on capital growth will also be established. The Administration's hospital cost containment proposal is designed as a transitional program, providing for establishment of a commission to consider future policy. Under a fully implemented NHP, hospital reimbursement can be expected to evolve further as a result of the commission's recommendations.

2. Physician fees. Phase I will establish areawide physician fee schedules for HealthCare, based on current Medicare rates but reducing urban/rural and specialty differentials. Low Medicaid fees will be phased up to the average Medicare level; providers now charging fees over the limit will be held harmless for two years.

    o The fee schedules will be mandatory for HealthCare and physicians will not be permitted to bill patients for additional amounts.

- o Published fee schedules, together with a list of physicians who accept them as payment in full, will serve to advise privately insured patients of reasonable fee levels and to encourage them to shop for less expensive care.

To aid in making the transition to the fully implemented NHP, a commission will be established to consider whether costs for privately insured physician services are being contained by the voluntary provisions of Phase I, to whether the absence of mandatory controls on the private side has adversely affected provider participation in HealthCare and access to care for public beneficiaries.

3. Competition. Phase I and NHP will provide incentives for enrollment in HMOs, Independent Practice Associations (IPAs) and other organized care settings. These incentives recognize that organized settings internalize cost containment measures and can replace certain forms of regulation for their enrolled population. They include:

   - o Requiring employers to offer coverage by any qualified HMO in an area.
   - o Requiring that employers make equal contributions to the health plans they offer their employees. Employees will thus have an incentive to choose more cost effective plans.
   - o Requiring that for subsidized beneficiaries, HealthCare reimburse HMOs and other organized settings at rates that encourage competition with the fee-for-service sector.

   As we move to a fully implemented NHP, consideration will also be given to changes in the tax laws to discourage spending for benefits outside the plan and to provide a disincentive to high provider fees.

4. Future options. The importance of correcting the underlying causes of runaway health costs -- an absence of market forces and the ability of providers to determine the type and quantity of service purchased -- cannot be over-emphasized. HMOs, which have reduced total costs dramatically, are a key element in this strategy. NHP must be structured to pass on these savings to the consumer, thus encouraging greater and greater competition.

At the same time, the Administration recognizes the limits on competitive forces in a system traditionally characterized by third party payments and cost-plus reimbursement. If the combination of hospital regulation, physician reimbursement reform and competitive incentives does not substantially lower health care cost inflation and ensure provider participation in HealthCare, stronger and more comprehensive measures may be needed.

One method that has been suggested is a national health budget set by the Congress (or some other, newly created, national entity) in relation to GNP and allocated to hospital, physician and other sectors. Rates could be negotiated by providers, consumers and insurors to meet the sector allocation.

F. Administration

In accord with the goal of a significant role for private insurors, the fully implemented NHP will minimize disruption of existing administrative arrangements. At the same time, it will provide appropriate regulation of private plans and shift some public functions from States to the federal level to enhance equity.

Again, the two basic structural elements established during Phase I will provide the foundation for additional change.

1. HealthCare. HealthCare will be the key to increasing uniformity of treatment for public beneficiaries. During Phase I, Medicare and Medicaid rate setting will be merged and claims processing will be contracted to private firms on a competitive basis. Eligibility determination will remain split, with States continuing to certify current low income recipients whose eligibility is linked to welfare, and the federal Social Security Administration certifying the aged and disabled, as they do now. For the newly-entitled poor (55 percent of poverty and spend-down eligibles) the federal government will be responsible for eligibility and intake, although States can elect to operate these functions under performance contracts.

   When fully implemented, NHP will ensure uniformity of treatment for all those in need of subsidies through HealthCare. The combination of federal standards and private claims processing will improve efficiency of operation, prevent waste and fraud, and mitigate providers' and consumers' problems with the current Medicaid program.

2. Employer guarantee. The employer guarantee will move toward similar uniformity on the private side, but with insurors retaining the essential functions of marketing and claims processing. During

Phase I and subsequently, the federal government will be responsible for certifying the benefits, catastrophic coverage and the consumer protections offered by qualified private plans.

3. Results:

- o The important coordination of public and private standards to provide nationwide uniformity.
- o A major role for private insurors and increased income from claims processing.
- o Steps to increase equity and encourage competition.

G. System Reform Initiatives

Many serious problems in the U.S. health care system will not be relieved by insurance changes alone. NHP is designed as an umbrella, incorporating important non-insurance system reform supplements to guarantee access to care, limit and improve distribution of resources and promote efficiency. Phase I and a fully implemented NHP will deal with these problems in a very similar way.

1. Elements in Phase I legislation. The Phase I legislation itself will contain:

- o A new process for assessing health care needs and the adequacy of federal grant programs, in conjunction with insurance, to meet the needs. Beginning with the first year of Phase I implementation, this process will require the Secretary to submit a five year plan for each relevant federal program. It will subsequently serve as a guide to expansion from pre-Phase I efforts to initiatives consistent with the complete plan.
- o Strengthening the health planning program by imposing national and State limits on hospital capital spending, as noted.
- o Measures to increase competition by encouraging HMO enrollment, as also noted.
- o Expansion of utilization review.

2. Other initiatives. In addition, the following legislative and administrative initiatives already under way will be part of the Phase I and NHP system reform effort:

   - o Revising federal health manpower policy to discourage increases in physician supply and to provide incentives for change in specialty and geographic distribution.
   - o Seed money to expand HMOs and other innovative settings, helping to ensure consumers a wider choice among delivery systems.
   - o Improving efficacy and productivity through assessment of new technology and procedures.
   - o Expanding programs that provide basic primary care for the neediest of the nation's underserved areas.
   - o Implementing fully the proposed Mental Health Systems Act now before the Congress.
   - o Continuing to build disease prevention and health promotion through preventive dental services in Title I schools; anti-smoking, drinking moderation, nutrition and exercise campaigns; effective screening programs, and community based health fairs.
   - o Expanding government-wide efforts to eliminate the causes of disease through prevention of accidents and through occupational and environmental health programs.

3. Results:

   - o Coordination among federal grant efforts, while maintaining Congressional jurisdiction and valuable oversight of individual programs.
   - o Important incentives for change not possible with an insurance initiative alone.

IV. Conclusion

In summary, it is rarely possible to solve every problem in an important sphere of our national life with a single bill. Proceeding step by step, we can help millions of people -- people whose needs must not go unmet while we wait for the noble dream of comprehensive coverage for all to be realized.

Medicaid, Medicare and the proposed Child Health Assurance Program (CHAP) are incremental in nature. Phase I of the National Health Plan will be another, very major step toward equitable, adequate and cost conscious health protection for all Americans.

At the same time, as we approach our ultimate goal the broader vision must be clear. The National Health Plan set forth in this paper provides the context for orderly growth toward the universal comprehensive coverage this Administration supports.

JUNE 12, 1979

SUMMARY FACT SHEET:
PRESIDENT CARTER'S
NATIONAL HEALTH PLAN LEGISLATION

I. THE BASIC APPROACH

President Carter is committed to a universal, comprehensive National Health Plan that

- provides basic health coverage--hospitalization, physician services, lab-tests, X-ray and preventive care--to all Americans;
- systematically contains health cost inflation; and
- reforms the health system to improve the quality, efficiency and availability of health care services.

In a time of budgetary restraint and concern about inflation, it is not possible to enact a full universal, comprehensive plan. Accordingly, in order to address the most pressing health needs of the nation, the President has decided to send the Congress an outline of a complete National Health Plan and propose legislation embodying Phase I of that Plan. The Phase I legislation will

- achieve universality by setting a limit on the out-of-pocket costs faced by American families as a result of major illness. This dramatically improves protection for 56 million workers and their families (who will have a $2500 limit) and 24 million aged and disabled who do not now have such protection (and who will have a $1250 per person limit);
- achieve universality by providing all pregnant women and children in the first year of life with critical pre-natal, delivery, and infant services;
- achieve greater equity by extending fully subsidized comprehensive care to an additional 15.7 million aged and non-aged poor;
- hold down costs through physician reimbursement reform and limits on capital expenditures as a complement to the already pending hospital cost containment bill; and
- reform the health care system by enhancing competition, increasing access to needed health care services, emphasizing prevention and improving the management of public health care programs.

In so doing, the Phase I legislation will take a major step toward a fully developed, universal, comprehensive National Health Plan.

II. THE BASIC PROBLEMS

A National Health Plan--not just a National Health Insurance proposal--is needed because this nation's Health Care system, despite its many strengths, also has serious flaws:

- Inadequate Coverage:
  - -- 18 million Americans have no health insurance
  - -- 19 million Americans have inadequate health insurance
  - -- An additional 46 million have inadequate protection against the cost of major illness.
- Escalating Costs
  - -- Total health costs in 1979 are 9.1 percent of the GNP ($206 billion)--and will rise steeply to 10.2 percent of the GNP ($368 billion) by 1984 without hospital cost containment.
  - -- Federal health costs in 1979 are 12.7 percent of the Federal budget ($62 billion)--and will rise steeply to 14.5 percent of the budget ($110 billion) in 1984 without hospital cost containment.
- Other System Failures. For example:
  - -- There is little competition even though the Administration is removing barriers to the growth of alternative methods of health care delivery and reimbursement. There are not yet enough Health Maintenance Organizations to give many consumers a real choice, although with 8 million members, HMO's are emerging as a significant element in health care.
  - -- There is an insufficient emphasis on prevention, primary care and outpatient services. Existing insurance often does not cover these more effective, less expensive services.
  - -- 51 million Americans live in medically underserved areas.

III. THE BASIC STRUCTURE

President Carter's National Health Plan legislation proposes two basic structures that will help meet immediate needs and that can be expanded to achieve a universal, comprehensive plan (as described in the outline submitted to the Congress with the proposal).

- Healthcare will be a new umbrella Federal insurance program that will consolidate Medicare and Medicaid in a single administrative structure, that will introduce needed economies and efficiencies and that will reduce fraud, abuse and waste in public health financing program.

-- It will, to the maximum extent possible, use the private sector--on a competitive bid basis--to perform critical administrative functions

-- It will provide comprehensive coverage to the aged, the disabled and the poor.

-- It will offer insurance against major medical expenses, on an optional basis, to other individuals and to small firms unable to obtain such coverage from private carriers at a reasonable price.

- The Employer Guarantee builds on present group coverage and the strengths of the private insurance system. It is the fundamental mechanism for ensuring coverage for American workers and their families.

-- Many employers presently offer insurance to employees; the "employer guarantee" mandates that all employers provide minimum coverage. In Phase I, employers will be required to provide full-time employees and their families both a standard package of benefits and protection against the costs of major illness.

-- Subsequently, the employer guarantee can be expanded to require provision of comprehensive health care coverage by reducing the level of employee cost-sharing.

IV. IMPACT OF PHASE I

President Carter's National Health Plan Legislation will significantly improve health protection for every American: the aged and the disabled, the poor, the employed and their families, and all others.

A. The Aged and the Disabled

- Phase I will improve coverage for all 24 million now receiving Medicare

-- For the first time, the cost [illegible]ing faced by the aged and the disabled will be limited--to $1250 per person. (At present the aged and the disabled must pay coinsurance of 20 percent on all Medicare physician services.)

-- After the first day, the aged and the disabled will be entitled to an unlimited number of fully subsidized hospital days. (At present, the number of fully subsidized days is limited.)

-- The aged and the disabled will not face extra physician bills beyond those covered by Healthcare because physicians treating aged and disabled patients will be able to charge no more than the publicly set fee. (At present, physicians treating Medicare patients can charge extra, and about half do.)

- Phase I will increase the number of low-income aged and the disabled receiving fully-subsidized care by 1.2 million, from the 4 million presently receiving Medicaid to 5.2 million who will be covered under Healthcare.

B. Low-Income

- Phase I will provide fully subsidized comprehensive coverage to an additional 14.5 million non-aged low-income persons, as well as continuing to provide such coverage to the 15.7 million presently receiving Medicaid.

  -- The legislation will automatically make eligible for comprehensive care an additional 10.5 million non-aged poor with incomes below 55 percent of the poverty standard, who are not on Medicaid.

  -- In addition, the legislation will propose a "spend-down" provision to cover all those poor with incomes above 55 percent of the poverty standard. If a family of four has income of $5100 and it expends $1000 or more on medical expenses, it then "spends-down" to or below the 55 percent of poverty level ($4100 for a family of four) and becomes eligible for a year's fully-subsidized comprehensive care under Healthcare. An estimated 4 million will enter Healthcare by this route each year.

C. Employed

The mandated employer coverage required by the Phase I legislation will protect 156 million full-time workers (25 hours per week, 10 weeks) and their families by limiting out of pocket expenses to $2500 in a year. It will also provide prenatal, delivery and first year care without any patient cost-sharing.

- 56 million will receive protection against major illnesses that they do not have at present.

- These 56 million and tens of millions who already have group coverage against major illness will receive other improved benefits because the employer guarantee requires that:

  -- the employer plan offer a full benefit package (hospital, physician, lab, x-ray, preventive and mental health services) that would be available after $2500 in out-of-pocket expenses had been incurred.

  -- the employer plan pay at least 75 percent of the mandated premium costs; and

-- The employer plan continue to provide insurance 90 days after termination of employment.

-- The employer plan cover all dependents until age 22 (26 if in school) and for 90 days subsequent to the death of the worker.

-- The employer plan cover the mother and infant benefit discussed above.

D. All others

For the non-aged/non-disabled, non-poor, and non-employed--many of whom often have a difficult time obtaining individual insurance--Healthcare will

- Offer protection against the costs of major illness--by paying a premium to Healthcare, individuals can obtain a policy that limits out-of-pocket expenses to $2500.

- Offer just prenatal, delivery and first year care without any patient cost-sharing.

These individuals include the part-time employed, early retirees, divorcees and partially disabled individuals who do not qualify for Medicare.

V. OTHER PLAN FEATURES

A. Financing

1. The Aged and the Disabled. The present payroll tax of 1.05 percent on both the employer and the employee will continue to be paid to the Health Insurance Trust Fund. But there will be no payroll tax increases under Phase I. Similarly, the aged and the disabled will continue to pay a premium for physician services (presently $98), but the cost of this premium will count towards the $1250 per person out of pocket limit. In short, other than the premium for physician services, benefits for this group will be financed out of Trust Fund and general revenues.

2. The Low-Income. Benefits will be financed out of general Federal and State revenues. States will continue to contribute in an amount approximating what they otherwise would have paid under Medicaid, reduced by fiscal relief.

3. The Employed. Employers will pay at least 75 percent and employees at most 25 percent of the premium costs of the mandated plan. The National Health Plan Legislation will also address two special aspects of the employer mandate.

-- For the low wage or high risk employer, Phase I will provide a full subsidy for premium costs that, due to the premium, exceed 5 percent of payroll.

-- For the low-income worker with a family, Phase I will expand the Earned Income Tax Credit--beyond the expansion already proposed in the Administration's welfare reform proposal--to help defray employee premium costs.

4. All Others. The benefits offered to this group will be financed out of general revenues and individual premium payments to Healthcare.

B. Administration

- The private insurance industry will administer the "employer guarantee" consistent with National Health Plan standards. It will, of course, continue its role of underwriting and marketing private coverage to employed groups and individuals both within the standards and beyond those minimum requirements.

- The Federal government will administer Healthcare but make maximum use of private industry as carriers and claims handlers on a competitive bid basis. It will take over from the States the claims processing and reimbursement function and merge this function for both the low income and aged and disabled populations in order to reduce error and waste to the greatest extent possible in Federally-financed health programs.

- The States will continue their traditional functions of certification and licensure of health facilities and personnel as well as general regulation of private insurance. They will continue to determine eligibility for those who qualify for Healthcare through AFDC.*/ The Federal government will determine eligibility for other low-income entrants to Healthcare, although States may undertake this function for the newly eligible if they meet performance standards.

C. Reimbursement

1. Hospitals. The Administration's Hospital Cost Containment legislation will establish the conditions for reimbursing hospitals and holding down costs in this most inflationary sector of the health care industry.

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*/ Long-term care is not part of Phase I. The present Medicaid long-term care program will continue as a separate State-run program for the categorically eligible with the present Federal-State matching rates.

2. Physicians

-- A mandatory fee schedule will be established in order to protect the aged and the disabled from extra physician charges and to increase physician participation in the low-income program. This schedule will be developed, in the first instance, by setting a standard fee at the Medicare average in States or Sub-State areas and then raising substandard Medicaid fees in those areas to that level over time. Physicians cannot charge--or be reimbursed--above the fees established in the schedule. A process of negotiation will be established for subsequent fee schedule changes.

-- On the private side, the Healthcare fee schedule will serve as an advisory schedule for physicians serving those covered by the "employer guarantee." The names of physicians who are willing to adhere to the schedule will be published in order to increase consumer choice. A commission will be established to look at reimbursement questions and to advise whether more stringent measures are necessary to hold down health costs and increase physician participation in the public programs.

D. System Reforms

1. The Phase I legislation will include the following system reform elements:

- Increased competition through development of HMOs and other alternative delivery and reimbursement systems, greater employee access to and incentives to use efficient health plans and greater consumer information about doctors fees.

- Limits on capital expenditures to reduce excess hospital capacity and to curb proliferation of expensive, unnecessary high technology equipment.

- Strong emphasis on prevention.

- Creation of a voluntary Reinsurance Fund that will allow HMOs and firms to buy protection against the costs (over $25,000) of truly extraordinary illness, thus providing protection for businesses to self-insure and have a direct interest in cost containment as well as giving HMO's umbrella protection in handling high risk populations.

- A five year plan to assess needs and the adequacy of Federal health programs.

2. Other Administration initiatives will complement the Phase I bill, including:

- health planning legislation
- health manpower legislation to improve physician distribution, both in terms of needed specialities and geography
- mental health legislation
- health promotion and other initiatives to prevent disease, illness and injury.

E. Fiscal Relief

There should be significant fiscal relief in the program. Approximately $2 billion dollars in fiscal relief will be distributed to State, county and local governments in each of the first two years of the program.

VI. COSTS

There will be no Federal expenditures under the National Health Plan Legislation until Fiscal 1983.

The costs of the program in the first full year of operation are as follows (this assumes 1980 population as well as 1980 dollars):

NET FEDERAL BUDGET AND EMPLOYER COSTS
(in billions: 1980 dollars)

		Federal	Employer
AGED AND DISABLED		$3.9	
-- Improved catastrophic	(1.8)		
-- Improved subsidy for poor and near poor	(2.1)		
LOW INCOME (NON-AGED)		$10.7	
-- Full coverage	(6.9)		
-- Spend down protection	(3.8)		
EMPLOYED			
-- Employer Guarantee			$6.1
-- Low income worker: premium subsidy		$ .9	
-- Small employer premium subsidy (for mandated coverage)		$ .7	
ALL OTHERS		$ .5	
-- Healthcare buy-in	(.3)		
-- Prevention	(.2)		
ADMINISTRATION		$2.1	
TAX EFFECTS		-$.6	
	TOTAL	$18.2	$6.1

Assuming 1983 dollars and 1983 population, very preliminary estimates of the Federal cost of Phase I are in the range of $23-25 billion. In the coming weeks, the Administration will work with CBO and others to refine these estimates.

VII. RELATION OF PHASE I TO A FULLY IMPLEMENTED NATIONAL HEALTH PLAN

Phase I is structured so that it can easily be converted into a universal, comprehensive plan.

- For the aged and the disabled, cost-sharing could be reduced further and a drug benefit added.
- For the poor, the low income standard could be raised from 55 percent of the poverty line to the poverty line itself, increasing the number of low income Americans who receive fully-subsidized comprehensive coverage.
- For the employed, the employer guarantee could be extended beyond full-time workers to part-time workers. Cost-sharing could be reduced and deductibles eliminated, converting catastrophic coverage to comprehensive coverage.
- For the non-aged, non-poor, non-employed, comprehensive coverage could be required, but there could be subsidized premium costs and cost-sharing for the near poor.
- For all mothers and children, the prenatal, delivery and infant benefit could be extended through the child's sixth year without patient cost-sharing.

The fully implemented National Health Plan would also meet a fundamental requirement: Total health system costs under the fully implemented plan, with both dramatically expanded coverage and effective cost containment, would be less than the present health system with its inadequate coverage and without effective cost containment.

This will result in the achievement of one of President Carter's fundamental goals. The costs of vitally needed health care benefits for those lacking adequate health insurance must, to the greatest extent possible, be offset by savings from cost containment in the inflationary health care industry.

APPENDIX:
COMPARISON OF THE COSTS OF PRESIDENT CARTER'S
NATIONAL HEALTH PLAN LEGISLATION (PHASE I)
WITH
THE HEALTH CARE FOR ALL AMERICANS ACT

The Administration's legislative proposal and the proposal announced several weeks ago present their costs in two different ways. In order to understand the differences between the two proposals it is helpful to compare them both ways. This is done below assuming 1980 dollars and 1980 population counts.

(When the Health Care For All Americans Act was announced it was costed in 1980 dollars using estimated 1983 population counts. By using 1980 population counts, the estimates below reduce the costs of the Health Care For All Americans Act slightly.)

- The Administration's approach looks primarily at net Federal budget and employer costs because taxpayers and employers are the ones being asked to shoulder the cost of new benefits. The costs to employers are especially vital in determining the employment and inflation effects of National Health Plan proposals. When viewed this way, the net costs of the two proposals are as follows:

	Phase I	Health Care For All Americans Act
Federal	+$18.2	+$30.7
Employer	+$ 6.1	+$33.1
COST	+$24.3 billion	+$63.8 billion

- The approach taken by the advocates of the Health Care For All Americans Act is to look at these and other costs now borne by individuals and state and local governments as well in order to determine the effect of National Health Plan proposals on total health system costs.

	Phase I	Health Care For All Americans Act
Federal	+$18.2	+$30.7
Employer	+$ 6.1	+$33.1
Individuals	-$ 4.0	-$25.4
State/Local	-$ 2.0	-$2.7
COST	+$18.3 billion	+$35.7 billion

* Includes reduced out-of-pocket and premium costs.

DETAILED FACT SHEET: June 12, 1979

PRESIDENT CARTER'S

NATIONAL HEALTH PLAN LEGISLATION

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NATIONAL HEALTH PLAN FACT SHEET

I. THE BASIC APPROACH: A PHASE I BILL THAT LAYS THE FOUNDATION FOR A UNIVERSAL AND COMPREHENSIVE NATIONAL HEALTH PLAN

President Carter is committed to a National Health Plan that would:

-- assure all Americans comprehensive coverage including protection against the costs of major illness;

-- eliminate those aspects of the current health system that often cause the poor to receive substandard care;

-- reduce inflation in the health care industry;

-- be financed through multiple sources; and

-- include a significant role for the private insurance industry

Following the President's instructions, the Department of Health, Education and Welfare last year developed a plan meeting these criteria. Leaders of Congress, State and local officials, consumer groups, health care providers, the insurance industry, employers and other interested parties were then consulted.

Following those discussions, Secretary Califano reported to the President that there was a general consensus among these groups that a comprehensive universal health insurance plan would not be enacted in the 96th Congress. The President accordingly directed Secretary Califano to design a Phase I Plan that could lay the foundation for a comprehensive health plan while immediately addressing the nation's most pressing health needs.

The President is now submitting to Congress:

o an outline of the universal, comprehensive national health plan which should be the goal of a national health policy; and

o a proposal for the first phase of this plan.

II. PROBLEMS: THE NEED FOR A NATIONAL HEALTH PLAN

There are three sets of problems facing our health care system today which can be effectively addressed only through a national health program.

o Lack of Coverage. Millions of Americans lack coverage for basic health services and protection against the rising cost of major illness.

— 18 million Americans have no health insurance — most of these people are poor or near-poor.

-- 19 million Americans have inadequate health insurance coverage that fails to cover ordinary hospital and physician services.

-- an additional 46 million Americans have inadequate insurance against large medical bills. These individuals and families may have basic coverage but they are not protected against major medical expenses.

Eligibility policies of public programs -- coupled with restrictions in private health insurance -- are largely reponsible for these gaps in coverage.

-- Medicaid fails to cover millions of poor Americans. For example, more than 10 million individuals with incomes below 55% of the official poverty standard are not covered by Medicaid.

-- Many employers do not offer insurance to their workforce. 10.1 million full-time workers have no insurance. Another 18 million are not covered by employer or union group health plans. Employees who have coverage find that, during periods of unemployment, their health insurance lapses but they are ineligible for public programs.

— The average family often finds that common exclusions and limitations in insurance severely restrict their protection. Literally millions find their coverage restricted because they suffer from a pre-existing medical condition. Thus, people with heart trouble may find their insurance excludes all treatment of heart-related problems. Many middle-class families learn that, when a child becomes 21 years old, he or she is no longer included in the family's insurance, although the child is frequently not able to afford separate coverage.

o Inflation in the Health Sector. The costs of health care are sharply increasing, adding to inflation and threatening the stability of governmental budgets. Spending for health care -- the nation's third largest industry -- rose at an average annual rate of 12.7 percent from 1968 to 1978. Unless meaningful cost containment measures can be instituted through hospital cost containment and effective restraints in a national health plan:

-- National health costs will rise from $206 billion in 1979 to $368 billion in fiscal year 1984 -- up from 9.1% of GNP to nearly 10.2%.

-- Federal health care expenditures will rise from $62.0 billion in 1979 to nearly $110 billion by FY 1984 -- up from 12.7 cents of every Federal tax dollar to 14.5 cents under current projections for that year (without hospital cost containment).

-- The cost of individual health care will rise steeply. The average cost for a family of four will leap from $2372 in 1979 to $4064 in 1984, and the average cost for an elderly individual will soar from $2259 to $3868 during the same period.

- Inefficiency of the Health Delivery System. The health care delivery system is financed in large part through a system of third-party (insurance) payments that pay institutions on the basis of "cost" reimbursement and pay professional providers their "usual and customary" fee.

  -- over 90% of hospital bills are paid by third parties

  -- hospitals are reimbursed by an inefficient "cost plus" system which gives them no incentive to save on costs because the more they spend the more they get paid

  -- there is no buyer/seller relationship; physicians make 70% of health care decisions but have no incentive to hold down costs.

  There have been very few market incentives operating to restrain costs and encourage prudent use of resources. This system of payments has contributed powerfully to inflation in the health sector, and has also:

  -- Inhibited competition among providers. Consumers frequently have no incentive to choose the most economical method of care and little information upon which to base such a choice.

  -- Encouraged maldistribution of health care providers. Highly specialized practices -- almost always in urban areas -- are rewarded much more generously than primary care and rural practice, leaving rural areas and inner-cities underserved.

  -- Discouraged the growth and utilization of preventive services. Insurance benefits are heavily prejudiced in favor of hospital-based care and against preventive and primary care. Very few insurance plans provide coverage for routine preventive services such as immunizations and regular check-ups for infants.

III. MAJOR PROGRAM ELEMENTS

A. An Overview

The President's Phase I NHP is designed to address the most urgent of these problems and to put into place the institutional structures necessary to guarantee comprehensive coverage for every American. It builds on the strengths of our present system -- for example, employment based coverage of the working population -- while at the same time providing new structures to make coverage universally available.

There are two major institutional features of the Phase I bill:

- o HealthCare will be a new umbrella Federal insurance program that will consolidate Medicare and Medicaid in a single administrative structure, that will introduce needed economies and efficiencies and that will reduce fraud, abuse and waste in public health care financing programs.

  -- It will, to the maximum extent possible, use the private sector -- on a competitive bid basis -- to perform critical administrative functions.

  -- It will provide comprehensive coverage to the aged, the disabled and the poor.

  -- It will offer insurance against major medical expenses, on an optional basis to other individuals and small firms unable to obtain such coverage from private carriers at a reasonable price (a comparable subsidy will be provided should these employers prefer to purchase insurance privately).

- o Mandated Employer Coverage (The Employer Guarantee) All employers will be required to provide full-time employees (25 hours, 10 weeks) with insurance which meets Federal standards. Premium costs can be shared with employees, (75%/25%), but employers must pay at least 75% of the total.

The majority of employers will purchase this coverage from private insurance firms which sell plans certified to meet the Federal standards. Employers for whom insurance premiums would impose significant burdens will have the option of purchasing coverage from HealthCare at subsidized rates, or of applying to HealthCare for a comparable subsidy which can be applied to private premiums.

Over time, the terms of the employer guarantee can be modified to achieve a more comprehensive level of coverage than Phase I by first reducing the maximum beneficiary cost-sharing permitted (e.g., it could be reduced to $1500 per family) or subsequently through expanding the benefit package to broaden coverage of certain services that have been limited or excluded from the initial mandate.

These two insurance structures together -- HealthCare and approved private insurance plans -- together will provide every American with the opportunity to obtain insurance protection in Phase I. Equally important, it will put into place institutional structures which can be expanded -- in large or small steps -- to move toward a universal and comprehensive plan.

The Phase I NHP links together HealthCare and private insurance plans so that policies of national importance can be made consistent across the public insurance plan and all private plans. For example, all private plans will cover, at minimum, the HealthCare basic benefit package, reimburse all classes of providers recognized under the HealthCare program (e.g., clinics, nurse practitioners, alcohol treatment centers), and include incentives for system reform.

Thus all Americans will understand the basic coverage to which they are entitled; providers will face more consistent policies from public and private insurance plans, and both public and private incentives for cost control and system efficiency will work in tandem, not in opposition to each other. An example of consistent cost containment policy across public and private plans is the hospital cost containment plan which will limit payments to hospitals by both public and private insurance programs.

B. HealthCare

HealthCare will be a new Federal insurance plan which expands Medicare for the aged and disabled and replaces Medicaid as an insurance program to pay for acute care services used by poor families.

HealthCare is a new insurance structure which can be flexibly adapted over time to solve a number of special coverage problems which do not readily lend themselves to solution through the private sector. HealthCare will:

- Establish uniform and consistent policies governing eligibility, benefits, cost-sharing, reimbursement and quality assurance for the beneficiaries of Federal health insurance: the aged, low-income and disabled. This will improve program performance for each beneficiary group:

  -- the aged and disabled will have an expanded, integrated benefit package which removes the current dichotomy between Medicare "Part A" (hospitalization) and "Part B" benefits (physician services) and does away with limits on hospital coverage.

  -- aged and disabled beneficiaries currently enrolled in both Medicare and Medicaid (4 million individuals) will deal with a single program -- HealthCare. This will simplify enrollment and program contacts for the beneficiaries and will enable the program to handle their claims more efficiently and expeditiously. At present, claims for these beneficiaries are paid by both State Medicaid programs and Medicare. Co-ordination of claims payment between the State and Federal programs often results in long payment delays for physicians and other providers.

  -- the low-income will benefit from national minimum eligibility standards for acute care services. At present, there are 53 separate Medicaid programs, each with differing standards governing eligibility and benefits.

  -- the low-income as well as the aged and disabled will benefit from the new provider payment policy. The low-income will have greater access to mainstream medicine because HealthCare will pay physicians a higher fee than most Medicaid programs. The aged will be protected against excess physician fees that are higher than the HealthCare approved rate.

- Increase administrative efficiency and improve quality assurance activities by establishing single claims processing agents in wide geographic areas. At present, multiple private insurance firms may handle Medicare

claims processing in a single area. The State or a private contractor handles Medicaid claims. HealthCare will select one private contractor -- for example, an insurance company or data processing firm -- to handle all claims in a State or multi-State area. This will:

- -- reduce contracting costs by the award of contracts on the basis of competitive bids. At present, Medicare must honor the claims agent designated by providers. However, experiments in several areas show that contracts awarded on the basis of competitive bids are significantly less costly.

- -- enable economies of scale in bill processing. One contractor in a geographic area will be able to utilize efficiently advanced claims processing technologies such as on-line computer terminals for billing in every hospital. Hospitals, physicians, and other providers will also realize efficiencies in billing. Use of one agent and a single claims form will permit bulk billing and faster cash flows to physicians.

- -- enhance program ability to identify fraud and abuse problems by establishing a single identifying number for all participating providers. Computer profiles maintained by the claims processing agent should permit ready identification of those providers whose billing patterns indicate an abnormal volume of claims or other questionable practices.

These management improvements are not feasible under current law because Medicare requires DHEW to employ the fiscal agent designated by providers in the area and because there cannot be administrative integration of Medicare with the 53 separate Medicaid programs. The State-by-State variations in benefits, provider participation policy, reimbursement policy and other administrative features makes integration of the two programs almost impossible even if the hurdle of Federal/State management control could be surmounted.

- o Establish a new national insurance structure which can provide assistance to those individuals and employment groups whose special problems make it difficult for them to be adequately served by the private insurance market.

  - -- Non-employed, non-aged or non-low-income individuals whose health is poor or who have a history of serious medical problems in the past (a "pre-existing" medical condition).

These individuals cannot generally obtain insurance in the private market or, if it is available, must pay exorbitantly high premiums or accept a policy which excludes the pre-existing condition.

— Non-aged spouses of workers who have reached age 65. Once the worker enters HealthCare, or today, Medicare, spouses often have great difficulty in obtaining private insurance. This problem is most troublesome for women in their late 50s or early 60s who are not employed outside the home. They will be able to buy HealthCare.

— Individuals who work intermittantly and in hazardous occupations. Private insurance plans are customarily reluctant to insure these individuals. They will be able to buy HealthCare.

-- Employment groups which have a concentration of high-risk individuals or those in which the nature of work is so hazardous that private plans are not available or available only at an exorbitant premium. They will be able to buy HealthCare.

For these kinds of individuals and groups, HealthCare will be available to make adequate coverage available at a reasonable premium.

Specific features of the HealthCare plan are summarized below:

1. Eligibility

o Aged and disabled. Medicare eligibility standards would continue under HealthCare for all persons over age 65 and those persons under age 65 who meet the Social Security test of total and permanent disability, or who suffer chronic renal failure. The 500,000 aged persons who do not have sufficient quarters of coverage to gain entitlement but whose incomes are less than 55% of poverty will also be enrolled in HealthCare.

- o The Low-Income. There are three eligibility gates into HealthCare for the low-income:

  -- Through cash assistance eligibility. All persons who qualify for cash assistance under the program for Aid to Families with Dependent Children (AFDC) or Supplementary Security Income (SSI) will be automatically enrolled in HealthCare at the time they qualify for cash assistance payments. Eligibility will extend to all cash assistance recipients including those who do not currently qualify for Medicaid because of optional State restrictions and those who would not automatically qualify for Medicaid under the Administration's Welfare Reform proposal (newly mandated AFDC-U families). Eligibility levels for AFDC and SSI families will vary by State, mirroring the cash assistance standard in that State.

  -- Through the national low income standard. Other individuals or families whose incomes are less than the HealthCare low income standard -- equivalent to 55% of povertyin Phase I -- will also be eligible for HealthCare. This is an important extension of entitlement to 10.5 million non-aged low-income perons not now on Medicaid.

  -- Through the spend-down standard. Any individual or family whose health expenses exceed the difference between their income (minus a 20% of earnings work expense deduction) and the 55% of poverty can apply to HealthCare for complete coverage of all further expenses for a year. This is an important extension of spend-down protection, now provided by only 30 States, but available nationally under HealthCare. Thus, for example, a family of four with earnings of $7000 per year could apply for HealthCare coverage through the "spend-down" if their medical, if applicable, expenses (plus certain allowances for child care) exceed $1400 (55% of poverty equals $4200 — $7000 - $1400 = $4200).

     This will provide critical assistance to 4 million additional people. In States where spend-down standards for Medicaid exceed the HealthCare standard, HealthCare will maintain the higher standard for single parent families with children and aged, blind or disabled individuals.

- o Others. All other persons can buy into HealthCare by paying the premium for individuals and small groups. The benefits purchased under this buy-in are the same as those provided to other HealthCare beneficiares, subject to a $2500 deductible on all services.

- o Employment Groups. Although employers will generally fulfill their obligations under the employer guarantee by purchasing private insurance, HealthCare will serve as a back-up insurance plan for those who find private coverage difficult to obtain or unreasonably expensive. Any employer can buy into HealthCare for the mandated coverage (HealthCare benefit package but with a $2500 deductible on all services except prenatal, delivery and infant care.)

2. Benefits

The HealthCare benefit package includes a comprehensive range of acute care services, and complete preventive as well as acute care benefits for pregnant women and infants. The benefits are similar to those provided under Medicare, with some improvements. HealthCare benefits are more generous than Medicaid benefits in about half the States, but more restrictive than in certain high-benefit States. The most significant exclusions from current Medicaid benefits are drugs, dental care, eyeglasses and hearing aids, and long term care. Drugs, dental care, eyeglasses and hearing aids will continue to be provided in a residual Medicaid program, with administration handled by HealthCare or by State governments, at the State's option. Specific benefits included in HealthCare are:

- o Inpatient hospital services (unlimited)

- o Physician and other ambulatory services (including laboratory and excluding dental and psychiatric care) (unlimited)

- o Skilled nursing service (100 days per year). These skilled nursing home benefit days are intended to permit patients who still require the support services of an institution -- but no longer the range and intensity of services provided by a hospital -- to be released from the hospital to a less costly level of care. The skilled nursing benefit will reduce the length of hospital stays for many admissions.

- o Home health visits (100 visits per year)

- o Mental health (20 days of inpatient hospital care; $1000 in ambulatory services)

- o Preventive Care. HealthCare covers two important preventive care packages

  -- complete prenatal, delivery, and total infant care (preventive and acute services) for all mothers and children

  -- a schedule of preventive services for all children up to age 18

Except as noted above, long term care services will be continued as a separate program under State Administration, financed under the current Title XIX program grant system.

3. Cost-Sharing

Different cost-sharing requirements apply to persons who enter HealthCare through the various eligibility standards.

- o Aged/Disabled. At present, the aged and disabled pay a single day hospital deductible of $160 (July 1, 1979) for each admission per "spell-of-illness" plus a $60 deductible and 20% co-insurance on non-hospital services. There is no limit on coinsurance payments. In addition the aged pay fees charged by physicians which exceed the Medicare maximum payment rate. In combination, these requirements leave the aged exposed to high and unpredictable out-of-pocket costs. That will change under HealthCare.

  Medicare cost-sharing requirements are extended to HealthCare with the following important modifications:

  -- there will be an annual hospital deductible rather than a new hospital deductible applicable to each spell-of-illness. The annual deductible will be the same.

-- no cost-sharing will be required after an individual has paid $1250 in out-of-pocket costs

-- aged persons whose income is below 55% of poverty standard have no cost-sharing. Neither do those who spend down the 55% standard.

-- All physicians bills will be assigned -- that is, physicians will be required to bill HealthCare, not the beneficiary, and to accept HealthCare's payment rate as full compensation for the service. No extra billing will be permitted.

o The Low-Income. Persons eligible because they are entitled to cash assistance or because their income is less than the low-income standard do not face any cost sharing. Individuals who enter HealthCare through the "spend-down" do not face cost-sharing after they spend-down below low-income standard. Only expenses related to services covered under the HealthCare mandate will be counted toward the spend-down.

o Others

-- Individuals or employer groups who buy into HealthCare by paying a premium, face a deductible of $2500 on all services. However, because of the importance of good pre-natal care and comprehensive health care services for all infants, a special maternity and infant benefit is provided under the HealthCare buy-in. All pre-natal care services, the costs of delivery, and total preventive and treatment costs for an infant in the first year of life will be covered under the buy-in without cost-sharing. This will remove all financial barriers to seeking care for pregnant women and infants.

4. Financing

- o Aged and disabled. The current Medicare payroll tax (1.05% on employer and employee, applied to a $22,900 earnings base) will be continued. In addition, all aged and disabled persons with incomes above the 55% of poverty standard will be required to pay a premium equivalent to the Medicare Part B premium, which is now $98. Additional subsidies will be provided through Federal general revenues to pay the cost of protecting the aged against catastrophic expenses.

- o The Low-Income

  State and local governments will continue to share with the Federal government in the costs of financing HealthCare covered services for the low-income population in a manner that will retain State incentives to restrain health cost inflation. State fiscal liabilities under HealthCare will approximate those which would have occurred under Medicaid reduced by fiscal relief

- o Others

  Individuals who buy into HealthCare will pay a national community rated premium which is based on the average per capita costs for all individuals and groups of less than 50. It will cover about 75% of their actual costs. The remaining costs will be provided through a Federal general revenues subsidy.

5. Administration

HealthCare will be a new national insurance program with uniform standards governing benefits, eligibility, provider reimbursement, quality assurance, and other aspects of law and regulation which determine the adequacy, equity, and performance of the program. As such, it will be quite similar in concept to Medicare.

Under Medicare, the same eligibility standards apply to aged and disabled persons throughout the country. All Medicare enrollees have the same benefits, cost-sharing obligations, and rights under the program, no matter where they live. Although Medicare is governed by national law and policy, it is in large measure, administered locally -- all claims processing is contracted out by HEW to "fiscal intermediaries" and "carriers", most often the local Blue Cross and Blue Shield plans.

Medicaid, by contrast, is not a national program. Eligibility standards, benefits, provider participation policy, and reimbursement rates differ among the States. Thus, equally poor individuals may be entitled to benefits if they live in one State but not entitled in another. Providers are also treated unevenly. Some States so drastically limit payments that only 25% of physicians accept Medicaid patients, while other States pay adequately. Payment error rates are high and payments are generally slow. For these and similar reasons, the program is widely criticized by beneficiaries who use it, providers who are paid by it and the taxpayers who finance it.

One of the most important objectives of the Phase I NHP is to create the framework for a national health insurance plan which is viewed as a valued part of our social insurance system. It should be equally available to all Americans -- no matter where they live. It should be viewed as treating both beneficiaries and providers fairly, equitably, adequately, and efficiently. It should be seen by the public as operating efficiently, and with accountability -- minimizing problems of fraud and abuse by providers or beneficiaries.

These are ambitious goals, and cannot be accomplished within the framework of multiple Federal and State insurance programs in which accountability is diffuse and standards variable.

Instead, HealthCare creates a new administrative structure which permits the implementation of national standards governing benefits, provider participation, reimbursement policy, quality assurance and fraud control. It will closely resemble Medicare in the sense that claims administration will continue to be handled under contract with private fiscal agents. However, because of

the multiple gates into HealthCare -- through Social Security, through cash assistance, or through the spend-down -- there will be several different agencies determining eligibility, not a single agency (as the Social Security Administration now determines eligibility for Medicare.) Regardless of how they enroll initially, however, all beneficiaries will enter the same program. Providers can be assured consistent treatment and fair reimbursement on behalf of all HealthCare patients.

Specific functions will be handled as follows:

- o All claims processing will be handled by private fiscal agents (insurance companies, data processing firms or others) covering a specified geographic area. Today, there are multiple claims agents in an area -- the Medicare intermediary and carrier and the Medicaid claims processing agent (either a State or its designee). HealthCare will shift all responsibility for management of claims processing to the Federal level. This will permit merger of this function for all aged and low-income beneficiaries, and should reduce error and waste to the greatest extent possible in Federally-financed health programs. Contracts will be awarded on the basis of competitive bids. This will reduce administrative costs, and improve speed of payment to providers. Use of a single fiscal agent will enhance our ability to detect problems of fraud and program abuse.

- o Eligibility determination will be handled by the Federal government for aged and disabled persons. States will handle eligibility determination for categorically eligible families (AFDC). The Federal government will determine eligibility for other low-income entrants to HealthCare, although States may undertake this function for the newly eligible if they meet performance standards.

6. Reimbursement

- o Hospital. Payment for hospital services under the Phase I NHP will be governed in both HealthCare and private plans by the Administration's hospital cost containment program.

- o Physicians and other providers of ambulatory care services. Physicians and others who provide ambulatory (non-institutional) services to HealthCare patients will be paid on the basis of a fee schedule. The fee schedule for physicians will be based on average Medicare physician payment levels. Medicaid fees will be brought up to the Medicare level in the three years prior to implementation of the schedule. After the first year implementation of the fee schedule, subsequent alterations in the schedule will be developed through a process of negotiation between HealthCare and physician representatives.

  All physicians who accept HealthCare patients will be required to take assignment of claims -- that is, to accept the HealthCare fee as payment in full for the service rendered. This is one of the most important new protections extended to the aged and disabled and will save them approximately $1 billion in charges now billed by physicians. This will protect all HealthCare beneficiaries from being billed for excess physician fees. Private plans will be encouraged use the HealthCare fee schedule as a guide in determining their rates of payment.

7. System Reform

Many serious problems in the U.S. health care system will not relieved by insurance changes alone. NHP is designed as an umbrella, incorporating important non-insurance system reform supplements to guarantee access to care, redirect and improve distribution of resources and promote efficiency and competition.

- o A new process for assessing health needs and determining the adequacy of federal programs. This program will require a five-year plan for each relevant federal program.

- o Strengthening the health planning by imposing national and State limits on hospital capital spending, as noted.

- o Measures to increase competition by encouraging HMO enrollment, as also noted.

- o Expanding utilization review

In addition, the following legislative and administrative initiatives already under way will be part of the NHP system reform effort:

- o Revising federal health manpower policy to prevent a potentially costly physician surplus and to provide incentives for change in specialty and geographic distribution.

- o Seed money to expand HMOs and other innovative settings, helping to ensure consumers a wider choice among delivery systems.

- o Improving efficacy and productivity through assessment of new technology and procedures.

- o Expanding programs that provide basic primary care for the neediest of the nation's underserved areas.

- o Implementing fully the proposed Mental Health Systems Act now before the Congress.

- o Continuing to build disease prevention and health promotion through preventive dental services in Title I schools; anti-smoking, drinking moderation, nutrition and exercise campaigns, effective screening programs, community based health fairs and environmental improvements, WIC, occupational health and safety and other relevant programs throughout the government.

C. The Employer Guarantee

All employers will be required to provide full time workers (persons who have worked at least 25 hours per week for 10 consecutive weeks) and their families with a health insurance plan which meets Federal standards. For the 100 million workers and their families who now have coverage the effect of the guarantee generally will be to enrich their benefit package by adding important new protections such as mental health coverage and skilled nursing care. But for the 56 million workers and their families who do not now have insurance providing comprehensive protection against catastrophic costs, the guarantee will provide important new financial security against bankruptcy.

Insurance companies marketing plans to meet Federal standards and clearly designate those policies which meet Federal requirements.

The requirements of the mandate encompass benefits, cost-sharing liability, extensions of coverage after termination of employment, to spouses and dependents in the event of death of the wage earner or divorce; plus other consumer protection standards. All employers must offer their employees a choice between an insurance plan meeting Federal standards and enrollment in any Federally qualified HMO (or Independent Practice Association -- IPA) in the area.

1. Eligibility. All full-time employees, their spouses and dependents. Dependents include children through their 22nd birthday or through age 26 if enrolled in school on a full-time basis or otherwise a dependent of their parent. Children disabled before their 22nd birthday are continued as dependents as long as they live with their parents. Any employer who fails to meet his obligations under the mandate will be subject to a fine. The self-employed will be treated like any other employer.

2. Benefits and Cost-Sharing: The benefit package in the employer plans must include the same services as those insured under HealthCare. The employer may agree to provide broader benefits, but cannot provide a smaller package. For most employed persons and their families, cost-sharing under the plan will be relatively limited because employers will continue and improve coverage now in force. However, no individual or family will face cost-sharing in excess of $2500 per year for services covered under the mandate. Within this constraint, employers (and unions) may arrange any combination of cost-sharing ranging from complete coverage without cost-sharing to a $2500 deductible on all services. One exception will be applied: there can be no cost-sharing on pre-natal and delivery services for a pregnant woman or for all acute care provided to an infant in the first year of life. These special preventive services are recognized to have extremely high pay-off in terms of improved delivery outcome, lowered infant and maternal mortality, and long term child health. Therefore, all financial barriers to seeking these services will be eliminated.

3. Financing and Special Subsidies. Employers will be required to pay at least 75% of the premium cost for a plan meeting the Federal mandate standards. Higher employer premium shares can, of course, be agreed to in collective bargaining. Today more than 85% of workers with employer-financed insurance are covered in plans where the employer pays at least 75% of the premium. Any collective bargaining agreements in force that call for higher employer shares when Phase I NHP is implemented will be protected for the life of the contract.

   Because premiums are assessed by private insurance companies on the basis of the health risk presented by an employment group and the composition of that work force -- e.g. the number of workers with families -- a traditional premium will create problems for marginal firms andlow-wage workers, particularly workers with families. In order to protect employers and low-wage workers from undue hardship resulting from premium payments, several special subsidies are included:

   - Employers will not be required to spend more than 5% of payroll on a mandated plan. (On average, employers who now provide no coverage will be able to buy the mandated package from insurance firms for 2.5% of payroll.) Subsidies for costs in excess of 5% will be available by buying coverage from HealthCare at a premium rate equal to 5% of payroll or by applying for an equivalent subsidy to purchase coverage from private insurance firms. Data limitations prevent a precise estimate of the number of firms that would be likely to take advantage of this subsidy provision. However we are able to estimate that firms employing approximately 7 million workers (out of a work-force of 73 million full-time workers) might take advantage of one of the two subsidy options.

   - The Earned Income Tax credit which assists low-income working families will be expanded to provide a maximum benefit of an additional $150 to largely offset the cost of the employee premium share for such families.

5. Administration. Phase I NHP establishes national minimum standards for all health insurance plans provided to meet the employer mandate. To assure uniform application of these standards, the certification process will be Federally administered. The Federal government will also offer a reinsurance program to health maintenance organizations, employers and small insurance companies.

   o Standards for employer plans: All employers will be expected to provide coverage conforming to Federal standards, whether they obtain this coverage through private insurance companies, HealthCare, provide it by self-insuring or through multi-employer trusts. The purpose of the standards is to assure consumers adequate protection and information about their insurance coverage, and to link private coverage standards with HealthCare to achieve a national guarantee of basic protection. To meet the conditions of the employer mandate a plan must:

   — provide, at a minimum, the HealthCare benefit package with a maximum out-of-pocket liability of $2500 policy. Plans may include any cost-sharing configuration desired, so long as the out-of-pocket limit is retained. However, there will be no cost-sharing for pre-natal and delivery services for pregnant women or preventive and acute care services provided to an infant in the first year of life.

   — provide the same benefits to all persons. There will be no waiting period for coverage after the 10th week of employment, and coverage must continue at least 90 days after termination of employment, or after the death of a worker or divorce of a worker and spouse.

   — not limit or exclude coverage due to pre-existing conditions; provide care for newborns and have no restrictions on coverage or benefits for those in poor health.

— cover spouses, dependents, including children (and adopted children) up to age 22, (or age 26 if a full-time student or otherwise a dependent of the wage-earner) and children disabled prior to age 22, if living with their parents. Employees and/or their dependents must be given the right to continue to buy comparable individual plan from the insurance company after termination of employment, regardless of their health risk.

— provide adequate, clear information regarding policy provisions, benefits, costs and conform to any further public disclosure requirements or standards for policies.

— publish a reasonable relationship of premiums charged for qualified plans to benefits paid to policyholders.

o Enforcement of Standards. DHEW will review and certify all private plans. Similar standards and certification processes will be applied to insurance companies seeking to market to employer groups and to self-insured plans of a single employer or a multi-employer employer trust. States will continue most of their insurance regulatory activities (e.g., review of premiums and plans for financial solvency). While traditional State roles in insurance regulation will be largely preserved, the Federal government has a responsibility to assure that plans purchased under the mandate are uniform and meet minimum standards. In the event of a conflict between the Federal mandate and State requirements, the Federal standards will be primary.

An insurance company which alters a previously qualified health insurance plan -- or otherwise misrepresents a plan as conforming to Federal standards when it does not -- will be liable for several penalities:

-- The company will not be allowed to market any health insurance under the Federal program for a specified period.

-- The company will be assessed a financial penalty.

-- The company will be liable for civil suit and subject to criminal penalties.

o Reinsurance Program. Creation of a voluntary Reinsurance Fund that will allow HMOs and firms to buy protection against the costs (over $25,000) of truly extraordinary illness, thus providing protection for businesses to self-insure and have a direct interest in cost containment as well as giving HMOs umbrella protection in handling high risk populations.

6. Reimbursement

o Hospitals. Payment for hospital services in approved private plans, as in HealthCare, will be based on implementation of the Administration's hospital cost containment program.

o Physicians and other ambulatory care services. The issue of what -- if any -- restraints should be placed on payment to physicians under participating private insurance plans was one of the most difficult questions to resolve in designing Phase I of NHP. Clearly, fee schedules and mandatory assignment are essential components of HealthCare plan; needed to control costs, protect beneficiaries, and institute more equitable reimbursement rates for primary care physicians than exist in Medicare and Medicaid today.

Extension of the same fee schedule to private plans and requirement of mandatory assignment plans were considered, but rejected, for Phase I NHP. Instead, the Phase I, NHP will attempt to stimulate competition among providers and assist beneficiaries in knowing which physicians accept insurance payments as full compensation for a service.

-- The HealthCare fee schedule will be furnished on an advisory basis to all insurance plans marketing coverage to meet the employer mandate. Plans may use -- or not use -- the schedule in guiding the rates they will pay for a given service.

-- Insurance plans will furnish enrollees with lists of physicians in the State who agree to accept the insurance plan's reimbursement as full compensation for their services. This will enable consumers to make a better-informed choice of physicians.

-- The various incentives to establish or expand pre-paid practice systems (HMOs, IPAs) may serve to restrain fee increases by physicians, who must compete with the pre-paid plans for patients.

The success of these incentives to restrain physician fees through competition and consumer information will be studied for three years by a Presidential Commission. Following that study, the Commission will make recommendations.

7. System Reform: Competition

A number of incentives to increase competition among providers have been included in the private mandate provisions. The most important of these include:

o The requirement that employers make equal dollar premium contributions to (all plans offered by the employer (e.g., an insurance plan or plans and HMOs or IPAs). This will encourage employees to seek out lower-cost plans because the employer's relative contribution would be greater. It will encourage employers to help establish HMOs in order to hold down their premium liabilities.

In the event the employer's contribution would exceed 100% of the premium cost for a low-cost plan, alternative fringe benefits or other compensation to the employee would be required.

- Improved consumer information will be available including:
  - -- the list of participating physicians furnished by private insurance plans
  - -- information regarding area HMOs or IPAs (available from HealthCare Office.)

IV. CONSEQUENCES

Phase I of the National Health Plan will be universal, reaching every American. For the most vulnerable in our society -- the aged, the poor, the disabled, mothers and infants -- it will provide comprehensive care, that is a full range of benefits subject to either limited or no cost-sharing. For all others, it will at minimum provide protection against the cost of major illness, while establishing a framework upon which comprehensive protection can be built through voluntary improvements and through statutory enlargement of the employer guarantee. The consequences of NHP Phase I for beneficiaries, employers, State and local governments, the private insurance industry and employers is described in the following sections.

A. Beneficiaries

1. Aged and Disabled: HealthCare will continue and expand the coverage now available under Medicare.

   - For the first time, 24 million aged and disabled Americans will have a limit on their out-of-pocket medical expenses. No enrollee will pay more than $1,250 for covered medical services. The poor aged and disabled will pay nothing.
   - Current Medicare benefits will be improved through providing unlimited days of hospital care and expanded benefits for mental health and alcoholism services
   - One-half million of our poorest elderly citizens, who do not now have sufficient Social Security coverage to be eligible for Medicare, will receive insurance for the first time under HealthCare.

- o About 20,000 disabled individuals, who now lose Medicare benefits when they return to work, will retain their health insurance coverage for three additional years.

- o In total, the elderly will save almost $1 billion in out-of-pocket payments for physician services, because physicians will not be allowed to bill at more than the approved rate.

2. The Low-Income: Medicaid coverage will be significantly altered and expanded.

   - o 15.7 million non-aged poor now on Medicaid will be automatically converted to full subsidy coverage under HealthCare. This includes SSI recipients who live in the 15 States that do not provide Medicaid to all these individuals.

   - o Current Medicaid recipients will receive a similar package of acute care services through HealthCare. They will continue to receive long term care services through State-run programs.

   - o An additional 10.5 million persons with family incomes under 55 percent of poverty will, for the first time, be brought into a health care financing program. These people will receive fully-subsidized coverage through HealthCare.

   - o An estimated four million additional individuals will obtain HealthCare coverage because their medical expenses are so high as to reduce their effective family income to 55% of the official poverty level.

   - o Another 7 million people who are within $3000 of the 55% of poverty level are thus insured by the spend-down even if their expenses in a given year are not sufficiently high to qualify them for HealthCare coverage.

3. The Employed: Under Phase I NHP all full-time employees and their families will be guaranteed a minimum level of health insurance coverage.

   - o 156 million workers and their families will finally be protected against the devasting costs of catastrophic illness. None will have to pay more than $2500 per family on out-of pocket expenses.

- o Every worker will have coverage for prenatal, delivery and infant care with no cost-sharing requirements.

- o No worker will have to pay more than 25% of the premium for mandated coverage.

- o All workers will be assured extension of health benefits during short periods of unemployment, and their families will be similarly protected if the wage-earner dies or if the family is separated. Workers and their families will have an opportunity to convert their health insurance to an individual policy if they desire after leaving employment.

- o For many workers and their families, the scope of benefits will be improved through coverage of physician services and home health visits.

- o Low-income workers and their families will receive subsidies for their share of the premium through an expanded Earned Income Tax Credit.

- o Employees will be able to join any qualified Health Maintenance Organization or Independent Practice Association in their area, if they desire.

4. All Others: About 9 million Americans will not automatically be insured under HealthCare or through mandated employer coverage. These people are unemployed or work part-time, but are not over age 65 nor poor enough to be entitled to fully-subsidized care. HealthCare offers a basis of catastrophic protection for this group in two ways:

   - o Any non-employed person can purchase HealthCare coverage at a national community-rated premium. (Federal subsidies will hold the premium rate to no more than the average per capita health expenditure for all individuals and persons in small groups in the country. Because the nine million individuals in this group have much higher than average health costs -- approaching $3000 each -- a subsidy is required to make coverage affordable.) About 1 million are likely to buy a plan including the complete HealthCare benefit package, with a deductible of $2500.

B. Employers: Under Phase I NHP employers will be required to provide coverage meeting Federal standards to all full-time employees and their dependents.

- Most firms in well-insured industries (manufacturing, transportation) will have to make only small changes in their current plans - e.g., adding physician office visits or the mental health benefit. In poorly-insured industries, such as agriculture and retail trade, many will for the first time provide at least catastrophic protection for their employees. Various measures have been included in the Phase I NHP to assure that meeting the terms of the guarantee will not cause undue hardship to employers and will not result in substantial job loss.

  -- the guarantee requires only that the employer purchase insurance covering costs in excess of $2500. This holds the average premium rate for the mandated plan to $450 per worker.

  -- For those employers whose work force includes a large proportion of workers with higher than average health costs (older workers, a high proportion of women in their childbearing years, or those with large families) subsidies have been included as part of the Phase I package.

- Any employer will be able to buy the mandated insurance from HealthCare by paying a premium equal to 5% of payroll. Or, if the employer prefers to purchase coverage privately, a similar subsidy will be provided to pay private premiums.

- Within the framework of Federal requirements for certified plans, employers will continue to negotiate coverage with insurance companies as they do today. Large firms, (with over 50 employees) will be able to purchase experience-rated contracts whereby premiums are set according to individual utilization experience. Firms of 10-50 workers will pay a community-rated premium for firms of that size. This will protect a small firm (10-50 workers) with exceptionally high-risk employees from paying a premium which is substantially higher than that paid by other firms of a comparable size.

- The availability of the voluntary Federal Reinsurance Fund will enable many medium-size firms to self-insure. Because the Reinsurance Fund will insurance exceptionally large claims (over $25,000) many employers may find it cheaper to self-insure for claims under that amount.

C. State and local governments

Because the Phase I NHP is putting into place a national health program the current responsibilities of State and local governments will be altered in several respects.

1. As Employers

State and local governments in their capacity as employers will be required to provide insurance coverage to their workers which meets the standards of the mandate.

2. Administration

States will conduct eligibility determinations for those families who enter the program because of eligibility for cash assistance. They also will have the option, subject to meeting appropriate performance standards, of contracting with the HealthCare program to conduct eligibility determinations for all persons entering through the national low-income standard or through the spend-down provisions. States will retain administrative responsibility for financing services not covered by HealthCare (primarily long term care), although provision would be made at State option for administration through HealthCare of the non-covered acute services that some States now provide through HealthCare at State option.

3. Other Continued Functions

States will continue their traditional functions in certification and licensure of facilities and personnel and the regulation of private health insurance. However, to the extent that federal regulations governing the employer mandate plans conflict with State regulations, the federal regulations will be primary.

4. Fiscal Responsibility/Fiscal Relief

State and local financial responsibilities for public health care programs will be affected in two major ways by this proposal: (see following table)

- The NHP Phase I will provide $2 billion in fiscal relief for State and local governments (see tables at end of fact sheet for the geographic distribution of this fiscal relief). This fiscal relief will result from:

-- A $0.5 billion decrease in the State share for current Medicaid services

-- The fact that HealthCare provides low-income individuals and families with additional insurance coverage which will help pay bills to State and local hospitals or replace payments made by other State and local programs - $1.5 billion.

- States will continue to share with the Federal government in the costs of financing HealthCare covered services for low-income population in a manner that will retain State incentives to restrain inflation in health care costs. State liabilities will approximate those they would face under Medicaid, (less the fiscal relief, indicated above). To insure no State faces a greater liability there will be a five year hold-harmless provision for any increased health care costs (relative to Medicaid) resulting from expansion of coverage, improved benefits or upgrading of physician fees.

- Federal and State Financial Responsibilities During the Transition Period

  Currently the States share in Medicaid costs according to a formula that yields a range from a low of 22% to a high of 50%, depending on State per capita income. At present the States have a great deal of flexibility to influence total Medicaid costs in the State by modifying plan provisions such as benefits covered (except for those required in the core benefit package necessary to meet the conditions of the Federal grant-in-aid program), reimbursement levels, and other provisions including income eligibility levels for entering the program.

  During the first two years subsequent to the implementation of HealthCare, the Medicaid matching formula would continue to determine the States share for financing those services not covered by HealthCare. However, in order to hold States harmless for the anticipated increased costs for expansions in full subsidy and spend-down coverage, improved benefits and fee upgrading for HealthCare covered services, and to provide some fiscal relief, the State share in HealthCare costs will be calculated as follows:

- the Medicaid expenditures that each State would have incurred during these two years for HealthCare covered services will be projected by indexing actual Medicaid costs in the prior year to the average growth rate of State Medicaid expenditures during the prior three years. (Maintenance-of-effort of the current State Medicaid plan would be required from the time of enactment of NHP Phase I until implementation of HealthCare.)

- States will be required to pay 90% of these estimated expenditures which, in the aggregate, are expected to be about $5.5 billion.

  This procedure will guarantee States fiscal relief during the first two years of the program and produce a predictable HealthCare expense for them. It also will maintain their incentives to hold down inflation in medical care costs after the enactment of NHP Phase I.

- Federal and State Financial Responsibilities After the Transition Period

  In the third and subsequent years after implementation of the program, States will share in the actual cost -- excluding that portion attributable to the eligibility expansion, benefit improvement and fee upgrading -- of providing HealthCare covered services to the low income population on the basis of the Medicaid matching formula.* However, this formula will be adjusted to provide a 5% reduction in all States' matching rate as it applies not only to their new HealthCare cost-sharing, but also their continued Medicaid service expenditures for non-HealthCare covered services. This will provide additional continuing fiscal relief

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* Estimated Medicaid expenditures will be subtracted from total HealthCare costs for the low-income population in year two. The remainder will reflect those costs attributable to the eligibility expansion, benefit improvement and fee upgrade which are being borne 100% by the Federal government. This figure, indexed by the rate of growth of the nominal GNP, will be subtracted from the subsequent years' costs of HealthCare for the low-income population in order to arrive at that portion in which the States would share.

for the States which is estimated to be about $.5 billion in the third year. Furthermore, a general hold-harmless will remain in effect through the fifth year of HealthCare based upon projections of what the States otherwise would have paid under Medicaid for HealthCare covered services (calculated in the same manner as described above for the transition period).

These cost-sharing arrangements will insure that States, as well as the Federal government, are sensitive to the need to restrain health care cost increases. States will continue to enjoy substantial fiscal relief beyond the third year as long as the rate of growth of HealthCare program costs increases for the low-income population does not substantially exceed that of the GNP.

States also will be protected from the costs of any future eligibility and benefit expansions in the program in subsequent phases.

o Savings in State and Local Public Facilities and Grant Programs

There will be additional immediate fiscal relief for State and local governments in the amount of $1.5 billion.

This fiscal relief results from the extensions of insurance protection in HealthCare (the new coverage for 10.5 million low-income persons and 4 million through spend-down) and through the employer guarantee. These insurance plans -- HealthCare and private plans -- will reimburse municipal, county and State hospitals for services that must now be financed through tax revenues. Insurance payments will also replace payments to providers made by State and local grant programs such as those for crippled children. Approximately half of the $1.5 billion in fiscal relief will flow to State governments. The table which follows details fiscal relief by State.

D. The Insurance Industry

The decision to provide insurance coverage for the working population primarily through private insurance companies will create an initial increase in insurance premiums paid by employers and employees of $8.5 billion. These are not voluntary premium payments, they are made by employers and employees as a result of Federal law.

A government requirement that all working people purchase protection against major medical expenses imposes a corollary obligation on the Federal government to assure the value and availability of protection offered to meet the guarantee. For this reason, new Federal regulations will be established to qualify insurance plans which are sold to meet the conditions of the guarantee. These regulations will supercede any similar regulations imposed by States. States will, however, continue to regulate private health insurance for solvency and other aspects of insurance sales which are now regulated by State law.

E. Providers

The combination of HealthCare and extended private insurance as a result of the employer guarantee will effect major health care provider groups in the following ways:

- o Hospital revenues will be contained through the provisions of the Administration's hospital cost containment plan. However, as a result of extending coverage to persons now either uninsured or inadequately insured, revenues to hospitals and skilled nursing facilities will increase by $5.5 billion.

- o Physicians and other providers of ambulatory care services will continue to operate their practices just as they do under current law and programs. Nothing in the NHP Phase I will alter the professional relationship between physician and patient. Nothing in the NHP Phase I will restrict the right of individual patients to choose their own physician.

The most significant change from current law for physicians is the requirement that any physician treating HealthCare beneficiaries agree to submit their bill to the HealthCare program rather than billing the patient directly, and to accept the HealthCare payment as full compensation for the service -- not to bill the patient for any additional amount. As a result of the extension of coverage to those not previously insured for physician services and because of the upgrading of Medicaid fees, total payments to physicians and other providers of ambulatory care services will increase by $10.3 billion under NHP Phase I.

V. Cost of the Phase I NHP and Economic Impact

Expansion of coverage and benefits under the Phase I plan will not begin until FY 1983. This provides time for administrative planning; gives initial cost controls and system reform incentives an opportunity to slow increases in health care costs prior to the expansion of coverage, and gives employers an opportunity to plan for proposed standards on health insurance coverage for employees.

The actual first year cost of the program will depend, in part, upon the restraint in health care costs brought about by other Administration initiatives prior to 1983 such as:

- o hospital cost containment
- o strengthening of health planning and utilization review under the Professional Standards Review Organizations (PSROs)
- o emphasis upon technology assessment
- o expansion of health maintenance organizations

The uncertainty as to the magnitude of savings brought about by these types of system reforms and cost costraints makes any projection of first year costs more problematic the further out in time the estimates are presented. To reduce this uncertainty, all cost figures are for FY 1980, assuming that the Phase I plan were in effect in that year. In addition, estimating change in Federal expenditures and total health system costs due to Phase I is a complex technical task. We will work with CBO over the next few months to further refine these estimates.

A. Total Health Spending

As shown below, the Phase I plan will increase total health spending for the covered benefit package (hospitalization, physician services, lab and X-ray, and prenatal, delivery, and infant care) by $17.8 billion (in 1980 dollars and population) or 0.7% of GNP.

EXPENDITURES FOR COVERED SERVICES, CURRENT LAW AND UNDER NHP-PHASE I
(FY 1980: AMOUNTS IN BILLIONS)

	CURRENT LAW	NHP PHASE I	CHANGE
TOTAL SYSTEM SPENDING*	$148.0	$166.3	$18.3
FEDERAL	45.0	63.2	+18.2
EMPLOYER	42.6	48.7	+ 6.1
INDIVIDUAL	52.0	48.0	- 4.0
STATE	8.4	6.4	- 2.0

*For NHP covered services

The net impact on total health spending during the 1980s, however, will depend upon total system savings from hospital cost containment, reimbursement reforms for physicians and other health care providers, and other health system reform measures included in the Phase I plan or other Administration initiatives. Reductions from cost controls and system reform incentives are estimated to more than offset the expanded utilization and expenditures generated by the Phase I plan after the third year of operation. Even with the expansion to the fully implemented universal, comprehensive plan, total health spending is expected to be lower than it would be under the current system.

B. Federal Budget

The net effect on the federal budget of the Phase I plan will be $18.2 billion (FY 1980 dollars and population). Federal tax revenues are used to:

- o Improve major medical protection for the aged and disabled
- o Subsidize coverage for the poor and near-poor
- o Provide financial protection for selected low-wage and/or high-risk workers and unemployed persons; and
- o Guarantee access to adequate prenatal, delivery, and infant care to non-employed families

1. Aged and Disabled -- $3.9 billion

Coverage for the aged and disabled is improved in two major respects:

- o A ceiling on cost sharing of $1250 per person is imposed, and the limits on covered hospital days are removed -- Net cost $1.8 billion
- o All aged below 55% of poverty are fully subsidized, and spend-down protection is provided for all aged with incomes above this level -- Net cost $2.1 billion

2. Low-Income (Non-Aged) -- $10.7 billion

All cash assistance recipients and person below 55% of poverty receive fully subsidized care. Others above this income may "spend-down" and receive coverage. Major costs for this group are allocated as follows:

- o Improved coverage for current cash assistance recipients (primarily an upgrade in physician fees under the Medicaid program) -- $1.4 billion
- o Expansion of coverage to all below 55% of poverty -- $5.5 billion
- o Spend-down coverage -- $3.8 billion

3. Employed -- $1.6 billion

Federal revenues are used to subsidize care for selected low wage and/or high risk workers:

- o An Earned Income Tax Credit provides relief from additional mandated premiums for low wage workers -- Net cost $0.9 billion

- o Any firms may purchase HealthCare at a subsidized premium if their costs for the mandated benefit would otherwise exceed 5% of payroll (a comparable subsidy will on the experience of individuals and firms be provided if they buy private). Federal general revenues are used to subsidize the difference between premium payments and benefit payments -- Net Cost $0.7 billion

4. Others -- $0.5 billion

-- Financial protection and access to prenatal, delivery, and infant care services are guaranteed for the non-employed through the purchase of HealthCare coverage:

- o Such individuals may purchase a $2500 deductible plan covering hospitalization, physician services, lab, X-ray -- by paying a premium set at the average community rate equivalent to the average cost for individuals and firms with fewer than 50 employees. Federal general revenues are used to subsidize the difference between premium payments and benefit payments (premiums cover 75% of benefit costs) -- Net Cost $0.3 billion.

- o Non-employed families may also enroll once a year for comprehensive prenatal, delivery, and infant care up to age 1 by paying a premium set at one-fourth the cost of this coverage for employed families. Federal general revenues are used to subsidize the difference between premium payments and benefit payments -- Net Cost $0.2 billion.

5. Administrative Expenses — $2.1 billion

The additional federal administrative costs are $2.1 billion. The greatest proportion of this increased cost is for intake and eligibility determination of the approximately 15.7 million newly covered persons (1.2 million aged, 10.5 million fully subsidized low-income non-aged, and 4 million spend-down into fully subsidized coverage).

6. Tax Effects — $ -0.6 billion

The Phase I will also affect the federal budget indirectly through its impact on federal tax receipts. There are three important effects:

- o Out-of-pocket payments will be reduced, and itemized deductions under the personal income tax will be lowered. This will increase federal tax payments, and reduce the net deficit to be financed. Net Cost -- $ -0.5 billion.

- o The personal income tax provisions for health insurance premiums and medical expenses will be changed. A deduction will be provided only to the extent that premium and medical expenses exceed 10 percent of adjusted gross income (rather than 3 percent as in current law). This will increase federal tax payments, and reduce the net deficit to be financed. Net Cost -- $ -1.3 billion.

- o Employers will be required to spend $6.1 billion more under the employer guarantee plan than they would under current law. To the extent that employers substitute these premium payments for wage payments, taxable income of employees will be reduced (or, in practice, increased less than they otherwise would have increased). This will reduce federal tax payments, and increase the net deficit to be financed. Net Cost -- $1.2 billion.

C. Other Financial Flows

Some provisions of the Phase I plan will increase both federal receipts and expenditures, with no net effect on the deficit. These include:

- o A voluntary reinsurance plan will be provided to any insurance company, health maintenance organization or other organized delivery setting, or employer choosing to self-insure employees. This reinsurance plan will be self-financing through the assessment of premiums sufficient to cover expenses. It is estimated that premium payments of $0.3 billion will be made to the plan.

- o Individuals and employers may purchase HealthCare coverage by paying a premium set at the community-rated premium for individuals and firms with fewer than 50 employees. Premium payments which will go to cover benefit payments will be $0.9 billion.

In total, these provisions will increase both federal outlays and federal receipts by $1.2 billion, with no net effect on the federal budget deficit.

D. Impact on Employers and the Economy

The Phase I plan takes care to minimize the impact on employers to avoid any serious economic effects on employment or inflation. The net increase in employer premiums, over and above current health insurance premium payments is expected to be $6.1 billion (in 1980 dollars). If the plan were implemented immediately upon enactment, it might be expected to cause a one-time increase in the CPI of 0.2 percentage points (assuming all new employer costs were reflected in higher prices) and result in the loss of about 50,000 jobs. However, no changes in employment-based insurance are proposed until FY 1983. This should provide time for employers to make adjustment in their wage and fringe benefit packages to accommodate the standards set by the plan and, as a result, cause only inconsequential employment and inflation effects.

Also, in order to ameliorate any adverse impact on selected firms, subsidies are provided to small firms and to firms with unusually high premiums as a percent of payroll (either because workers have low wages or are high risks). Any firm with premiums exceeding 5 percent of payroll will be eligible for a subsidy to purchase HealthCare coverage or comparable coverage from a private insurance firm.

VII. RELATION OF PHASE I TO A FULLY IMPLEMENTED NATIONAL HEALTH PLAN

Phase I is structured so that it can easily be converted into a universal, comprehensive plan.

- For the aged and the disabled, cost-sharing could be reduced further and a drug benefit added.
- For the poor, the low income standard could be raised from 55 percent of the poverty line to the poverty line itself, increasing the number of low income Americans who receive fully-subsidized comprehensive coverage.
- For the employed, the employer guarantee could be extended beyond full-time workers to part-time workers. Cost-sharing could be reduced and deductibles eliminated, converting catastrophic coverage to comprehensive coverage.
- For the non-aged, non-poor, non-employed, comprehensive coverage could be required, but there could be subsidized premium costs and cost-sharing for the near poor.
- For all mothers and children, the prenatal, delivery and infant benefit could be extended through the child's sixth year without patient-cost sharing.

The fully implemented National Health Plan would also meet a fundamental requirement: Total health system costs under the fully implemented plan, with both dramatically expanded coverage and effective cost containment, would be less than the present health system with its inadequate coverage and without effective cost containment.

This will result in the achievement of one of President Carter's fundamental goals. The costs of vitally needed health care benefits for those lacking adequate health insurance must, to the greatest extent possible, be offset by savings from cost containment in the inflationary health care industry.

The CHAIRMAN. Senator Hart, I would be happy to hear your suggestions.

STATEMENT OF HON. GARY HART, U.S. SENATOR FROM THE STATE OF COLORADO

Senator HART. Mr. Chairman, I am grateful for the opportunity to present another approach to national health care, and I am grateful the staff designated this approach as one of the major ones, because I think it is. I have introduced it in the last two Congresses. This is the third time it has been introduced. I am sort of the garage inventor, of health care systems. We don't have the assets of this committee staff, let alone HEW. We have had the benefit of a number of very qualified outside volunteers and consultants in helping us put this proposal together. Former Secretary Wilbur Cohen of HEW has endorsed this type of plan in the past.

[The bill S. 1014 follows:]

II

96TH CONGRESS
1ST SESSION

S. 1014

To establish a national system of maternal and child health and preventive care, and a system for protection against catastrophic health care costs.

IN THE SENATE OF THE UNITED STATES

APRIL 25 (legislative day, APRIL 9), 1979

Mr. HART introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

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A BILL

To establish a national system of maternal and child health and preventive care, and a system for protection against catastrophic health care costs.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Maternal and Child Health Protection Benefits and Catastrophic Medical Expense Reimbursement Act".

FINDINGS AND DECLARATION OF PURPOSE

SEC. 2. (a) The Congress finds and declares that—

(1)(A) the children of the United States are vital members of society and hold the promise of the Nation's future;

(B) pregnant women and young children are recognized as a segment of the population with a substantial unfulfilled need for health care services;

(C) the provision of appropriate preventive health care services has the potential for improving the health of the population and restraining present and future health care costs;

(D) there is a wide disparity (particularly in medically underserved inner-city and rural areas) in the various areas of the Nation as to the cost, quality, and availability of health care services; and

(E) all children and pregnant women should be assured adequate health care services regardless of their medical history; and

(2) all individuals should be protected against the costs of catastrophic illness.

(b)(1) It is therefore the purpose of this Act to—

(A) to establish, in title I of this Act, a program for the provision of comprehensive health care services for children and pregnant women, and

(B) to establish, in title II of this Act, a program to protect families (including one-member families) against financially ruinous health care costs.

(2) It is further the purpose of this Act, in carrying out the programs established by titles I and II of this Act to—

(A) improve the organization, delivery, and financing of health care for children and pregnant women, and

(B) to provide access to services to persons residing in areas in which there is a shortage of such services.

TITLE I—COMPREHENSIVE MATERNAL AND CHILD HEALTH PROTECTION PROGRAM

PART A—BASIC PROGRAM

DEFINITIONS

SEC. 101. For the purposes of this title—

Secretary

(a) The term "Secretary" means the Secretary of Health, Education, and Welfare.

Eligible Individual

(b) The term "eligible individual" means an individual who meets the conditions prescribed in section 102.

Carrier

(c) The term "carrier" means an individual, a voluntary association, corporation, partnership, or other nongovern-

mental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier.

Participating Carrier

(d) The term "participating carrier" means a carrier which has in effect an agreement entered into with the Secretary pursuant to section 105.

Health Service Area

(e) The term "health service area" means a geographic area, within the United States, established in accordance with section 104.

State

(f) The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

United States

(g) The term "United States", when used in a geographical sense, means the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

Qualified Provider of Services

(h) The term "qualified provider of services" means a health care facility which, in the case of a hospital, skilled nursing facility, or home health agency, meets the conditions for participation in the health insurance program established by title XVIII of the Social Security Act, and in the case of any other health care facility, meets applicable standards, and any licensing or similar requirements, of the State and locality in which it is situated.

Qualified Health Care Practitioner

(i) The term "qualified health care practitioner" means an individual who furnishes health care services, and who, if such individual furnishes services of the type for which payment is authorized to be made under title XVIII of the Social Security Act, meets the conditions of participation under such title, and, in the case of any other such individual, meets applicable standards, and any licensing or similar requirements, of the State and locality in which he furnishes services, plus any standards which the Secretary prescribes to assure the adequacy of the quality of the services furnished by such individual.

Board

(j) The term "Board" means the Maternal and Child Health Board established pursuant to section 132.

ELIGIBLE INDIVIDUALS

SEC. 102. (a) Every child and every woman who—

(1) is a citizen of the United States, or

(2) is an alien resident of the United States and has been lawfully admitted to the United States,

shall be eligible to secure the benefits provided by this title—

(A) in case of a child, during any period after birth and prior to the date he attains six years of age, and

(B) in the case of a woman, during the period commencing on the date she becomes pregnant and ending with the close of the twelth week which follows the week in which her pregnancy ends.

For purposes of paragraph (2), an alien shall be deemed to be a resident of the United States, if at the time he receives any health care service with respect to which he seeks to secure the benefits provided by this title, he has been continuously physically present in the United States for not less than three months, or he is legally authorized to remain in the United States for the immediately succeeding three-month period.

(b)(1) The benefits provided by the program established by this title may (except as is otherwise provided in section 106) be secured by an eligible individual only through a participating carrier with which such individual is enrolled.

(2)(A) Any eligible individual may enroll with a participating carrier serving the health service area in which he resides.

(B) The enrollment of an eligible individual with a participating carrier shall be applicable to any covered health care service received by such individual during the 6-month period immediately preceding such date of enrollment, if—

(i) at the time any such service was received, such individual was an eligible individual, and

(ii) such carrier furnished such service, or such carrier did not furnish such service but would have made payment therefor on behalf of such individual if such individual had been enrolled with such carrier at the time such service was furnished.

SCOPE OF BENEFITS

SEC. 103. (a) The benefits provided by the program established by this title to an eligible individual who is enrolled with a carrier shall consist of—

(1) in the case of a child, all health care services related to the diagnosis and treatment of any disease, injury, or disability, as well as any other health care services necessary for the adequate protection, maintenance, or restoration of mental or physical health; and

(2) in the case of a woman, all health care services related to the diagnosis and treatment of pregnan-

cy; the diagnosis and treatment of disease or injury during pregnancy relating to or resulting from pregnancy; or any injury, disability, or disease relating to or resulting from pregnancy that occurs during the twelve-week period immediately following the end of the pregnancy, including, but not limited to the physical well-being of the woman;

except that no health care service shall be covered under such program unless the service—

(3) is provided by a qualified provider of services, or a qualified health care practitioner, and

(4) is furnished directly by the carrier or by a person with whom the carrier has an arrangement under which the person will accept as full payment for the service the amount specified in the arrangement; except that the preceding provisions of this paragraph shall not be applicable in the case of services provided on an emergency basis when the enrollee could not reasonably obtain such services from a person meeting such provisions.

(b) No item or service shall be included in the benefits provided by the program established by this title, if and to the extent that such item or service—

(1) is an item or service for which the enrollee to whom it was furnished has no legal obligation to pay,

and for which no other person (by reason of such enrollee's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for,

(2) constitutes a personal comfort item,

(3) consists of custodial care,

(4) consists of cosmetic surgery (or is furnished in connection therewith), except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member,

(5) is furnished by immediate relatives of such enrollee or members of his household, or

(6) is furnished outside the United States (except to the extent otherwise provided in regulations).

HEALTH SERVICE AREAS

SEC. 104. (a) In the case of any State in which there is established one or more (or part of one or more) health service under section 1511 of the Public Health Service Act, the areas so established shall constitute health service areas for purposes of this title, except that the Secretary, with the approval of the Board, may divide any such area into two or more parts, and, in such case each of such part shall constitute a health service area for such purposes.

(b) In the case of any State in which there is not established one or more (or part of one or more) health service areas under section 1511 of the Public Health Service Act,

the Secretary, with the advice of the Board, shall establish within such State (or such State and any adjoining State or States) such geographic areas as are appropriate for purposes of this title, and the areas so established shall constitute health service areas for such purposes.

AGREEMENTS WITH CARRIERS

SEC. 105. (a)(1) Subject to paragraph (2), any carrier which desires to do so may enter into a contract with the Secretary under this section.

(2) No contract under this section shall be entered into with a carrier unless the Secretary (in conformity with appropriate standards and criteria established by him with the advice and approval of the Board) finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as the Secretary finds pertinent.

(b) Any contract with a carrier under this section shall provide that—

(1) the carrier will furnish (directly or through arrangements with others), or will pay for, health care services for eligible individuals residing in a specified health service area who have enrolled with such carrier to receive the benefits under the program established by this title,

(2) the carrier shall not deny enrollment to any eligible individual residing in such area who seeks to enroll with such carrier for benefits under such program, unless enrollment of such individual would result in the number of individuals enrolled by the carrier in the area to exceed the maximum number of enrollees allocated to such carrier under the contract,

(3) the health care services to be so furnished or paid for by such carrier to such eligible individuals residing in such area who are enrolled with such carrier shall include all of the services described in section 103, and shall contain a detailed statement of benefits to be provided thereunder to enrollees (including any maximum limitations or exclusions, applicable to such benefits),

(4) the carrier will be paid, in consideration of its undertaking to furnish or pay for such health care services to eligible individuals enrolled with the carrier, a uniform per capita amount with respect to each such individual enrollee who is a child meeting the conditions specified in section 102(a)(3), and another uniform per capita amount with respect to each such individual enrollee who is a woman meeting the conditions specified in section 102(a)(4),

(5) the uniform per capita amount payable with respect to (A) a child meeting the conditions specified in section 102(a)(3) shall (except as is otherwise provided pursuant to subsection (f)) constitute the full consideration to the carrier for the furnishing of, or payment for, such health care services for such child for a one-year period, and (B) a woman meeting the conditions specified in section 102(a)(4) shall cover the furnishing of, or payment for, such health care services for the period specified in such section 102(a)(4),

(6) the carrier will take appropriate measures to notify eligible individuals residing in the health service area that such carrier is a participating carrier and inviting such individuals to enroll with such carrier for the health benefits provided under the program established by this title,

(7) in case the carrier undertakes directly to furnish any such health benefits, to display in a manner to be prescribed by the Secretary, public notice that the carrier is a participating carrier in the health benefits program established by this title,

(8) the carrier will establish and maintain procedures, which conform with specifications prescribed by the Secretary with the advice and approval of the Board, pursuant to which an eligible individual enrolled

with the carrier will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more when requests for the furnishing of or payment for any health care service covered under the program established by this title is denied or not acted upon with reasonable promptness or when the amount of payment for any such service is in controversy,

(9) the carrier will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this title,

(10) the carrier will maintain such records and afford such access thereto as the Secretary finds necessary to assure the verification of the information and reports referred to in paragraph (9) and otherwise to carry out the purposes of this title, and

(11) contain such other terms and conditions not inconsistent with this section as the Secretary (with the advice of the Board) finds necessary or appropriate.

(c)(1) In the case of any contract with a carrier entered into under this section, the uniform per capita amount with respect to a child (referred to in subsection (b)(4)), and the uniform per capita amount with respect to a woman (referred to in such subsection), shall each be fixed by the Secretary, with the advice of the Board, so as reasonably and equitably

to reflect (A) the cost of the health care services which will be furnished or paid for by the carrier under the contract, after taking into account all relevant data (including the accessibility to residents of such area of each health care service involved), and (B) the reasonable and necessary cost incurred by the carrier in the administration of the contract.

(2) Any such contract shall provide for an appropriate reduction of any such uniform per capita amount payable to the carrier with respect to any enrollee who is not enrolled for the full length of time specified in subsection (b)(5).

(d) Such per capita amounts payable to any carrier under such a contract shall be paid in advance or in such installments as is specified in the contract.

(e) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier involved as may be provided in regulations if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the health benefits program established by this title.

(f) The Secretary, with the advice and approval of the Board, shall establish a limit, in the case of any enrollee, on the maximum amount of health care expenses that a participating carrier for any health service area will be responsible for meting out of the per capita payment fixed for enrollees in such area. With respect to health care services furnished to an enrollee after such maximum amount has been reached in his case, the Secretary shall pay the carrier the reasonable cost therefor (in the case of services furnished directly by the carrier or by a qualified provider of services) or the reasonable charge therefor (in the case of services not so furnished). For purposes of this subsection, reasonable cost and reasonable charge shall be made in accordance with criteria which is consistent with the criteria employed in determining reasonable cost and reasonable charge in the case of services for which payment is authorized to be made under title XVIII of the Social Security Act.

HEALTH SERVICE AREAS NOT ADEQUATELY SERVICED BY CARRIERS

SEC. 106. (a)(1) If the Secretary finds that eligible individuals residing in any health service area do not have an adequate opportunity of securing the health service benefits authorized by the program established by this title by enrolling with a participating carrier, the Secretary shall establish,

for such individuals, a special program in which they may enroll to secure such benefits.

(2) References in other provisions of this title to an "enrollee" or an eligible individual "enrolled" with a participating carrier shall, unless the context otherwise indicates, shall be deemed to include an eligible individual enrolled in such special program.

(b)(1) A special program established under this section for eligible individuals residing in any health service area shall be in effect only for such period as there is a lack of an adequate opportunity on the part of such individuals to secure the health service benefits authorized by this title by enrolling with a participating carrier.

(2) A special program established under this section for any health service area shall contain incentives designed to attract carriers to become participating carriers for such area.

COORDINATION WITH OTHER HEALTH BENEFITS

SEC. 107. (a)(1) It is the public policy of the United States that, in the administration of this title, an item or service which, in the absence of the program established by this title, would be furnished or paid for by another person (other than a Federal or federally supported program) by reason of a legal obligation of such person to do so shall be furnished or paid for by such person in like manner as if the program so established had not been established.

(2) It is further the public policy of the United States that any item or service which, in the absence of the program established by this title, would be furnished or paid for, in the case of any eligible individual (as defined in section 101(b)), under any Federal program (or any State or local program in which there is Federal financial participation), shall be furnished or paid for under the program established by this title and not under any other Federal program or such a State or local program; and such individual shall not be eligible to have any such item or service furnished or paid for under any such other Federal program or State or local program.

(3) Any provision of law, or of any contract or agreement, which is contrary to the policy stated in paragraph (1) is hereby declared to be void and of no force or effect.

(b) The enrollment of any eligible individual with a participating carrier under this title shall constitute an assignment of his rights against any other person who has a legal obligation to furnish any item or service to such individual, or to pay for any item or service provided to such individual by others, if and to the extent that such item or service is one which is covered by the program established by this title.

(c)(1) If an item or service described in subsection (b) is furnished or paid for under this title, the Secretary shall—

(A) take appropriate measures to recover from the person referred to in subsection (b) an amount equal to

(i) if the item or service was so furnished, the value of such item or service, or, if the item or service was so paid for, the amount paid therefor, or (if less), (ii) the cost which such person would have incurred if such person had furnished or paid for such service in accordance with its legal obligations to do so, and

(B) make an appropriate reduction in the amount of the uniform per capita payments payable to the participating carrier with which the enrollee who was provided such item or service was enrolled.

(2) The provisions of paragraph (1)(A) shall not be applicable in the case of any program or activity established by, or pursuant to, or receiving Federal financial support, under the Social Security Act, or the Public Health Service Act.

(d)(1) It shall be the duty of the head of each Federal Department having administrative responsibility for any Federal program, which furnishes or pays for health care items or services or under which there is Federal financial participation in a State or local program which furnishes or pays for such items, to administer any such Federal program in such manner as to effectuate the policy set forth in subsection (a)(2).

(2) It shall be the responsibility of the Secretary (with the advice of the Board) to serve as coordinator, among the

several Federal departments and agencies, in the carrying out of such policy.

QUALITY AND MEDICAL NECESSITY OF ITEMS AND SERVICES

SEC. 108. (a) Of the items and services determined under section 103 to comprise the health services benefits authorized by this title—

(1) no participating carrier shall be obligated to furnish or pay for, and no enrollee with such carrier shall be entitled to receive or have paid for by the carrier, as a benefit under this title, any such item or service if it is not (A) medically necessary (as determined in the exercise of reasonable limits of professional discretion), or (B) furnished by (i) a qualified provider of services, or a qualified health care practitioner, and (ii) directly by the participating carrier or by a person with whom (or which) the carrier has in effect an arrangement whereby such person will accept as full payment for the service the amount specified in the arrangement, except that this clause (ii) shall not be applicable in the case of services provided on an emergency basis where the enrollee could not reasonably obtain such services from a person meeting such provisions (and when services are provided on an emergency basis by a person other than one meeting the condi-

tions specified in such provisions, the carrier shall be obligated to pay for such services the reasonable cost thereof if the services are provided by a provider of services, or the reasonable charge therefor in any other case, or if less the charge actually imposed),

(2) any participating carrier shall be obligated to furnish or pay for, and any enrollee with such carrier shall be entitled to receive or have paid for by the carrier, as a benefit under this title, any such item or service if it is medically necessary, and

(3)(A) any item or service meeting the conditions specified in paragraph (2) shall, when furnished by the carrier (directly or through arrangements with others) shall be of a quality which meets professionally recognized standards of health care, and

(B) in any case in which an enrollee secures an item or service meeting conditions specified in paragraph (2) from a person other than the carrier with which the enrollee is enrolled (or an individual or entity having an arrangement with the carrier to furnish such item or service to enrollees of the carrier), the carrier may not deny payment for such item or service (in whole or in part) on the grounds that the item or service was of too high a quality, if the quality

thereof meets minimal professionally recognized standards of health care.

(b) For purposes of this section, determinations of whether an item or service is medically necessary, or is of a quality which meets professionally recognized standards of health care, shall be made in accordance with criteria employed to determine such matters by the professional standards review organization designated, pursuant to part B of title XI of the Social Security Act, for the area in which the item or service is provided (or if no such organization has been designated for such area, in accordance with appropriate criteria and procedures employed under title XVIII of such Act).

AGREEMENTS FOR UTILIZATION OF SERVICES OF STATE AGENCIES

SEC. 109. (a)(1) The Secretary (with the advice of the Board) shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate agency (or the appropriate local agencies) will be utilized for the purpose of determining whether an agency or institution meets or continues to meet applicable conditions for a qualified provider of services.

(2) Any such agreement shall fix the frequency of inspection of the agencies and institutions concerned, and shall

prescribe the qualifications of indiviudals making determinations with respect to such agencies and institutions.

(b) The Secretary shall pay to any such State, in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable costs of performing the functions specified in the agreement.

PART B—ADMINISTRATION

ADMINISTRATION BY SECRETARY WITH ADVICE OF BOARD

SEC. 131. (a) This title shall be administered by the Secretary, with the advice of the Board.

(b) The Secretary, in the administration of this title, shall (i) utilize the administrative unit or units, within the Department of Health, Education, and Welfare, utilized for the administration of title XVIII of the Social Security Act, and (ii) coordinate procedures employed in the administration of this title with the procedures employed in the administration of such title XVIII.

MATERNAL AND CHILD HEALTH BOARD

SEC. 132. (a)(1)(A) There is hereby established, within the Department of Health, Education, and Welfare, a Maternal and Child Health Board to be composed of nine members to be appointed by the President, by and with the advice and consent of the Senate. During an individual's term of mem-

bership on the Board, the individual shall not engage in any other business, vocation, or employment. Not more than five members of the Board shall be of the same political party. At least five members of the Board shall be members of the health or medical professions who are experts in the delivery of health care services.

(B) Of the nine Board members at least one member shall be a medical doctor; at least one member shall represent the hospital industry; at least one member shall represent the insurance industry; and at least one member shall represent the interest of enrollees. The person representing enrollees shall be familiar with the health care needs of eligible individuals, experienced in dealing with problems associated with the furnishing of such services, and not engaged in or have any financial interest in any trade, business, or employment which furnishes or pays for health care items or services which are included in the benefits under the health care services program established by this title.

(2)(A) Each member of the Board shall hold office for a term of five years, except that—

(i) a member appointed to fill a vacancy occurring during the term for which his predecessor was appointed shall be appointed for the remainder of that term, and

(ii) the terms of office of the members first appointed shall expire, as designated by the President at the time of their appointment, at the end of one, two, three, four, and five years, respectively, after the date of enactment of this Act.

(B) A member who has served for two consecutive five-year terms shall not be eligible for reappointment until two years after he most recently ceased to serve as a member of the Board.

(3) The President shall designate one of the members of the Board to serve, at the will of the President, as Chairman of the Board.

(b) The Board shall—

(1) provide advice to the Secretary as specified in other provisions of this title, and in general furnish its advice and recommendations to the Secretary with respect to the administration of this title (including recommendations regarding the appropriate level of capitation payments for enrollees in each health service area and the maximum limit (as established pursuant to section 105(f)) for such enrollees),

(2) continually monitor, study, and review this title and its administration with a view to (A) determining the extent to which it is effectively, efficiently, and economically achieving its purpose, (B) identifying

and recommending to the Secretary and the Congress changes in this title and its administration needed in order more effectively, efficiently, or economically to achieve such purpose, and

(3) annually submit to the Congress a report on the administration of this title, which report shall disclose the cost of administration of this title for the year with respect to which the report is submitted, and shall include the Board's recommendations for any legislative changes in or affecting this title.

(c)(1) The Secretary shall make available to the Board all information pertaining to the functions of the Board which is available to him (exclusive of information which is protected by privilege or immunity) from sources within the Department of Health, Education, and Welfare.

(2) The Secretary shall use his good offices to acquire and make available to the Board all information pertaining to the functions of the Board (exclusive of information which is protected by privilege or immunity) from Federal, State, and local government agencies outside the Department of Health, Education, and Welfare.

(d)(1) The Secretary shall furnish the Board with such staff as may be required to enable the Board effectively to carry out its duties and functions.

(2) The Secretary, in furnishing such staff for the Board, is authorized to establish and fix the compensation for, not more than twenty positions in the professional, scientific, and executive service. The fixing of compensation of any such position shall be subject to the approval of the Office of Personnel Management.

(e) There is hereby established the position of Executive Director of the Board. The Executive Director shall be appointed by the Board, with the approval of the Board, and shall perform such duties as the Board may assign to him.

HEALTH SERVICE AREA OFFICES

SEC. 133. (a) The Secretary shall establish in each health service area a Maternal and Child Health Protection Office, together with such branch facilities as he may find necessary or appropriate to carry out the duties of the Office.

(b) It shall be the duty of each such Area Office (as well as that of any branch facility thereof) to—

(1) provide to individuals in the area pertinent information regarding the health insurance program established by this title, and its administration (including a list of all participating carriers serving the area),

(2) receive, investigate, and make proper referral of, and suggest appropriate corrective measures in connection with, complaints received by eligible individuals and enrollees regarding such program, the carrier with

whom they are enrolled, or any item or service with respect to which they are entitled to secure benefits under such program,

(3) make to the Secretary (and in accordance with regulations, to the Board) recommendations with respect to the administration of such program.

AREA ADVISORY BOARDS

SEC. 134. (a) The Board shall appoint for each of the administrative areas, established or utilized by the Secretary for the administration of this title, an Area Advisory Board.

(b) Each Area Advisory Board shall be composed of ten members appointed by the National Maternal and Child Health Board, and shall include—

(1) individuals who are representatives of—

(A) qualified health care practitioners (or organizations or associations thereof),

(B) qualified providers of service (or organizations or associations thereof), and

(C) carriers (or organizations or associations thereof),

each of whom is outstanding in fields related to maternal and child health care; medical, hospital or other health activities; or the carrying on of the business of a carrier; and

(2) individuals (who shall constitute a majority of the Area Advisory Board) who are representatives of eligible individuals, each of whom is familiar with the needs of eligible individuals in the region for health care services, is experienced in dealing with problems associated with the furnishing of such services, and is not engaged in, and does not have any financial interest in, any trade, business, or employment which furnishes or pays for health care items or services which are included in the benefits under the health care services program established by this title.

(c) Each Area Advisory Board shall meet as often as it deems appropriate.

(d) It shall be the function of each Area Advisory Board to advise the National Maternal and Child Health Board (through such representative as it may specify) of all matters directly relating to the administration of this title in the area in which such Board is established, including (1) methods and procedures employed in the handling of complaints, and (2) recommendations regarding the appropriate capitation payment for enrollees in the area and the maximum limit (as established pursuant to section 105(f)) for such enrollees, and methods and procedures necessary to assure public comment in determining such payments and such limit.

(e) Members of each Area Advisory Board, while serving on business of such Council (inclusive of traveltime) shall receive compensation at rates fixed by the Board, but not in excess of the daily equivalent of the rate of pay prescribed for GS-18 of the General Schedule under section 5332 of title 5, United States Code; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 136. (a) Except to the extent that the Secretary (with the advice of the Board) shall by regulations otherwise provide, the provisions of part B of title XI of the Social Security Act shall be applicable to services furnished to eligible individuals under the health services program established by this title in like manner and to the same extent as such provisions are applicable to health care services for which payment may be made under the Social Security Act. Such regulations shall exempt from application to health services under the program established by this title, provisions of part B of title XI of such Act which are inconsistent with any specific provision of this title, are contrary with the purposes of this title, or would be counterproductive to the effective, efficient, and economical administration of this title.

(b) Expenses incurred in the administration of part B of title XI of the Social Security Act shall be payable from funds appropriated to carry out the provisions of this title, in such amounts as the Secretary shall deem to be fair and equitable after taking into consideration the costs attributable to the administration of such part with respect to the health service benefits program established by this title, and each of the several plans and programs referred to in section 1168 of such Act.

(c) If in any health service area (or part thereof), there is no active Professional Standards Review Organization established pursuant to part B of title XI of the Social Security Act, or, if the Secretary (with the advice of the National Maternal and Child Health Board or the Area Advisory Board) determines that such an Organization which is established with respect to such area (or part thereof) is not properly performing utilization and related review functions, the Secretary shall assure that an appropriate system to perform utilization and related review functions with regard to benefits under this title for such area until such time as there is for such area such an Organization which effectively performs such functions.

PART C—MISCELLANEOUS PROVISIONS

INITIAL RULES AND REGULATIONS

SEC. 151. The Secretary shall, with the advice of the Board, promulgate the rules and regulations to carry out the health protection program established by this title and to implement any other provisions of this title within eighteen months following the date of enactment of this Act. All such rules and regulations shall be promulgated in accordance with the administrative procedure established by subchapter II of chapter 5, United States Code.

OBSERVANCE OF RELIGIOUS BELIEFS

SEC. 152. Nothing in this title shall be construed to authorize the Secretary, the Board, or any other person to compel any individual to undergo any medical screening, examination, diagnosis, or treatment, or to accept any other health care services provided under this title, if such individual objects (or, in the case of a child, his parent or guardian objects) thereto on religious grounds.

FREE CHOICE BY PATIENT

SEC. 153. Any eligible individual may enroll for the health benefits program established by this title with any participating carrier serving the health service area in which such individual resides, and may, in accordance with and subject to the contract between such carrier and the Secretary, obtain health care services covered under such program from

any qualified provider of services or qualified health care practitioner who undertakes to provide him such services.

EFFECTIVE PERIOD OF PROGRAM

SEC. 154. Benefits under the health services program established by this title shall be provided only during the last thirty-six months of the sixty-month period which begins on the first day of the month following the month in which this Act is enacted. Not later than the end of the first twenty-four months of such sixty-month period, the Secretary and the Board shall have taken such steps as are necessary or appropriate to assure that eligible individuals will, to the maximum extent feasible, have adequate opportunity to have enrolled with participating carriers so as to be able to secure benefits under such program on account of services received during the first and succeeding months of such last thirty-six months.

AUTHORIZATION OF APPROPRIATION

SEC. 155. There are hereby authorized to be appropriated for each fiscal year such sums as are necessary to carry out the provisions of this title.

REDUCTION IN PERSONAL EXEMPTION UNDER INTERNAL REVENUE CODE FOR ELIGIBLE INDIVIDUALS

SEC. 156. Section 151 of the Internal Revenue Code of 1954 is amended by adding at the end thereof the following new subsection:

"(f) REDUCTION IN AMOUNT OF EXEMPTION IN THE CASE OF ELIGIBLE INDIVIDUALS UNDER TITLE I OF THE MATERNAL AND CHILD HEALTH PROTECTION BENEFITS AND CATASTROPHIC MEDICAL EXPENSE REIMBURSEMENT ACT.—If during any period within the taxable year an individual is an eligible individual as defined in section 101(b) of the Maternal and Child Health Protection Benefits and Catastrophic Medical Expense Reimbursement Act, the amount of the exemption otherwise allowable with respect to such individual under the preceding provisions of this section shall be reduced by $100, but only if, during such period, benefits under title I of such Act were authorized to be provided to eligible individuals enrolled with participating carriers thereunder.".

TITLE II—CATASTROPHIC ILLNESS BENEFITS PROGRAM

PART A—BASIC PROGRAM

DEFINITIONS

SEC. 201. For purposes of this title—

Secretary

(a) The term "Secretary" means the Secretary of Health, Education, and Welfare.

Eligible Individual

(b) The term "eligible individual" means an individual who meets the conditions prescribed in section 202.

Carrier

(c) The term "carrier" means an individual, a voluntary association, corporation, partnership, or other organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to it.

Participating Carrier

(d) The term "participating carrier" means a carrier which has in effect an agreement entered into with the Secretary pursuant to section 208.

Health Service Area

(e) The term "health service area" means a geographic area, within the United States, established in accordance with section 207.

State

(f) The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

United States

(g) The term "United States", when used in a geographical sense, means the States, the District of Columbia,

the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

Qualified Provider of Services

(h) The term "qualified provider of services" means a health care facility which, in the case of a hospital, skilled nursing facility, or home health agency, meets the conditions for participation in the health insurance program established by title XVIII of the Social Security Act, and in the case of any other health care facility, meets applicable standards, and any licensing or similar requirements, of the State and locality in which it is situated.

Qualified Health Care Practitioner

(i) The term "qualified health care practitioner" means an individual who furnishes health care services, and who, if such individual furnishes services of the type for which payment is authorized to be made under title XVIII of the Social Security Act, meets the conditions of participation under such title, and, in the case of any other individual, meets applicable standards, and any licensing or similar requirements, of the State and locality in which he furnishes services, plus any standards which the Secretary prescribes to assure the adequacy of the quality of the services furnished by such individual.

Board

(j) The term "Board" means the Catastrophic Medical Expense Reimbursement Board established pursuant to section 232.

Area Advisory Board

(k) The term "Area Advisory Board" means the Area Board established pursuant to section 235.

Enrollee

(l) The term "enrollee" means an eligible individual who is enrolled with a participating carrier under the catastrophic reimbursement program established by this title, and includes an eligible individual who is enrolled for benefits with the Secretary under section 209.

Income

(m) The term "income" has the meaning assigned thereto in section 211.

ELIGIBLE INDIVIDUALS

SEC. 202. (a) Every individual who—

(1) is a citizen of the United States, or

(2) is an alien resident of the United States and has been lawfully admitted to the United States,

shall be eligible to secure the benefits provided by this title. For purposes of paragraph (2), an alien shall be deemed to be a resident of the United States, if at the time he receives any health care service with respect to which he seeks to secure

the benefits provided by this title, he has been continuously physically present in the United States for not less than three months, or he is legally authorized to remain in the United States for the immediately succeeding three-month period.

(b)(1) The benefits provided by the program established by this title may (except as is otherwise provided in section 209) be secured by an eligible individual only through a participating carrier with which such individual is enrolled.

(2)(A) Any eligible individual may enroll with a participating carrier serving the health service area in which he resides.

(B) The enrollment of an eligible individual with a participating carrier shall be applicable to any covered health care service received by such individual during the calendar year in which the enrollment occurred (and, if such enrollment occurs prior to April 16 of such year, the enrollment shall also be applicable to the preceding calendar year).

SCOPE OF BENEFITS

SEC. 203. (a) An eligible individual who is enrolled in a calendar year with a participating carrier under this title shall, subject to and in accordance with the succeeding provisions of this title, be entitled to be reimbursed for, or have paid on his behalf, with respect to health care expenses incurred by him during such year an amount equal to—

(1) 50 per centum of so much of such expenses as are in excess of 10 per centum but not in excess of 20 per centum of such individual's income for such year, and

(2) 100 per centum of so much of such expenses as are in excess of 20 per centum of such individual's income for such year.

(b)(1) In determining, for purposes of subsection (a), the amount of the health care expenses incurred by an individual during a calendar year and the amount of such individual's income for such year, there shall be included the health care expenses incurred, and the amount of income received, during such year by each other member of such individual's family, but only if such other member is (A) the spouse of the individual, (B) a dependent of such individual, (C) the person (or the spouse of the person) of whom such individual is a dependent, or (D) a person who is a dependent of the same person of whom such individual is a dependent.

(2) For purposes of paragraph (1)—

(A) the term "dependent" shall have the meaning assigned to it by regulations of the Secretary;

(B) the term "family" means two or more individuals who are (i) related by blood, marriage, or adoption, and (ii) living in a place of residence maintained by one or more of them as his or their own home (and

for purposes of this clause, a child under age twenty-two who is absent from home for the purpose of attending an educational institution as a full-time student shall be deemed while so absent to be living in such place of residence); and

(C) the term "member", when used in reference to a family, means an individual described in clause (B).

(c) The Secretary, in order to assure that the protection against the costs of catastrophic illness which this title is designed to provide is reasonably effective in meeting its purpose, may insure regulations—

(1) providing that in general, or in cases where specified circumstances obtain, health care expenses and income will be determined with respect to periods of time less than a full calendar year (but not less than a full calendar quarter),

(2) providing that prospective income will be taken into account (as determined on the basis of current income, if any) and other relevant factors (including, in appropriate cases, actual income for preceding periods), and

(3) containing such other appropriate provisions as may be necessary to avert a distortion of an individual's income (including, but not limited to, distortions

brought about when a person first becomes or ceases to be a family member).

COVERED SERVICES

SEC. 204. Services with respect to which expenses, which may be taken into account for the purpose of determining benefits under this title, shall consist of such—

(1) hospital services,

(2) surgical services,

(3) medical services,

(4) dental services,

(5) prescribed drugs, medicines, and prosthetic devices, and

(6) other medical supplies and services,

as the Secretary (with the advice of the Board) shall determine to be appropriate for the provision of full and complete physical and mental health care (including, in the case of a child who is not an eligible individual enrolled for benefits under the program established by title I of this Act, comprehensive pediatric services), but only in the case of any such item or service, if it is furnished by a qualified provider of services or a qualified health care practitioner; and

(7) premiums for health insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged) if, and to the extent

that such premiums are attributable to insurance covering one or more of the services included under the preceding provisions of this subsection.

LIMITATIONS ON EXPENSES WHICH MAY BE COUNTED

SEC. 205. (a) No expense with regard to an item or service shall be taken into account in determining an individual's benefits under this title, if and to the extent that—

(1) such item or service—

(A) is an item or service for which the individual to whom it is furnished has no legal obligation to pay, and for which no other person (by reason of such enrollee's membership in a prepayment plan or otherwise) has a legal obligation to pay,

(B) constitutes a personal comfort item,

(C) consists of custodial care,

(D) consists of cosmetic surgery (or is furnished in connection therewith), except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member,

(E) is furnished outside the United States (except to the extent otherwise provided in regulations),

(F) is not medically necessary (as determined in the exercise of reasonable limits of professional discretion), or

(G) is of a quality which fails to meet professionally recognized standards of health care, or

(2) the charge therefor (A) in case the service is furnished by a provider of services, is in excess of the reasonable cost of providing the service, and (B) in case the service is furnished by a health care practitioner, is in excess of the reasonable charge for such service.

(b) Determinations under this section with respect to the reasonable cost of a service furnished by a provider of services, and the reasonable charge imposed for a service furnished by a health care practitioner shall be made in accordance with criteria which is consistent with the criteria employed in determining reasonable cost and reasonable charge in the case of services for which payment is authorized to be made under title XVIII of the Social Security Act.

(c) For purposes of this section, determinations of whether an item or service is medically necessary, or is of a quality which meets professionally recognized standards of health care, shall be made in accordance with criteria employed to determine such matters by the professional standards review organization designated, pursuant to part B of

title XI of the Social Security Act, for the area in which the item or service is provided (or if no such organization has been designated for such area, in accordance with appropriate criteria and procedures employed under title XVIII of such Act).

RESIDUAL NATURE OF BENEFITS

SEC. 206. (a)(1) It is the policy of the United States that, in the administration of this title, an item or service which, in the absence of the program established by this title, would be furnished or paid for by another person (by reason of a legal obligation of such person to do so, whether under a public program or otherwise) shall be furnished or paid for by such person in like manner as if the program so established had not been established.

(2) Any provision of law, or of any contract or agreement, which is contrary to the policy stated in paragraph (1) is hereby declared to be void and of no force or effect.

(b)(1) In determining the amount of the expenses with respect to health care which may be taken into account, in the case of an individual claiming benefits under this title, there shall, except as otherwise provided in the succeeding provisions of this subsection, not be included any expense (which except for this section would be taken into account) if and to the extent that such expense is attributable to an item or service described in subsection (a)(1).

(2) If an individual having a right to receive, or have paid for, an item or a service described in subsection (a)(1), after having made proper application therefor, is unsuccessful in obtaining such item or service, or having the same paid for, such individual, by causing an assignment to be made to the Secretary of all claims which he (or any other member of his family) has a right to receive, or have paid for, such item or service, shall be entitled to have the expense which he has incurred for such item taken into account for purposes of determining his benefits under this title in like manner, and to the same extent, as if the legal obligation referred to in subsection (a)(1) did not exist.

(3) Whenever an individual makes an assignment to the Secretary pursuant to paragraph (2) of his rights to have furnished or paid for, by a person referred to in subsection (a)(1), any item or service, the Secretary shall take appropriate measures to recover from such person (including the institution of legal proceedings where appropriate) the reasonable value of such item or service.

HEALTH SERVICE AREAS

SEC. 207. (a) In the case of any State in which there is established one or more (or part of one or more) health service areas under section 1511 of the Public Health Service Act, the areas so established shall constitute health service areas for purposes of this title, except that the Secretary,

with the approval of the Board, may divide any such area into two or more parts, and, in such case each of such part shall constitute a health service area for such purposes.

(b) In the case of any State in which there is not established one or more (or part of one or more) health service areas under section 1511 of the Public Health Service Act, the Secretary, with the advice of the Board, shall establish within such State (or such State and any adjoining State or States) such geographic areas as are appropriate for purposes of this title, and the areas so established shall constitute health service areas for such purposes.

AGREEMENTS WITH CARRIERS

SEC. 208. (a)(1) The Secretary shall (to the extent that he is able to do so) enter into contracts with carriers under which such carriers will administer the benefits authorized under this title in the various health service areas of the United States. Each such contract shall be with respect to a particular health service area.

(2) A contract with a carrier under this section shall require the carrier—

(A) to reinsure with other carriers which elect to participate, under an equitable formula based on the total amount of their group health insurance benefit payments in the health service area involved during the latest year for which the information is available,

to be determined by the carrier and approved by the Secretary, or

(B) to allocate its rights and obligations under the contract among its affiliates which elect to participate, under an equitable formula to be determined by the carrier and the affiliates and approved by the Secretary.

(b) No contract under this section shall be entered into with a carrier unless the Secretary (in conformity with appropriate standards and criteria established by him with the approval of the Board) finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as the Secretary finds pertinent.

(c) A contract entered into with a carrier under this section with respect to a health service area shall provide that—

(1) the carrier will make payment of the benefits authorized by this title to its enrollees (or on behalf of such enrollees, to persons furnishing covered health care services to them) in such area with respect to health care expenses (as determined under this title) incurred by them,

(2) payment of such benefits on account of expenses incurred by such enrollees for any health items

or service shall be paid to the qualified provider of services or the qualified health care practitioner furnishing such item or service on behalf of the recipient thereof or (in case such an item or service has already been paid for other than under this title) to such enrollees,

(3) the carrier shall not deny enrollment to any eligible individual residing in such health service area who seeks to enroll with such carrier for benefits under this title,

(4) eligible individuals residing in such health service area may enroll at any time during a calendar year and enrollment during any calendar year shall be effective for the entire calendar year,

(5) the carrier will furnish each enrollee a detailed statement of the benefits provided under this title and shall include such definitions, limitations, and exclusions as the Secretary considers necessary or desirable,

(6) the carrier will take appropriate measures to notify eligible individuals residing in the health service area with respect to which the contract is effective that such carrier is a participating carrier for such area and inviting such individuals to enroll with such carrier for the health benefits provided under this title,

(7) the carrier will establish and maintain procedures, which conform with specifications prescribed by the Secretary with the advice of the Board, pursuant to which an eligible individual enrolled with the carrier will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more when requests for payment of covered health care expenses are denied or not acted upon with reasonable promptness or when the amount of payment of covered expenses for any health item or service is in controversy,

(8) the carrier will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this title,

(9) the carrier will maintain such records and afford such access thereto as the Secretary finds necessary to assure the verification of the information and reports referred to in paragraph (8) and otherwise to carry out this title, and

(10) contain such other terms and conditions not inconsistent with this section as the Secretary (with the advice of the Board) finds necessary or appropriate.

(d)(1) Any contract with a carrier with respect to a health service area under this section shall provide for payment by the Secretary to the carrier of a uniform per capita

amount with respect to each eligible individual residing in such area who is enrolled with the carrier. Such uniform amount shall be fixed by the Secretary, with the advice of the Board, so as reasonably and equitably to reflect, after taking into account all relevant data, (A) the cost of benefit payments authorized by this title for the enrollees involved, and (B) the reasonable and necessary cost incurred by the carrier in the administration of the contract.

(2) Any such contract shall provide for retrospective adjustments in such uniform amount, if and to the extent that the Secretary determines that the amount established pursuant to paragraph (1) is greater or lesser than is required to meet the criteria prescribed in paragraph (1) for the fixing of such rate.

(3) Such per capita amounts payable to any carrier under such a contract shall be paid in advance or in such installments as is specified in the contract.

(e) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier involved as may be provided in regulations if he finds that the carrier has failed substantially to

carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the health benefits program established by this title.

CATASTROPHIC HEALTH BENEFITS IN HEALTH SERVICE AREAS WITHOUT A PARTICIPATING CARRIER

SEC. 209. During any period during which there is not in effect in any health service area a contract entered into under this title with a participating carrier for the provision on the benefits authorized by this title, the Secretary shall provide such benefits in like manner and on the same terms and conditions as would have been the case had there been in effect such a contract. Any eligible individual enrolled for such benefits with the Secretary under this section shall be regarded as an "enrollee" as that term is employed in this title.

BENEFITS IN HEALTH SERVICE AREAS HAVING NO PARTICIPATING CARRIER

SEC. 210. During any period that there is not in effect with respect to any particular health service area an agreement with a carrier entered into pursuant to section 208, the Secretary shall carry out the duties and functions which a carrier having such an agreement would have been required to perform under such a contract.

DETERMINATION OF INCOME

SEC. 211. (a) For purposes of determining benefits under this title, "income" means (subject to subsection (b)) both earned income and unearned income; and—

(1) "earned income" means only—

(A) wages as determined under section 203(f)(5)(C) of the Social Security Act, and

(B) "net earnings from self-employment", as defined in section 211 of such Act (without application of the second and third sentences following subsection (a)(11), and the last paragraph of subsection (a)), including earnings for services described in paragraphs (4), (5), and (6) of subsection (c); and

(2) "unearned income" means all other income, including—

(A) support and maintenance furnished in cash by a person other than a family member, of the individual whose benefits are being determined, whose income is included in determining such individual's income,

(B) any payments received as an annuity, pension, retirement, or disability benefit; including veterans' compensation and pensions; workmen's compensation payments; old-age, survivors, and

disability insurance benefits; railroad retirement annuities and pensions; and unemployment insurance benefits,

(C) cash gifts, support, and alimony payments provided to the individual whose income is being determined in connection with a claim for benefits under this title, by a person other than a family member, or such individual, whose income is included in determining such claim, and

(D) rents, dividends, interest, and royalties.

(b)(1) In determining, for purposes of this section, the income of any individual or family, for any period of time, there shall be excluded—

(A) the aggregate value of any cash gifts which do not exceed $240, if such period of time is equal to twelve months, or, if such period of time is less than twelve months, then an amount which bears the same ratio to $240 as such period bears to twelve months, and

(B) any scholarship, grant, fellowship, or loan received for use in paying for tuition, books, and related fees at any educational (including technical or vocational education) institution.

(2) For purposes of paragraph (1) and subsection (a)—

(A) a loan of $240 or more (or aggregate thereof) shall be regarded as a gift if such loan—

(i) is unsecured (or is without adequate security), or

(ii) has no maturity date; and

(B) in the case of a loan which—

(i) bears no interest, or

(ii) bears interest at a rate which is not more than one-half of the prevailing rate of interest imposed with respect to similar loans,

the recipient of such loan shall be regarded as having received, as a gift, an amount, with respect to any period of time, equal to the excess of—

(iii) the amount of interest which would have been payable by him, with respect to such period, on such loan if such loan bore a rate of interest equal to the prevailing rate of interest imposed (as of the time such loan was made) with respect to similar loans, over

(iv) the amount of interest (if any) payable by him, with respect to such period, on such loan.

AGREEMENTS FOR UTILIZATION OF SERVICES OF STATE AGENCIES

SEC. 212. (a)(1) The Secretary (with the advice of the Board) shall make an agreement with any State which is able

and willing to do so under which the services of the State health agency or other appropriate agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an agency or institution meets or continues to meet applicable conditions for a qualified provider of services.

(2) Any such agreement shall fix the frequency of inspection of the agencies and institutions concerned, and shall prescribe the qualifications of individuals making determinations with respect to such agencies and institutions.

(b) The Secretary shall pay to any such State, in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable costs of performing the functions specified in the agreement.

OVERPAYMENTS AND UNDERPAYMENTS

SEC. 213. (a) Any payment under this title to any qualified provider of service or other person with respect to items or services furnished an individual shall be regarded as a payment to such individual.

(b) Whenever the Secretary finds that more or less than the correct amount of benefits under this title has been paid with respect to an enrollee, proper adjustment or recovery shall be made, in accordance with regulations prescribed by

the Secretary (after consultation with the Board) for that purpose.

PART B—ADMINISTRATION

ADMINISTRATION BY SECRETARY WITH ADVICE OF BOARD

SEC. 231. (a) This title shall be administered by the Secretary, with the advice of the Board.

(b) To the maximum extent practicable, the Secretary, in the administration of this title, shall (i) utilize the administrative unit or units, within the Department of Health, Education, and Welfare, utilized for the administration of title XVIII of the Social Security Act, and (ii) coordinate procedures employed in the administration of this title with the procedures employed in the administration of title I of this Act and of such title XVIII.

CATASTROPHIC MEDICAL EXPENSE REIMBURSEMENT BOARD

SEC. 232. (a)(1) There is hereby established, within the Department of Health, Education, and Welfare, a Catastrophic Medical Expense Reimbursement Board to be composed of five members to be appointed by the President, by and with the advice and consent of the Senate. During an individual's term of membership on the Board, the individual shall not engage in any other business, vocation, or employment. Not more than three members of the Board shall be of the same political party. At least three members of the Board

shall be representatives of the health insurance business who are experts in the financing of health care services.

(2)(A) Each member of the Board shall hold office for a term of five years, except that—

(i) a member appointed to fill a vacancy occurring during the term for which his predecessor was appointed shall be appointed for the remainder of that term, and

(ii) the terms of office of the members first appointed shall expire, as designated by the President at the time of their appointment, at the end of one, two, three, four, and five years, respectively, after the date of enactment of this Act.

(B) A member who has served for two consecutive five-year terms shall not be eligible for reappointment until two years after he most recently ceased to serve as a member of the Board.

(3) The President shall designate one of the members of the Board to serve, at the will of the President, as Chairman of the Board.

(b) The Board shall—

(1) provide advice to the Secretary as specified in other provisions of this title, and in general furnish its advice and recommendations to the Secretary with respect to the administration of this title (including rec-

ommendations regarding the appropriate level of capitation payments for each health service area),

(2) continually monitor, study, and review this title and its administration with a view to (A) determining the extent to which it is effectively, efficiently, and economically achieving its purpose, (B) identifying and recommending to the Secretary and the Congress changes in this title and its administration needed in order more effectively, efficiently, or economically to achieve such purpose, and

(3) annually submit to the Congress a report on the administration of this title, which report shall disclose the cost of administration of this title for the year with respect to which the report is submitted, and shall include the Board's recommendations for any legislative changes in or affecting this title.

(c)(1) The Secretary shall make available to the Board all information pertaining to the functions of the Board which is available to him (exclusive of information which is protected by privilege or immunity) from sources within the Department of Health, Education, and Welfare.

(2) The Secretary shall use his good offices to acquire and make available to the Board all information pertaining to the functions of the Board (exclusive of information which is protected by privilege or immunity) from Federal, State, and

local government agencies outside the Department of Health, Education, and Welfare.

(d)(1) The Secretary shall furnish the Board with such staff as may be required to enable the Board effectively to carry out its duties and functions.

(2) The Secretary, in furnishing such staff for the Board, is authorized to establish and fix the compensation for, not more than twenty positions in the professional, scientific, and executive service. The fixing of compensation of any such position shall be subject to the approval of the Office of Personnel Management.

(e) There is hereby established the position of Executive Director of the Board. The Executive Director shall be appointed by the Board, with the approval of the Board, and shall perform such duties as the Board may assign to him.

HEALTH SERVICE AREA OFFICES

SEC. 233. (a) The Secretary shall establish in each health service area a Catastrophic Medical Expense Reimbursement Office, together with such branch facilities as he may find necessary or appropriate to carry out the duties of the Office.

(b) It shall be the duty of each such Area Office (as well as that of any branch facility thereof) to—

(1) provide to individuals in the area pertinent information regarding the health insurance program es-

tablished by this title, and its administration (including a list of all participating carriers serving the area),

(2) receive, investigate, and make proper referral of, and suggest appropriate corrective measures in connection with complaints received by eligible individuals and enrollees regarding such program, the carrier with whom they are enrolled, or any item or service with respect to which they are entitled to secure benefits under such program,

(3) make to the Secretary (and in accordance with regulations, to the Board) recommendations with respect to the administration of such program.

AREA ADVISORY BOARDS

SEC. 234. (a) The Catastrophic Medical Expense Reimbursement Board shall appoint for each of the administrative areas, established or utilized by the Secretary for the administration of this title, an Area Advisory Board.

(b) Each Area Advisory Board shall be composed of 10 members appointed by the Board, and shall include—

(1) individuals who are representatives of—

(A) qualified health care practitioners (or organizations or associations thereof),

(B) qualified providers of service (or organizations or associations thereof), and

(C) carriers (or organizations or associations thereof),

each of whom is outstanding in fields related to health care; health care financing; medical, hospital or other health activities; or the carrying on of the business of a carrier; and

(2) individuals (who shall constitute not less than 4 of the members of an Area Advisory Board) who are representatives of eligible individuals, each of whom is familiar with the needs of eligible individuals in the region for health care services, is experienced in dealing with problems associated with the furnishing of such services, and is not engaged in, and does not have any financial interest in, any trade, business, or employment which furnishes or pays for health care items or services which are included in the benefits under the health care services program established by this title.

(c) Each Area Advisory Board shall meet as often as it deems appropriate.

(d) It shall be the function of each Area Advisory Board to advise the National Medical Expense Reimbursement Board (through such representative as it may specify) of all matters directly relating to the administration of this title in the area in which such Advisory Board is established (including methods and procedures employed in the handling of

complaints and recommendations regarding the appropriate capitation payment for the area and methods and procedures necessary to assure public comment in determining such recommended payment).

(e) Members of each Area Advisory Board, while serving on business of such Council (inclusive of traveltime) shall receive compensation at rates fixed by the Board, but not in excess of the daily equivalent of the rate of pay prescribed for GS-18 of the General Schedule under section 5332 of title 5, United States Code; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 235. (a)(1) Except to the extent that the Secretary (with the advice of the Board) shall by regulations otherwise provide, the provisions of part B of title XI of the Social Security Act shall be applicable to services furnished to eligible individuals under the health services program established by this title in like manner and to the same extent as such provisions are applicable to health care services for which payment may be made under the Social Security Act. Such regulations shall exempt from application to health services under the program established by this title, provisions of part

B of title XI of such Act which are inconsistent with any specific provision of this title, are contrary with the purposes of this title, or would be counterproductive to the effective, efficient, and economical administration of this title.

(2) If in any health service area (or part thereof), there is no active Professional Standards Review Organization established pursuant to part B of title XI of the Social Security Act, or, if the Secretary (with the advice of the National Medical Expense Reimbursement Board or the Area Advisory Board) that such an Organization which is established with respect to such area (or part thereof) is not properly performing utilization and related review functions, the Secretary shall assure that an appropriate system to perform utilization and related review functions with regard to benefits under this title for such area until such time as there is for such area such an Organization which effectively performs such functions.

(b) Expenses incurred in the administration of part B of title XI of the Social Security Act shall be payable from funds appropriated to carry out the provisions of this title, in such amounts as the Secretary shall deem to be fair and equitable after taking into consideration the costs attributable to the administration of such part with respect to the catastrophic illness benefits program established by this title, and

each of the several plans and programs referred to in section 1168 of such Act.

PART C—MISCELLANEOUS PROVISIONS

INITIAL RULES AND REGULATIONS

SEC. 251. The Secretary shall, with the advice of the Board, promulgate the rules and regulations to carry out the health protection program established by this title and to implement any other provisions of this title within eighteen months following the date of enactment of this Act. All such rules and regulations shall be promulgated in accordance with the administrative procedure established by subchapter II of chapter 5, United States Code.

OBSERVANCE OF RELIGIOUS BELIEFS

SEC. 252. Nothing in this title shall be construed to authorize the Secretary, the Board, or any other person to compel any individual to undergo any medical screening, examination, diagnosis, or treatment, or to accept any other health care services provided under this title, if such individual objects (or, in the case of a child, his parent or guardian objects) thereto on religious grounds.

FREE CHOICE BY PATIENT

SEC. 253. Any individual entitled to benefits under this title may obtain health services covered therefor from any qualified provider of services or qualified health care practitioner which undertakes to provide him such services.

OPTION OF INDIVIDUAL TO OBTAIN OTHER HEALTH INSURANCE PROTECTION

SEC. 254. Nothing contained in this title shall be construed to preclude any individual from purchasing or securing (through collective bargaining or otherwise) protection against the costs of any health services.

EFFECTIVE PERIOD OF PROGRAM

SEC. 255. Benefits under the catastrophic illness benefits program established by this title shall be provided only during the last thirty-six months of the sixty-month period which begins on the first day of the month following the month in which this Act is enacted. Not later than the end of the first twenty-four months of such sixty-month period, the Secretary and the Board shall have taken such steps as are necessary or appropriate to assure that eligible individuals will, to the maximum extent feasible, have adequate opportunity to have enrolled with participating carriers so as to be able to secure benefits under such program on account of services received during the first and succeeding months of such last thirty-six months.

AUTHORIZATION OF APPROPRIATION

SEC. 256. There are hereby authorized to be appropriated for each fiscal year such sums as are necessary to carry out the provisions of this title.

TITLE III—GENERAL PROVISIONS

DETERMINATIONS; APPEALS

SEC. 301. (a) The determination of whether an individual is entitled to benefits under title I or II and the determination of the amount of such benefits shall be made (in accordance with regulations of the Secretary) by the participating carrier with which such individual is an enrollee.

(b)(1) Any individual who is dissatisfied with any determination under subsection (a) as to—

(A) whether he is entitled to benefits under this title, or

(B) the amount of such benefits,

shall be entitled to a hearing thereon by the Secretary as provided in subsection (d) and to judicial review of the Secretary's final decision after such hearing as is provided in section (e).

(2) Notwithstanding the provisions of subparagraph (B) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (B) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (B) if the amount in controversy is less than $1,000.

(c) Any organization dissatisfied with a determination that it is not a carrier, any institution or agency dissatisfied

with a determination that it is not a qualified provider of services, and any person who is dissatisfied with a determination of the Secretary that such person is not a qualified health care practitioner, or any participating carrier dissatisfied with a determination that such carrier is not substantially complying with an agreement entered into with the Secretary by reason of which it became a participating carrier, shall be entitled to a hearing thereon by the Secretary as provided in subsection (d), and to judicial review of the Secretary's final decision after such hearing as is provided in subsection (e).

(d) Upon request (filed in accordance with regulations of the Secretary) by a person who is dissatisfied with a determination of the Secretary with respect to which a hearing is authorized by subsection (b) or (c), the Secretary shall give such person reasonable notice and opportunity for a hearing with respect to such determination, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing, affirm, modify, or reverse his findings of fact and such determination. Any such request with respect to such a determination must be filed within sixty days after notice of such determination is received by the person making such request. The Secretary is further authorized, on his own motion, to hold such hearings and to conduct such investigations, and other proceedings as he may deem necessary or proper for the administration of

this Act. In the course of any hearing, investigation or other proceeding, he may administer oaths and affirmations, examine witnesses, and receive evidence. Evidence may be received at any hearing before the Secretary even though inadmissible under rules of evidence applicable to court procedure.

(e) Any person, after any final determination of the Secretary made after a hearing to which he was a party, irrespective of the amount in controversy, may (except as is otherwise provided in subsection (b)(2)) obtain a review of such determination by a civil action commenced within sixty days after the mailing to him of notice of such determination or within such further time as the Secretary may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the District Court of the United States for the District of Columbia. As part of his answer the Secretary shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the determination of the Secretary, with or without remanding the case for a re-

hearing. The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Secretary or a decision is rendered under subsection (c) which is adverse to a person who was a party to the hearing before the Secretary, because of failure of the claimant or such person to submit proof in conformity with any regulation prescribed under subsection (a) hereof, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court shall, on motion of the Secretary made before he files his answer, remand the case to the Secretary for further action by the Secretary, and may, at any time, on good cause shown, order additional evidence to be taken before the Secretary, and the Secretary shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm his findings of fact or his determination, or both, and shall file with the court any such additional and modified findings of fact and determination, and a transcript of the additional record and testimony upon which his action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and determination. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions. Any action insti-

tuted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Secretary or any vacancy in such office.

(f) The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 24 of the Judicial Code of the United States to recover on any claim arising under this title.

REPEAL OF MEDICAL DEDUCTION IN INTERNAL REVENUE CODE

SEC. 302. (a) Section 213 of the Internal Revenue Code of 1954 (relating to medical, dental, etc., expenses) is repealed.

(b) The table of sections to part VII of chapter 1 of such Code is amended by striking out

"Sec. 213. Medical, dental, etc., expenses.".

(c) Section 57(b)(1) of such Code (relating to items of tax preference) is amended by striking out subparagraph (B).

(d) Section 104(a) of such Code (relating to compensation for injuries or sickness) is amended by striking out "Except in the case of amounts attributable to (and not in

excess of) deductions allowed under section 213 (relating to medical, etc., expenses) for any prior taxable year, gross" and inserting in lieu thereof "Gross".

(e) Section 105(b) of such Code (relating to amounts received under accident and health plans) is amended by striking out "Except in the case of amounts attributable to (and not in excess of) deductions allowed under section 13 (relating to medical, etc., expenses) for any prior taxable year, gross" and inserting in lieu thereof "Gross".

(f) The amendments and repeals made by this subsection shall be effective only in the case of taxable years beginning after January 1, 1982.

PENALTIES

SEC. 303. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under the health benefits program established by title I, or under the catastrophic illness benefits program established by title II, or this Act,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (A) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under either such program, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (B) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction

thereof fined not more than $10,000 or imprisoned for not more than one year, or both.

(b)(1) Whoever solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under the health benefits program established by title I, or under the catastrophic illness benefits program established by title II, of this Act, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or items for which payment may be made in whole or in part under either such program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under either such program, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under either such program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under either such program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under such program, and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with re-

spect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a qualified provider of services, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

I would like to briefly outline my legislation for your consideration and attempt, even though we don't have a lot of charts and studies to back it up, to answer any questions you may have. Of course, my office will provide other detailed information for the record at a later time if requested.

The key features of this proposal, Mr. Chairman, are, first, it provides comprehensive health care services to preschool children and pregnant women. In addition, it provides comprehensive coverage for all Americans against the costs of catastrophic illness.

Second, it emphasizes preventive health care and contains provisions to help hold down overall health care costs. Third, it relies on private health insurers and existing medical institutions and it minimizes the role of the Federal Government. Fourth, it is completely voluntary, and it has a sunset provision requiring review of the program and reauthorization after 5 years.

Finally, Mr. Chairman, it is affordable in these belt-tightening times, and I think it should be relatively easy to administer. The proposal's centerpiece is the initiation of comprehensive medical and dental care for children aged 5 and under and pregnant women. It would provide complete care irrespective of ability to pay for every one of these persons in those categories who need it.

The selection of children and pregnant women is a logical one. They represent our future health care costs so that providing care as early as possible is a sound investment.

Mr. Chairman, this is the key to this proposal. It is in fact preventive medicine. It is in fact an attempt to cut off the costs of future medical costs, whether through the private sector or public sector, by taking care of the people who will eventually be the adult and senior citizens of the country.

Children and pregnant women also offer the ideal group on which to implement preventive practices and policies, a central component of a truly effective and cost-efficient national health care program.

Furthermore, Mr. Chairman, children are a fairly stable population for whom care can be provided routinely by primary care physicians or nurses and other health practitioners; therefore focusing a national health care plan on them would reduce the potential for providing unneeded services and runaway costs.

Mr. Chairman, in 1976, the per capita expenditure for children under 19 years of age was $249, compared to $547 for those age 19 to 64, and $1,251 for those 65 and older. Children constitute one-third of our population, yet use only one-seventh of our health resources.

Similarly, good health care for pregnant women is readily producible, fairly predictable, and though not minimal in cost, has been demonstrated time and again to be tremendously valuable in improving the health of newborn infants and reducing future illness. Despite existing Federal programs, children, especially poor children, receive fewer health care benefits than any other group. Less than 50 percent of eligible children receive standard immunization against costly and potentially fatal diseases.

Last year, only 21 percent, 15 percent under age 6, of children eligible for HEW's early and periodic screening, diagnostic and treatment program actually received benefits, 21 percent. One in five infants born prematurely will die within the first year of life, and the others will

be prone to serious and often irreparable illness, and yet it is medically possible to reduce much of the problem simply through routine care prior to and during pregnancy. Under this legislation, participation by both recipients and providers would be voluntary.

Physicians would have a choice of participating in the program exclusively, either participating simultaneously with the standard fee for service system or not participating at all. Patients could, of course, choose any doctor they wish. Payment by the Federal Government to providers of services would be a fixed amount per enrolled individual. Patients would sign up with participating providers who would receive payment in advance.

This so-called capitation form of payment provides incentives to physicians to deliver necessary care in the most efficient manner, and it eliminates any incentive to provide unnecessary goods or services. The program would be administered by two separate national boards established within the Department of Health, Education, and Welfare, and assisted by local boards.

The board would set capitation rates, administer the program, and review and improve it as needed. Boards would also involve public officials, doctors, and insurers in the task of holding down the tremendous costs of medical care.

Finally, Mr. Chairman, my plan has a Sunset provision, as I mentioned, so that after 5 years its continuation or expansion would require reauthorization by Congress. I fully expect the plan to provide a working example of an effective health care delivery system on which we might base implementation of a comprehensive program for the entire population if that is the direction in which the country chooses to go.

The program I advocate would be financed through general revenues plus a reduction in the personal exemption for eligible recipients from $1,000 to $900. According to our best estimates, the cost of this legislation would be between $13 billion and $18 billion. What will people get in return? In many families, there will be one child under 6. Under this plan, that family will save an average of $355 per year in medical costs for that young child.

In addition, when the wife becomes pregnant, the family will save about $1,700 in pre- and post-natal care. Clearly, this average family gains more in health benefits than it pays in taxes. Every family of any income would in addition have Government-funded insurance against catastrophic illness, protecting it from financial devastation by extremely expensive illness or injury.

This payment plan, Mr. Chairman, is fair because every taxpayer will participate in an improved national health system according to income level. Also, larger families which will benefit more will contribute a slightly larger amount if they have more children under 6 years of age.

Some of the major differences between this proposal and others are as follows. Senator Kennedy's proposal calls for uniform access for all citizens to a specified standard of care. To do this, employers would be required to provide insurance for Government-specified benefits. The Federal Government would pay for similar insurance for the poor, unemployed, and other uninsurables, and would control costs by means of prospective budgeting and deregulation. The estimated cost of that plan would be about $60 billion annually.

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My plan differs by offering a more limited approach. Specifically, it provides, as I said, comprehensive care for children and pregnant women. It uses capitation payments to control costs rather than Government-mandated fees, and uses income tax revenue for financing instead of the inherently inflationary employer-mandated insurance plan.

President Carter's proposal relies on passage of hospital cost containment legislation to control escalating costs and expands a program similar to the present medicaid system to additional poor and near-poor persons. The President's proposal also contains, as you know, a catastrophic plan with a fixed $2,500 deductible for individuals and $1,250 for senior citizen deductible.

The plan which I propose does not use the present health care delivery model to provide health benefits. Instead, access for women and children is provided without regard to income. While I agree that sectors of the population other than children need increased health services, I chose children because preventive health care for that population offers the greatest long-term health returns and, as I have said, I think it is the right thing to do.

The deductible in my catastrophic plan is income related, because financial catastrophe is a relative thing. This is an important distinction, Mr. Chairman. Under this plan, insurance would pay 50 percent of out-of-pocket costs between 10 and 20 percent of an individual's annual income. The plan would pay 100 percent of out-of-pocket medical expenses exceeding 20 percent of an individual's annual income.

A fixed deductible of $2,500 per senior couple would be absolutely devastating to most seniors on a fixed, limited monthly income.

Mr. Chairman, those are the principal details of the proposal. I would be very glad to try to answer any questions. Let me just contrast finally my proposal with the Dole-Danforth-Domenici plan, which offers some needed reforms for the medicare provisions of the Social Security Act and an employment-related catastrophic plan with an extremely high deductible.

Once again, my plan differs from this plan on the issue of deductibles. A fixed deductible, especially a high one, will offer no assistance to the persons who most need protection against financial catastrophe brought about by serious illness.

While this plan does not—indeed, no plan can—solve at once all of the ills of the present system, I think it does represent a reasonable, fiscally responsible, and administrable plan with which to begin.

Mr. Chairman, I will be glad to try to answer any questions you have. As I say, I don't have a lot of charts and graphs, but I appreciate this committee's consideration of what I consider to be a serious approach to a very serious problem.

The CHAIRMAN. Thank you very much, Senator Hart.

Senator Ribicoff?

Senator RIBICOFF. No questions.

The CHAIRMAN. Senator Dole?

Senator DOLE. I don't have any questions, except to compliment the Senator from Colorado, not just for his testimony today, but for his long interest in I think what we all agree is a very serious problem, and I think it has to be hopefully a bipartisan effort to find some solution, and I would hope that during the discussions, and I assume

we will have a number, that the Senator from Colorado will be available or his staff will be available for continuing input, because it occurs to me that the final product may well be a combination of four or five or six different proposals, certainly including the one that you have introduced. I appreciate your testimony.

Senator HART. I thank the Senator from Kansas for his remarks.

The CHAIRMAN. Senator Bradley?

Senator BRADLEY. No questions.

The CHAIRMAN. Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

Do I understand, Senator, from your testimony that you say that 50 percent of the children do not receive basic immunization that is available?

Senator HART. That is the information we have.

Senator CHAFEE. Yes. The problem, as I find it, and I think your approach is a good one—as I understand it, it is a concentration on preventive medicine for children 5 and under—isn't one of the problems so much of this immunization is free now, and that somehow people don't take advantage of it? I don't know how we get people there to use the immunization programs. Our State runs great antimeasles vaccination clinics and so forth, immunization programs, and I am sure yours does, too, and yet we end up with your statistics. How do you solve that problem?

Senator HART. Well, Senator, as you well know, I think all of us are aware of the maldistribution of care in this country and it relates a lot to geographics. People in rural areas generally don't have the kind of services people in urban areas do, and don't always have access to comprehensive health services, even where there are Federal programs. There are differing views as to how well the vaccination programs have been administered in terms of making those programs available to people in rural areas and in poor areas of cities. You still miss a lot of people.

I think if this were a comprehensive national program, available to every child in this country, and the weight of not only Congress but of the executive branch were behind it, we would overcome what I think have been some of the systematic barriers to making Government-sponsored programs available to people in rural areas. That is certainly one thing that I think any plan that any of us come up with ought to address; that is, how to overcome these geographic problems.

Senator CHAFEE. It isn't so much geographic, although I am sure that is a factor. It is somehow just getting the horse to water and making him drink. People just don't avail themselves. I suspect a substantial portion of the population just plain don't bother to take the polio vaccine that is available. Parents don't give it to their young children. They think polio seems to have disappeared.

Anyway, that is something that can be done, I think, with tremendous effort between the administration, State, and the medical societies.

Now, do I understand that you would finance your program through a reduction of the personal exemption on the income tax?

Senator HART. Yes.

Senator CHAFEE. What is the individual exemption now, $1,000?

Senator HART. $1,000.

Senator CHAFEE. And you would cut that back down to $900?

Senator HART. That's right, $100 per individual. We calculate that would raise about $3 billion in revenues of the $13 billion on the low side, $18 billion on the high side total program cost. The reason for the $5 billion discrepancy from the low side to the high side is, how many other Government programs this plan would replace. We calculate that possibly it could replace about $4 billion to $5 billion in other Federal expenditures, which would drive the total cost down to about $13 billion. If it didn't replace that much, obviously the cost would go up.

Senator CHAFEE. I just think your approach is a very exciting one, and I would like to know more about it. Frankly, I didn't get a copy of your statement. Were they distributed?

Senator HART. Yes. We can make one available to you.

Senator CHAFEE. OK, fine. Thank you very much.

Senator HART. Thank you.

The CHAIRMAN. Senator Durenberger?

Senator DURENBERGER. Senator, I compliment you on your area of concentration on the under 5, and potential and actual mothers. I am not sure I agree with some of the logic that I see articulated here, just because they are only consuming $250 per person per year against $1,200 and something in the over 65, but needless to say, my concerns are first about the financing, and second, the lack of an income standard, although that may not be a correct interpretation of what I see here. Third, I guess your choice of income tax revenues rather than the payroll tax which is in the Long bill or some other thing using inflation as a rationale, it seems to me that if there is anything inflationary in this system it is the income tax, in which we are being taxed on inflation to begin with. I guess I can't quite buy the logic that we can't look to a payroll tax or a premium tax or something else that puts at least part of the load on employers or insurers or whatever, but perhaps just in the form of a question, would you address yourself to the financing part of it and the eligibility as it relates to income?

Senator HART. Yes. First of all, let me make clear that by presenting the statistics about who consumes more, how much health care costs per age group, I did not by any means intend to suggest that this bill was pitched to the younger because they are cheaper to treat. The reason why it costs an average of $1,200 or $1,250 a year to treat a senior citizen is because they didn't get good treatment when they were 5 years old, and all I am saying is, we can do the right thing and the most economic thing at the same time for a civilized society: treat those who deserve and need the care most in some respects, the children, and save the society an enormous economic burden in later years by using essentially a preventive medicine approach.

So, I apologize if the statistics seem to indicate that I was going to the lower chronological end of the ladder essentially to save money. That wasn't the theory at all. It is essentially a preventive medicine idea.

Let me just say about the income tax system, the Senator from Kansas and I and a few others, have been very outspoken over the last few years, about the whole issue of indexing of the personal income tax brackets and rates. We have spoken out because of the very concern you mention. It is a serious issue we call the inherently inflationary impact of bracket creep. But I think the idea of going to the employer, or to the payroll tax system, is inflationary because

those costs obviously are passed on to the consumer in the economy. That is the whole point here. What we are trying to do is get away from that by suggesting the general revenue approach, which I think on balance would not be as inflationary as passing those costs on to the consumer and society.

We are going to try to balance the budget, to bring some control over inflation. I think that can be done, given the revenues figures I have seen on the Budget Committee. I believe we can balance the budget and afford a program of this magnitude.

Senator DURENBERGER. How about the issue of ability to pay as it relates to the provision of services? Catastrophic is free. The family will save $1,700 in prenatal and postnatal care. I take it that is all families, regardless of income.

Senator HART. That's right.

Senator DURENBERGER. Do you feel that is good public policy?

Senator HART. Provision of services to pregnant women and children is provided to all families regardless of the ability to pay is involved in the sliding scale of the deductible for the catastrophic plan. It isn't a fixed amount, but it is calculated as a percentage of income. That is in effect an ability to pay. If there is discrimination in my proposal, it is at the upper income levels, because people in the higher income brackets, in order to meet the first 10-percent break where 50 percent of costs are paid for, will obviously be talking about very large medical expenditures. And certainly for high income people to reach the 20 percent mark, after which everything is covered, we are talking about very large medical expenditures.

On the other hand, if you take the flat deductible approach you are discriminating against people at the lower income levels—senior citizens and very poor people who obviously can almost not at all afford the $2,500. So, there is, in effect, an ability-to-pay provision in the catastrophic by the sort of escalating step.

Senator DURENBERGER. Are you talking about a sliding scale deductible?

Senator HART. Yes, in effect. The individual under the catastrophic scheme would pay everything up to 10 percent of income; between 10 and 20 percent of income, he or she would pay 50 percent, the Government or the insurance would pay the other 50 percent; about 20 percent of income, everything is taken care of.

Senator DURENBERGER. Thank you.

The CHAIRMAN. Senator Danforth?

Senator DANFORTH. No questions, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Senator HART. Thank you, Mr. Chairman. I appreciate your time.

The CHAIRMAN. The Chair now recognizes the able Senator from Kansas, Mr. Dole.

Would you care to take the witness stand, Senator?

[The prepared statement of Senator Dole follows:]

DOLE CALLS FOR NATIONAL CATASTROPHIC HEALTH INSURANCE PLAN

WASHINGTON.—Senator Bob Dole (R-Ks.) today called for the enactment of a catastrophic health insurance plan before the Senate Finance Committee. The following is the text of Senator Dole's statement before the Committee:

Mr. Chairman, over a century has passed since Ralph Waldo Emerson told an audience "the first wealth is health." Emerson's maxim remains true; the health of a nation is intimately related to the wealth of its economy. America

is a rich nation, whose people are nonetheless drained by the costs of an enormous governmental structure. She is a nation proud of her achievements in the medical field; yet, as many as 46 million of her people have been estimated to have little or no protection from the economic ravages of catastrophic illness.

It is to correct this sad oversight, that Senators Danforth and Domenici have joined me in introducing S. 748.

It has been estimated that as many as seven million American families paid 15 percent or more of their income for medical care last year. Because all Americans share the fear of financial destruction, I believe we have an obligation to address this issue and move beyond the arguments of the past, which tell us that we should do nothing unless we do everything.

In seeking agreement on a proposal, I ask the Committee to keep in mind two fundamental principles: first, it scarcely bears repeating that our number one problem today is persistent, double digit inflation. It tears at the very fabric of American society, dividing people among artificial and deadly lines. And the number one cause of our current inflation is excessive Federal spending.

As a result, we who desire a system of health insurance must also remember this: we accomplish little or nothing if we protect our citizens from catastrophic health costs, while driving up the cost of all other goods and services. We would only rob an already impoverished Peter to pay Paul.

The second basic principle I ask you to keep in mind is this: experience teaches us that cost controls invariably lead to scarcity, rationing and further inflation. We need look no further than the current oil shortage for confirmation. To those waiting in line to buy gasoline—and that may well include some of the faces in this room—I ask you to think twice before adopting any grandiose new scheme of regulating a free market. Contrary to some, the Federal government is not divine—we cannot feed the multitudes with a few loaves and fishes. Neither can we guarantee quality health care for every American, while rigidly controlling prices. For all the public disagreement, both Senator Kennedy and President Carter would do this, and they would do something else. They would overlook the basic economic fact that cheap health services, like cheap gasoline, benefit no one if they are unavailable.

The proposals introduced by the distinguished Chairman, Senator Long, and S. 748, focus on catastrophic protection. The proposals outlined, but not yet introduced by the Administration, Senator Schweiker, and Senator Kennedy include protection against catastrophic expenses as well as various elements of comprehensive protection. In my opinion, a program providing catastrophic coverage as well as some needed changes in Medicare will resolve most of the real problems that we face in this area. It is also my opinion that such a program can be accomplished by relying almost entirely on the strong parts of our private health sector.

The first decision, then, that the Commimttee must make is whether we will propose a program of catastrophic coverage, or whether we will report out a bill that provides comprehensive, government controlled health care for everyone in this country. A complete government takeover of the health industry is unneeded and unwise. The cost controls measures included in these comprehensive bills may result in a decrease in the quality of health care and the availability of this care. One objection to comprehensive bills and which rises above all of these others, however, is that we simply cannot afford the price tag.

During the recent press debate over various health insurance proposals, the bill introduced by Senators Danforth, Domenici and me has often been ignored. The political pundits have chosen rather to concentrate on the grander proposals made by Senator Kennedy and President Carter.

As the debate now shifts from the media to the Congress, the responsible legislation that we have introduced will, hopefully, be seriously considered. One thing is certain, however; no health insurance proposal will become law without strong support from Republicans as well as Democrats. While the press may choose to ignore Repubican proposals, the Congress must weigh the input of all its members.

The principle assets of the 3 "D" bill, I believe, closely reflect the needs and wants of the American people. Our proposal provides protection for all Americans against financial ruination from the costs of catastrophic illness. It accomplishes this goal in the least expensive way and it accomplishes it through the private sector without creating another mammoth governmental bureaucracy.

In these times of fiscal restraint and talk of balanced budgets, the 3 "D" bill would cost the Federal Treasury about $3 billion and private employers approximately the same amount. By contrast, the Administration proposal is estimated to

to cost $30 billion and Senator Kennedy's bill is estimated at $40 billion. Even the Chairman's most recent proposal has a price tag in excess of $10 billion. I suggest that the country cannot afford so lavish a program.

There is no secret to the relative frugality of the 3 "D" bill. It cost less because it does not attempt to pay for all of the health needs of all Americans. It sets out to protect our citizens against the cost of catastrophic illness and it accomplishes its goal without frills or excess.

Second, our proposal is preferable to the others before the Committee because it accomplishes its end almost entirely through the private sector. No new bureaucracy is needed and none was created. The 3 "D" bill relies on the strengths of our present health system to provide needed catastrophic coverage.

There are basically three population groups of Americans that need catastrophic health protection: the elderly, the workforce and the poor. Using these three categories as a framework, I will describe the Dole, Danforth, Domenici proposal.

MEDICARE RECIPIENTS

The Medicare program currently provides coverage to 27 million elderly and disabled. The program covers approximately 38 percent of the health care expenses incurred by the elderly--leaving them responsible for 72 percent; on the average of $1,360 per year per individual.

In spite of these statistics, Medicare has, to a great extent, been a relatively successful program, and with some limited improvements such as those that we suggest, could solve many of the problems faced by the elderly.

The Dole-Danforth-Domenici bill, unlike the other proposals, maintains the Medicare program, essentially expanding it to include catastrophic benefits.

HOSPITAL CARE BENEFIT

Current law requires an initial patient deductible ($160 in 1979) and then medicare pays in full for hospital services for the first 60 days. Medicare continues to pay for these services from the 61st through the 90th day, except for a daily copayment ($40 in 1979). After the 90th day, beneficiaries are required to pay an additional amount per day ($80 in 1979). It is easy to see that an extended illness of more than 60 days could quickly exceed most senior citizens' budgets.

The proposed plan deletes the limitaton on the number of days covered by inpatient hospital services and eliminates all copayment requirements after the 60th day. The deductible remains in recognition of the importance of some cost sharing at the noncatastrophic level for the patient.

It is clear that after the 60th day, the cost starts to escalate and many senior citizens would be literally wiped out financially without some additional assistance.

SKILLED NURSING HOME SERVICES

The same is true of nursing homes. Under current law, medicare will pay for inpatient care in a participating skilled nursing facility following hospitalization. After the 20th day, however, there is a daily patient copayment requirement ($20 in 1979). Our plan makes skilled nursing facility services more available by eliminating the copayment requirement and lengthening the time after discharge from a hospital during which you can transfer to an SNF. It is also our intention to ease restrictions on reentry into an SNF after discharge from such a facility.

By making these services more readily available, unnecessary use of acute hospital services can often be avoided.

HOME HEALTH SERVICES

Home health services benefits are improved by deleting the current 100 visit limitation and 3-day prior hospitalization requirement. Also, the home bound requirement for such services will be liberalized, occupational therapy will be considered a primary service, and all home health aids will require appropriate training.

By upgrading home health services, more patients will be offered the opportunity of being cared for in the home. Patients should be encouraged to participate in limited activities such as adult day care as they might desire and not be forced to return to more expensive skilled nursing facilities or acute care facilities because of rules that do not accommodate reasonable circumstances.

MENTAL HEALTH BENEFITS

The plan calls for a modest increase in coverage of out-patient psychiatric benefits to $750 per year with cost-sharing that is consistent with other physician services.

Additionally, community mental health centers are recognized as providers. The Secretary of Health, Education, and Welfare is directed to determine the appropriate number of visits which will be covered. We believe we must move cautiously in this area to avoid the potential for abuse or overuse in the future, while still moving forward in making these important services more available.

LONG-TERM DRUG BENEFIT

"Catastrophic" coverage will begin for Medicare beneficiaries when they have incurred $5,000 in expenses for certain covered services or have spent an amount equal to 20 percent of that deductible out-of-pocket for these same services. The deductible amount is for fiscal year 1980. In future years, this amount will be indexed to the medical care component of the consumer price index and other health care economic measures.

Certain prescription drugs, while not normally a covered expense, would count toward calculating the deductible and would be covered under the catastrophic program after the deductible has been met. This limited drug benefit (similar to one passed by the Senate as part of the 1972 Medicare/Medicaid Amendments) would include payment for drugs traditionally used on a long-term basis for chronic problems, such as hypertension. Such drugs often comprise a significant portion of the patient's out-of-pocket expenses. Once the beneficiary meets the $5,000 incurred expense deductible or the out-of-pocket deductible, payment for these drugs would be made until termination of the catastrophic benefit period. Although this drug provision is limited because of cost, it is our hope that fuller coverage could be provided in the future.

Once the catastrophic test has been met, Medicare would pay 100 percent of the usual and customary charges or reasonable cost, whichever is appropriate, for services covered under Medicare, Part B, such as doctor bills. Since Medicare usually pays 80 percent of such charges, this provision would serve to protect the Medicare beneficiary from additional out-of-pocket expenses during a catastrophic situation.

The financing mechanism for these modifications in the present Medicare benefits will be unchanged from the existing program. Although estimates are still very preliminary, our current projections for the cost of these program changes are between $500 to $700 million in fiscal year 1981. All of these Medicare changes will go into effect January 1, 1981, except for the drug benefit which would begin January 1, 1982.

PRIVATE CATASTROPHIC INSURANCE

The intent of the second part of the plan is to assure that the large majority of the employed population has available the option of protecting themselves and their families from catastrophic illness through the purchase of private insurance.

This, I am sure, will cause some controversy and some opposition to our proposal, but all employers will be required to offer their employees group health insurance with minimal catastrophic benefits. These plans will include coverage for inpatient hospitalization after the 60th day of hospitalization and payment for certain services which are identical to those provided under Part B of Medicare without copayment after $5,000 in medical expenses for those services has been incurred.

Because of the problems evident with a two part deductible, I now believe a single dollar limit would be a better approach. I propose that we report a bill with a maximum personal liability deductible of $3,000 for an individual and $5,000 for a family. This would mean a new cost of approximately $2 billion to the employer and employee combined.

This minimal coverage would have to be offered to all who have been employed for 30 days and work at least 25 hours per week without regard to health status. Employees would be free to choose to participate or not, and plans could not exclude benefits for preexisting medical conditions.

The plan calls for a cost-sharing which would limit the employee's share of the premium to a maximum 25 percent of the cost of catastrophic coverage.

The bill includes provisions to allow tax deductions for premium costs for both the employer and employee. The employer would be allowed to claim a business expense for health insurance premiums only if the policy contains the requisite catastrophic coverage. As under current law, employees would be able to deduct one-half of the cost of their premiums (up to $150). However, we require that the plan, in order to qualify for deduction purposes, must include the minimum catastrophic benefits defined by this act.

There are provisions to continue coverage during periods of unemployment. The employer will be required to continue his contribution for a maximum of 3 months; after which the employee could continue coverage at his own expense.

The 3 "D" proposal provides a limited, five year, sliding scale tax subsidy to employers whose payroll costs increase 2 percent or more because of compliance with this mandate.

The employer should receive assistance at the time of most severe impact. A five year limit on the subsidy program provides ample opportunity to the employer to adjust their budget, and protects the Federal Treasury against long term revenue losses.

Employers would be subject to a civil penalty for not offering an appropriate plan to their employees. Employees would also be able to bring a private right of action against any employer, who fails to make available the required catastrophic coverage, for amounts that would have been payable under such coverage.

It is our belief by requiring at least minimum catastrophic insurance coverage for those who are employed we will significantly decrease the total number of unprotected individuals since over one-third of those without any health insurance are full-time wage earners and heads of families. Also, when an employed family head is without insurance, the chances are 8 in 10 the family members are also without insurance. This proposal recognizes the importance in reaching those without adequate coverage by including the entire family unit in approved plans. All employers will be required to comply by January 1, 1982.

RESIDUAL MARKET PLAN

While there appears to be a consensus growing, or at least the ground work for consensus in the areas of Medicare reform and employer based insurance, there is little agreement in the area regarding protection for the poor and near poor.

The Administration bill, the Kennedy bill and two of the three Long proposals, suggest we substantially expand the Federal role in providing care to those individuals and their families through Medicaid or a similar program.

While I agree that some changes in the Medicaid program are necessary, I do not believe that further expansion of this government program or creation of yet another program is the only solution to assisting those not currently eligible.

Those who choose (except those covered by Medicare, Medicaid, or private insurance) can participate in the third portion of this program. The purpose of this portion of the plan is to provide the opportunity for those who are not otherwise covered to purchase a private catastrophic health insurance plan.

The Secretary of Health, Education, and Welfare will enter into agreements with private insurance companies for them to make available policies which provide catastrophic coverage. These benefits would include coverage for hospital services after the individual or family unit has been hospitalized for 60 days in a year and coverage for medical services after $5,000 expenses have been incurred for these services. I believe these deductibles should also be changed to a single indexed deductible as I explained earlier.

The second—alternative—deductible included in these plans would allow coverage to begin once the individual or family has an out-of-pocket for covered services equal to 15 percent of their adjusted gross income. This allows for a much truer definition of catastrophic for the low income.

Possible improvements in the administration of this section have become evident to us since introduction of our bill and should be considered. However, the concept of assisting people purchase private insurance rather than expanding Government programs is clearly preferable.

Insurance companies would establish premiums which would be community rated. The premiums might vary from one area to another, but they would not vary based on the individual's or his family's health status.

A subsidy would be provided to those with lower incomes to assist them in purchasing a policy. This subsidy would be indexed according to income such that someone without income could have their entire premium paid for by the Government while someone whose income was 120 percent of the national poverty level would pay the entire premium. The indexing would be phased in such a manner as to avoid an "notching." We believe that this approach will enable all those who so desire to purchase catastrophic health insurance for a price they can afford.

The 3 "D" would also expand the existing Medicaid program. The bill mandates that states provide catastrophic coverage for their recipients once an individual or family meets the $5000 or 60 day deductible. However, I now believe we might consider other changes in the Medicaid program which would afford the states the opportunity to test out alternatives to their present systems best suited to the problems they have experienced.

A block grant approach to medicaid title XX moneys and title V moneys, similar in design to the welfare block grant program that Senator Long and I intend to introduce tomorrow, should be considered.

Our goal with the welfare block grant program is to provide a strong incentive for the states to eliminate error, waste and fraud in welfare programs, and to reduce overall welfare spending, while at the same time allowing the states to mold their own programs to their particular needs.

The welfare bill also provides fiscal relief to all states which may be used to reduce overall state welfare spending and increase basic benefits for the truly needy.

A similar approach with similar goals might well be appropriate in an attempt to solve the many problems facing the Medicaid program.

CONCLUSION

The bill that Senators Danforth, Domenici, and I introduced was a working document. We sought out and received many suggested improvements which I believe should be included in our bill. I believe the authors of the other proposals pending before us feel much the same way about their bills.

Let us deliberate over the merits and flaws of the health proposals before us. Let us try for a moment or two to put away the siren call of partisan politics and keep in mind what it is we're doing here.

We're here to confront a serious national problem. We're charged with addressing that problem in a manner that is cost efficient and protective of the quality of American health care.

I look forward to working with each of you in addressing these concerns.

STATEMENT OF HON. ROBERT DOLE, U.S. SENATOR FROM THE STATE OF KANSAS

Senator DOLE. Senator Danforth may want to join me. He is the second of the three D's

Senator DANFORTH. I am going to sit up here and throw you hanging curve balls.

[General laughter.]

Senator DOLE. Mr. Chairman, I think in the interest of time, I would ask that my statement be made a part of the record, and I will summarize, because I think there is some interest in knowing a little about what the various proposals do and do not do.

I think Under Secretary Champion indicated the need for us to do something. I don't have any quarrel with his first few charts, which point up the millions of people who don't have adequate coverage, and some who have none at all. That is an oversight that we have tried to address in the Dole-Danforth-Domenici proposal. It has also been estimated that about 7 million Americans paid 15 or more percent of their income for medical care last year, and it seems to me that this is why we ought to address in particular the one area of catastrophic

coverage. I guess it may bear repeating; the problem is, as everyone on this committee knows, this double-digit inflation. How much can we afford? Maybe not what we would like to do if we had the resources, but how much can we afford?

I think the second basic principle is that if we mandate cost controls, it is going to lead to scarcity and rationing and further inflation. I think we can look at the current oil shortage for confirmation. To those waiting in line to buy gasoline, and that may well include some of the faces in this room, I ask you to think twice before adopting any grandiose new scheme of regulating a free market.

Contrary to some, the Federal Government is not divine. We cannot feed the multitudes with a few loaves and fishes. Neither can we guarantee quality health care for every American while rigidly controlling prices. For all the public disagreement, both Senator Kennedy and President Carter would do this, and they would do something else. They would overlook the basic economic fact that cheap health services, like cheap gasoline, benefit no one if they are unavailable.

The proposal introduced by the distinguished chairman, Senator Long—S. 760—and my proposal—S. 748—focus on catastrophic protection. The proposals outlined but not introduced by the administration, Senator Schweiker, and Senator Kennedy, include protection against catastrophic expenses as well as various elements of comprehensive protection.

In my opinion, a program providing catastrophic coverage as well as some needed changes in medicare will resolve most of the real problems that we face in this area. It is also my opinion that such a program could be accomplished by relying almost entirely on the strong parts of our private health sector, and so I guess the first decision the committee must make is whether we are going to impose a program of catastrophic coverage or provide out a bill that provides comprehensive Government health care for everyone in this country.

We have had a lot of debate, a lot of indication in the press, in the media. It seems to me, as I have said earlier, and I don't fault anyone for the interest when you have such powerful leaders as Senator Kennedy and President Carter with differing views on health care, but it is time now to move, to shift the attention to the Congress, to see if we can pass with bipartisan support responsible legislation.

Now, I believe that the principal assets of the "3D" bill closely reflect the needs and wants of the American people. It does provide protection for all Americans against financial ruination from the costs of catastrophic illness. It accomplishes this goal in the least expensive way and through private sector without creating another mammoth governmental bureaucracy.

Now, we look at the cost, and I would assume that probably none of the cost figures are totally accurate at this point, but ours would cost the Federal Treasury about $3 billion, and private employers about the same amount, and we have all had estimates on the costs of the administration proposal and the Kennedy proposal, and even the chairman's most recent proposal has a price tag in excess of $10 billion, and so we get into a question of just how much we can afford, notwithstanding how much we might want to do.

There is no secret about the relative frugality of the 3D bill. It costs less because it doesn't attempt to pay for all the health needs of all Americans. It sets out to protect our citizens against the cost of catastrophic illness, and it accomplishes this without frills or excess.

Second, I believe the proposal is preferable to others before the committee because it accomplishes its end almost entirely through the private sector. We don't need a new bureaucracy. We rely on the strengths of our present health system to provide needed catastrophic coverage.

Then I would just very quickly indicate just which groups the 3D proposal addresses. First, it addresses the elderly. It addresses the work force, and it addresses the poor. Using these three categories, I will quickly indicate how it does this.

We are all aware that the medicare program currently provides coverage to 27 million elderly and disabled. It covers approximately 38 percent of the health care expenses incurred by the elderly, leaving them responsible for 72 percent, on the average about $1,360 per year per individual.

In spite of these statistics, medicare has to a great extent been a relatively successful program, and with some limited improvements, such as those that we suggest, can solve many of the problems faced by the elderly.

The 3D proposal, unlike the others, maintains the medicare program, essentially expanding it to include catastrophic benefits. Current law requires an initial patent deductible of $160 in 1979, and then medicare pays in full for hospital services for the first 60 days. Medicare continues to pay for these services from the 61st through the 90th day, except for a daily copayment of $40 in 1979. After the 90th day, beneficiaries are required to pay an additional amount per day of $80 in 1979.

It is easy to see that an extended illness of more than 60 days could quickly exceed most senior citizens' budgets. The 3D plan deletes the limitation on the number of days covered by inpatient hospital services, and eliminates all copayment requirements after the 60th day.

The deductible remains in recognition of the importance of some cost sharing at the noncatastrophic level for the patient. It is clear that after the 60th day the cost starts to escalate, and many senior citizens could be literally wiped out financially without some additional assistance. The same is true of nursing homes.

Under current law, medicare will pay for inpatient care in a participating skilled nursing home facility following hospitalization. After the 20th day, however, there is a daily patient copayment requirement, $20 in 1979. Our plan makes skilled nursing facility services more available by eliminating the copayment requirement, and lengthening the time after discharge from the hospital during which you can transfer to a skilled nursing facility.

It is also our intention to ease restrictions on reentry into a skilled nursing facility after discharge from such facility. By making these services more readily available, unnecessary use of acute hospital services can often be avoided.

Another portion of our bill that is of particular interest to Senator Domenici and I think also to Senator Packwood, who is not a cosponsor

but who has an interest in this area, home health service benefits are improved by deleting the current 100-visit limitation, and 3-day prior hospitalization requirement. Also, the homebound requirement for such services will be liberalized. Occupational therapy will be considered a primary service, and all home health aides will require appropriate training.

By upgrading home health services, more patients would be offered the opportunity of being cared for in the home, and patients should be encouraged to participate in limited activities such as adult day care, as they might desire not to be forced to return to more expensive skilled nursing facilities or acute care facilities because of rules that do not accommodate reasonable circumstances.

The plan calls for a modest increase in coverage of outpatient psychiatric benefits, $750 per year, with cost sharing that is consistent with other physician services. Additionally, community mental health centers are recognized as providers. The Secretary of HEW is directed to determine the appropriate number of visits which will be covered.

We believe we must move cautiously in this area to avoid potential abuse or overuse in the future while still moving forward in making these important services available.

LONG-TERM DRUG BENEFITS

Catastrophic coverage will begin for medicare beneficiaries when they have incurred $5,000 in expenses for certain covered services or spent an amount equal to 20 percent of that deductible out of pocket for these same services. The deductible amount is for fiscal year 1980. In future years, this amount will be indexed with the medical care component of the consumer price index and other health care economic measures.

Certain prescription drugs, while not normally a covered expense, would count toward calculating the deductible and would be covered under the catastrophic program after the deductible has been met. This limited drug benefit, similar to the one passed by the Senate as a part of the 1972 medicare-medicaid amendments, would include payments for drugs traditionally used on a long-term basis for chronic problems such as hypertension.

Such drugs often comprise a significant portion of the patient's out-of-pocket expenses. Once the beneficiary meets the $5,000 incurred expense deductible or the out-of-pocket deductible, payment for these drugs would be made until termination of the catastrophic benefit period. Although this drug provision is limited because of cost, it is our hope that fuller coverage can be provided in the future.

Once the catastrophic test has been met, medicare would pay 100 percent of the usual and customary charges or reasonable cost, whichever is appropriate, for services covered under medicare part B, such as doctors' bills.

The financing mechanism for these modifications to the present medicare benefits will be unchanged in the existing program. Although estimates are still very preliminary, our current projection of the cost of these program changes are between $500 million to $700 million in fiscal year 1981. All of these medicare changes will

go into effect on January 1, 1981, except for the drug benefit, which will begin in January of 1982. That is the first part of the plan.

I think the second part is very much like that proposed by the administration, and somewhat like Senator Kennedy's, and very much like S. 760 proposed by Senator Long. The intent of the plan is to assure that the large majority of the employed population has available the option of protecting themselves and their families from catastrophic illness through the purchase of private insurance.

I am certain there is going to be some controversy. Some of the employers will be under some stress having to meet some of the payments, paying for the coverage, but these plans will include coverage for in-patient hospitalization after the 60th day of hospitalization, and payment for certain services which are identical to those provided under part B of medicare without copayment after $5,000 in medical expenses for those services.

Because of the problems evident with a two-part deductible, which we have in our bill, I now believe that a single dollar limit would be a better approach. I propose that we report a bill with a maximum personal liability deductible of $3,000 for an individual and $5,000 for a family. This would mean a new cost of approximately $2 billion to the employer-employee combined.

This minimal coverage would have to be offered to all who had been employed for 30 days and who work at least 25 hours per week, without regard to health status. The plan calls for cost sharing, which would limit the employee's share of the premium to a maximum of 25 percent, which is somewhat different than the chairman's proposal, where I believe the employer would pick up all the costs.

The bill includes provisions to allow tax deductions for premium costs for both the employer and employee. The employer would be allowed to claim a business expense for health insurance premiums only if the policy contains the requisite catastrophic coverage. As under current law, employees would be able to deduct one-half the cost of their premiums up to $150. However, it would require that the plan, in order to qualify for deduction purposes, must include the minimum catastrophic benefits defined by this act.

We also provide in our proposal that the employee would be required to continue his contributions for 3 months after termination of employment. After that, the employee would have to provide his own coverage at his own expense. We provide a limited 5-year sliding scale tax subsidy to employers whose payroll costs increase 2 percent or more because of compliance with this mandate.

The employer should receive assistance at the time of most severe impact. A 5-year limit on the subsidy program provides ample opportunity, we believe, for adjustment.

Employers would be subject to a civil penalty for not offering an appropriate plan to their employees. Employees would also be able to bring a private right of action against any employer who fails to make available the required catastrophic coverage for the amounts that would have been payable under such coverage.

It is our belief that by requiring at least a minimum catastrophic insurance coverage for those who are employed, we will significantly decrease the total number of unprotected individuals, since over one-third of those without any health insurance are full-time wage earners

and heads of families. Also when an employed family head is without insurance, the changes are 8 in 10 the family members are also without insurance, and this proposal recognizes the importance in reaching those without adequate coverage by including the entire family unit in approved plans.

All employers will be required to comply by January 1, 1982.

Then, finally, the so-called residual market plan, and I don't believe we do as much in this area as the chairman would do under some of the medicaid changes, there seems to be a consensus growing, or at least the ground work for a consensus in the areas of medicare reform and employer based insurance. There is little agreement in the area regarding protection for the poor and the near poor. The administration bill, the Kennedy bill, and two of the three Long proposals suggest we substantially expand the Federal role in providing care for those individuals and their families through medicaid or a similar program.

While I agree that some changes in the medicaid program are necessary, I do not believe that further expansion of this program or creation of another program as the administration would do through their new health care program is the only solution.

Those who choose, except those who are covered by medicare, medicaid, or private insurance, can participate in the third portion of the so-called "3D" proposal, and the purpose of this portion of the plan is to provide the opportunity for those who are not otherwise covered to purchase a private catastrophic health insurance plan. The Secretary of HEW will enter into agreements with private insurance companies for them to make available policies which provide catastrophic coverage. These benefits would include coverage for hospital services after the individual or family unit has been hospitalized for 60 days in a year, and coverage for medical services after $5,000 expenses have been incurred for these services.

I believe that we also should change these deductibles to a single indexed deductible, as I explained earlier.

The second alternative deductible included in these plans would allow coverage to begin once the individual or family has an out-of-pocket expense for covered services equal to 15 percent of their adjusted gross income, which would mean it would be triggered very early in most cases. This allows, I think, for a truer definition of catastrophic for the low income.

Possible improvements in the administration of this section have been evident to us since the introduction of our bill and should be considered. However, the concept of assisting people to purchase private insurance rather than expanding Government programs I think deserves some attention. Insurance companies would establish premiums which would be community rated. The premiums might vary from one area to another, but they would not vary based on the individual or his family's health status.

A subsidy would be provided to those with lower incomes to assist them in purchasing a policy. This subsidy would be indexed to income so that someone without income could have their entire premium paid for by the Government, while someone whose income was 120 percent of the national poverty level would pay the entire premium. The indexing would be phased in such a manner as to avoid any notching. We believe this approach has merit.

Finally, we do expand the existing medicaid program. We mandate that States providing catastrophic coverage for their recipients once an individual or family meets the $5,000 or $60 deductible. However, I now believe we might consider other changes in the medicaid program which would afford the States the opportunity to test out alternatives to their present systems best suited to the problems they have experienced.

A bloc grant approach to the medicaid title XX moneys and title V moneys similar to the design of the welfare bloc grant program might be such an approach. We are looking at the possibility of introducing a bloc grant welfare program, and that might provide the States with a strong incentive to eliminate error, waste, and fraud in welfare programs and reduce overall welfare spending, while at the same time allowing the States to mold their own programs to their particular needs.

Let me say finally, this bill was introduced as a working document. It is the result of months and months of effort by my staff, Senator Danforth's staff, Senator Domenici's staff, and by those of us, the three of us involved directly. We tried to seek out as many suggestions as we could, keeping in mind the budget constraints, and just what the direction was that we wanted to pursue, and it seems to me that we have reached a point now where, with the different programs that are available for consideration, and those that will be introduced by Senators Kennedy and Schweiker and the administration, that this exercise this morning is a good beginning. At least we are off and running. I am not certain in which direction, but we are off and running.

It seems to me there is a possibility we will all end up going in the same direction. Maybe some will veer a little to the left or a little to the right, but I think most of us will go right down the middle, and it seems to me the middle ground would be along the lines suggested over the years by Senators Ribicoff, Talmadge, Long, myself, Senator Danforth, and others in an effort to point out some of the differences, I think.

We should make an effort to point out some of the differences, I think. They are all pointed out in the blue book, but they should be made a part of the record. I would hope that they are made a part of the record so that when we review the record, we can see that a line of this bill does this, the Danforth bill does this, the Carter bill does this.

We have a preliminary breakdown of this, which I ask to be made part of the record, Mr. Chairman, because I think that it is important. It is based on what we believe will be in the Kennedy bill, and what we believe will be in the administration proposal.

The CHAIRMAN. We have a rather large chart available here, Senator. Maybe it can be put in the centerfold, or included somehow.

[The following was subsequently supplied for the record:]

	Kennedy	Dole/Domenici/Danforth	Carter	Long
General approach	Establishes comprehensive national health insurance program for entire population financed by numerous sources. Expansion of medicare Medicaid eligibles covered through new program. Mandates employer coverage for employees.	Creates health insurance program providing opportunity to all Americans to protect themselves against catastrophic expenses. Expansion of medicare benefits Mandates States provide catastrophic benefits to medicaid eligibles. Employer-based program for employees that picks up costs after 60 days in hospital or $5,000 in medical expenses.	Creates a new $18,200,000,000 umbrella Federal insurance program—healthcare—consolidating medicaid for the elderly—into a single structure. It also would cover the near poor, small and and high-risk businesses, and others not covered. The employer guarantee: Requiring employers to provide minimum catastrophic coverage. Coverage starts after the 1st $2,500 of out-of-pocket expenses. For all pregnant women, prenatal care would be provided through healthcare or private plans, as would infant services for at least the 1st year of a child's life.	Creates health insurance program to program to protect poor and employed against catastrophic expenses. Federalizes medicaid program expanding eligibility. Employer-based program for employees that picks up costs after 60 days in hospital or $2,000 in medical expenses.
People covered	Every U.S. citizen and permanent resident alien regardless of whether they elect coverage. (legal nonresident aliens)	Every U.S. citizen who elects coverage	Every U.S. citizen and resident	Most U.S. citizens who are poor or who are employed.
Scope of benefits	Comprehensive (similar to medicare) limits applied primarily in areas of psychiatric care, nursing home care, and prescription drugs. No cost sharing requirements.	Comprehensive (similar to medicare) after individual has reached catastrophic limit $5,000, 60 hospital days).	Comprehensive (similar to medicare) after family has reached catastrophic limit of $2,500. Coverage of all prenatal, delivery, and infant services without any patient cost sharing.	For employed; comprehensive (similar to medicare) after individual has reached catastrophic limit ($2,000, 60 days). For poor; comprehensive—no limit.
Medicare changes	Program remains Expands eligibility Removes limits on hospital care Provides reimbursement for chronic illness drugs. Not included Mandates physician accept payment as payment in full. No limit on out of pocket	Program remains No expansion of eligibility Same Provides reimbursement for chronic illness drugs when individual hits catastrophic limit. Removes limits on home health care No physician mandate Limits out-of-pocket expenses to $1,000	Consolidate medicare Expands eligibility. Removes limits on hospital care. No increased drug coverage. No changes in home health care benefit. Mandates physician accept Federal payment as payment in full. Limits out-of-pocket expenses to $1,250.	None.
Medicaid	Is eliminated as separate program The poor are eligible for a health card and for all benefits.	Program remains State responsibility State must provide catastrophic coverage beyond $5,000, 60 days.	Federalizes program. Expand eligibility to all who meet income test. Expands services. Combines medicaid with medicare in 1 major Federal program. Pays all providers at medicare rates. Cost of administration of new program equals $2,100,000,000.	Federalized; eligibility increases.

	Kennedy	Dole/Domenici/Danforth	Carter	Long
Private system	Employer/employee premiums wage related for comprehensive coverage.	Employer/employee premiums for catastrophic coverage.	Employer/employee premiums for catastrophic coverage and for prenatal, delivery, and infant care services.	Mandated employer—premiums for catastrophic coverage for employees.
	Puts all institutions on prospective rate budgets.	Nothing included to change system	Assumes passage of hospital cost containment and controls on what is paid to hospitals by all payors.	No change in system.
	Puts all doctors on negotiated fee schedules. Employers use heavily regulated private sector "consortia" to purchase coverage.	No physician fee schedule. Employers use private sector to buy coverage.	Fee schedule developed and names of physicians willing to participate in fee schedule for the public program are published—this is to encourage shopping by consumers for cost efficient physicians.	Do.
	Creates massive new Federal and State bureaucracy to run new program.	No new Federal or State bureaucracy	Increased bureaucracy because of combination of medicare/medicaid.	An increase in Federal role in medicaid.
	No tax subsidy	Tax subsidy for employers whose payroll costs increase 3 percent or more because of catastrophic coverage.	Employers can choose to buy insurance from either the Government health-care program or through a private company—subsidy provided under limited circumstances. Standards for private insurers developed.	Tax subsidy for employers.
Cost	$35,700,000,000	$1,300,000,000	$18,300,000,000	$10,000,000,000.

Senator DOLE. There have been other kinds of comparisons. Frankly, there have been so many Long bills introduced, with the paper shortage being what it is, we addressed the most recent Long proposal, which is the one without the payroll tax. I am not certain where we will come out. We will try to take care of that. Thank you.

The CHAIRMAN. Thank you very much.

Senator Ribicoff?

Senator RIBICOFF. I have no questions, but I am very pleased with the constructive approach taken by Senators Dole, Danforth, and Domenici.

I agree with Senator Dole that there is an opportunity and that all of these suggestions have merit. It is surprising how many similarities there are in all the plans. That is why I am so encouraged. If we work carefully and cooperatively, we can really come through with a program and a bill that will have overwhelming support in the U.S. Senate.

The CHAIRMAN. Senator Dole, I appreciate your testimony. You have given us some very good suggestions here, and I am certainly going to give them further study over night.

I hope that you will see that every one of the points that were made here will be considered as we go through and vote on these various proposals. I am sure you will.

My thought is that if we have 100 suggestions, just to pick a number, and if we find that 25 of them are good, and we can muster up a majority vote, we should report the part that we can muster up a majority vote for, and let the Senate work its will. Maybe the Senate will want to make it smaller or make it bigger.

I have been around here for 31 years now. But it is a new experience for me to be told that what I have is a good proposal insofar as it goes, but that all I have is $24 billion worth of good, and that being the case they cannot go along with anything as austere as that. They say, if you cannot move up to the $70 or $80 billion figure, we will just have to reject your suggestion. I must say that to one who is sitting on the Finance Committee, that is hard to get adjusted to. If we cannot think in terms of $60 or $80 billion, we are not ready for the latter part of the 20th century.

I will personally vote for whatever we can report out, be it a part of the Long bill or the Dole bill, or whatever we can get a majority to agree on. We have to start looking after these catastrophic cases.

Now is it not true that in the main, that middle-income people are paying the full share in taxes directly and indirectly?

Senator DOLE. There is no doubt about it. They are probably paying more than their full share.

The CHAIRMAN. They are on the putting up end and have been there from the beginning. They have been waiting for a lifetime to be on the taking-down end.

At some point after taking care of everybody else's expenses, when they have a case where the cost is overwhelming and tends to wipe them out completely, that is their turn to be on the taking-down end for a change. That is basically the kind of thing that you are talking about here. One way or the other we must see that they are protected.

I would ask you this, what is your reaction to the spend-down pro-

vision? The administration favors it, and Senator Ribicoff favors that.

Let's say a low-income person, making the minimum wage, has a family and they are running into a very high medical expense. If that fellow has had even $2,000 of medical expenses, he is pretty well gone, and he does not have any resources left.

Our suggestion is, in that case, we would make him eligible for medicaid under the low-income part of our plan.

How does that strike you?

Senator DOLE. I am not certain what the cost would be, but I think it is an area that should be addressed. We did not go quite that far in expansion of medicaid. I have not talked with my prime cosponsor, Jack Danforth, but I recognize an area that we ought to look at.

We raise the question, what do we do about the poor and the near poor? Do you expand medicaid or do you try to dream up some insurance system which might be effective, or might not be effective, where you have, in effect, a pool directed by HEW, depending on your income.

We might make it so complicated that the proposal you suggest might have more merit, depending on the cost.

The CHAIRMAN. One other point. One of the arguments made against the catastrophic coverage is that this would tend to waste money by concentrating it on costs of exotic services. What is your reaction to that argument?

Senator DOLE. I have asked the question of Under Secretary Champion. That is an argument used. It is one that Senator Kennedy refers to.

The kidney program that started out at $40 million is now almost $1 billion. It is one of the bad examples when you start addressing the catastrophic area.

We do not totally subscribe to that view. It seems to us we are getting right back to the question you raised, there is always somebody on the paying end, never on the receiving end. We are trying to address that group as well as others, and it is not necessarily the catastrophic that is going to take care of all the money.

It is an area that should be addressed. We are willing to take a look at that. We asked Mr. Champion to give us more information. Maybe that can justify that statement. I am not satisfied that is the case.

The CHAIRMAN: We asked the witness for the UAW, which has major medical protection, which one of the services they have under contract with the automobile companies would they think to be exotic? The witness was not in a position to name one. I do not know of anybody who is going to write out $3,000 or $5,000 of medical expenses just so he can have the Government take care of the part or the private insurance company take care of the part that goes above the $3,000. Do you?

Senator DOLE. No.

Another point. Most people look at catastrophic, but they are only talking about senior citizens. That is not the case.

I assume there are percentage on this. My interest was, I think CBS a year ago showed a mother and father with a 3-year-old son who had been hospitalized almost every day since birth. They were in an income

bracket where they could not qualify for any assistance. Their insurance limit had been terminated. They exceeded their limit.

They were about $100,000 in debt. It seems to me that that is an area where we should address. That will be addressed in this proposal.

My point is that it does not just cover those who may be in the later years suffering some chronic illness. That is not the case at all.

The CHAIRMAN. Senator Durenberger?

Senator DURENBERGER. I have no questions.

The CHAIRMAN. Senator Danforth?

Senator DANFORTH. Mr. Chairman, this is something that Senator Dole has worked on for a long time and I think that it is really characteristic of him. It is something that is very responsive and well thought out and positive in its approach, and I really think that he is to be highly complimented on this approach.

It seems to me, as I read the Finance Committee, that there is an opportunity here to put together a consensus on some kind of health insurance program. Obviously when you put together a consensus, nobody is going to be totally satisfied, but there is an opportunity to move in a common direction, and we should take that opportunity.

I think the question is, where do we start? What are the first steps? What can we do?

I think that this is something that Senator Dole recognizes. Where we start are with the kinds of medical costs that wipe a family out. Those are the things that people should be protected against.

Most families, 90 percent, have some kind of first dollar coverage now. However, the problem we have here is when that first dollar coverage runs out, and when families are faced with the possibility of being wiped out by truly extraordinary medical expenses. Last year 7 million American families paid out of their own pockets medical bills which exceeded 15 percent of their income. That is the kind of thing that can destroy everything a family has been working for all its life, and it seems to me that that is the kind of thing that we should start acting against.

Now, one of the problems with some of the proposals, for example, the administration's $18 billion proposal, is that we just don't have that kind of money. It is just as simple as that. Our Government—I don't know a nicer way to say it—our Government is broke. We are broke, and every time we raise the debt ceiling, we recognize the fact that we are broke, and we have to engage in a kind of a slight of hand in order to save ourselves from true embarrassment, from going belly up, as we were told every year.

So, the question is, how much can we afford. Now, we are told that hospital cost containment will pay for the cost of national health insurance.

Mr. Chairman, that is not true. That is not true. Under the hospital cost containment bill that the administration is proposing, they anticipate saving $600 million the first year, and then it is supposed to go up, but it just seems that if you tell the average citizen, folks, we are going to greatly increase your benefits, and we are going to increase the reporting, informational, administrative costs of hospitals, and it is not going to cost anything, that is the kind of thing, when I was the

attorney general of Missouri, that was the kind of statement we investigated. [General laughter.]

Senator DANFORTH. So, I really think that to say, well, hospital cost containment is going to mean that all of this is free, that the people who say that there is no free lunch are really just a bunch of sourpusses and cynics, is not really a very honest statement It seems to me that as we proceed on the road to some sort of health insurance, the proposal Senator Dole has made is exactly the kind of thing that could win a consensus with the Finance Committee.

Let me just make one additional statement, and this is one that I don't think Senator Dole agrees with. It seems to me that one way to afford doing something on health insurance is to increase the excise tax on cigarettes. When I proposed that, the Winston-Salem newspaper ran an editorial saying that I was Califano's clone. [General laughter.]

Secretary Califano wrote me a note saying that in his opinion, that was a compliment to me. [General laughter.]

The cigarette tax, the Federal excise tax on cigarettes, was last increased in 1951, and at that time the Federal excise tax on cigarettes was one-third of the cost of a pack of cigarettes. Now it is about one-seventh of the cost of a pack. If we were to raise the cost of a pack of cigarettes by a dime, I think most Americans would not grouse about that. The cost to the Treasury obtained for health care related to cigarette smoking is estimated to be about $3 billion a year, and the amount of revenue we could raise from just that dime a pack increase would be about $3 billion a year.

So, that would pay for the Dole approach to health insurance right there, and it would be my hope that that would be something that we as a committee could consider.

Senator DOLE. I am willing to consider that later. [General laughter.]

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. I would simply like to thank Senator Dole for what he has proposed and for what his colleagues have proposed, and say that for a generation now of American Government, catastrophic health insurance has been blocked by the unwillingness of people who want a total program, however they define it, to accept something less than total. It is a syndrome almost. We sought welfare reform, and the good becomes the enemy of the best, and in the end you get nothing, and I think this committee is disposed at this time to do something, and we probably want to do more than you do, but less than those who want everything and nothing if they can't have everything. It is characteristically a Dole proposal to propose what can be had, and what you propose is very much worth having.

I would just like to congratulate you and of course Senater Danforth and Senator Domenici. I think also, as you are aware of course, they are looking in New York State on a State level at catastrophic coverage. I had an opportunity to visit with Senator Lombardi, and it seems to me if I have one view about this, I would ask you this question. One of the things we are trying to do here is to establish a uniformity of protection and availability of health services in these matters at different ranges perhaps, different categories, but uniformity.

and yet we persist in the extraordinary lack, extraordinary inequalities in our medicaid program, I mean, from States with a very high level of protection to States with very low, and this seems to me to be a legacy of administrative policy decisions made during the New Deal which don't really serve the country that well, and certainly don't serve this object well.

If we want good health care, it ought to approach uniformity of cost as well as uniformity of concept, if you follow what I mean. There is not that much difference in levels of cost, price levels. Don't you think we ought to have more uniform benefit levels in medicare?

Senator DOLE. In medicare or medicaid?

Senator MOYNIHAN. I'm sorry, in medicaid.

Senator DOLE. Medicaid. Yes. In fact, we address that in our statement.

Senator MOYNIHAN. I think you do.

Senator DOLE. We don't do as much in the medicaid area, I might add, as Senator Long and Ribicoff would do, but it is an area that I think we need to consider as we are trying to find a consensus that Senator Danforth talked about.

Senator MOYNIHAN. Yes. I was very encouraged by what you did say, and I think there is a consensus emerging here. I thank the chairman and I thank you particularly, Senator Dole.

The CHAIRMAN. Thank you very much.

Let me just announce that Senator Kennedy and Senator Schweiker have announced major health insurance proposals, and unfortunately they were not able to be with us today. Perhaps they can meet with us later on, but they couldn't be here today because of conflicts in their schedules. However, they have both submitted detailed information on their proposals, and I would like to ask that their proposals with the details submitted be added to the record, and perhaps they would like to come and testify at a later date. If so, we will try to work them in.

Senator RIBICOFF. In view of the fact that the Kennedy proposal is out front in the country and it is one of the major bills that we will have to consider. He should be extended an invitation at the mutual convenience of the Senator and the committee and you, Mr. Chairman. I think if we can find time in the next few days he could come and spend a little time with us.[1]

The CHAIRMAN. The Senator has been invited, and he is always welcome, and the same thing is true of Senator Schweiker.

[The prepared statement of Senator Schweiker follows:]

TESTIMONY OF SENATOR RICHARD S. SCHWEIKER

Mr. Chairman, I appreciate the opportunity to present my views on the subject of "national health insurance" to this distinguished panel. Since my committee shares jurisdiction over health care matters with yours, I have devoted a great deal of thought to the issues you consider today. Last Tuesday, June 12, I presented a comprehensive health care reform proposal to the full Senate. I would like ot summarize this proposal for you today in hopes that you will take it into consideration as you act on this important matter. I believe you will find much of my proposal compatible with proposals you have introduced or are actively considering, such as Senator Dole's.

My proposal outlines legislation I will soon introduce on the subjects of health care cost containment, catastrophic health insurance, and preventive health care.

[1] See p. 357.

This comprehensive approach to the fundamental problems facing our health care delivery system will: (1) Reduce health-cost inflation by encouraging large employers to offer their employees at least three competitive health insurance plans and by requiring that at least one plan offered by all employers contain a 25-percent costsharing provision for hospital services up to 20 percent of family income in order to be tax deductible, (2) provide all Americans with protection against the costs of catastrophic medical expenses through tax incentives to the private sector and improvements in the medicare program, and (3) encourage preventive health care by requiring that any tax deductible health insurance plan must contain a prescribed level of preventive benefits.

My package is designed to respond to three pressing health care needs that are inextricably linked: Hospital cost containment, catastrophic health insurance, and preventive health care. Hospital cost containment has been the subject of intensive debate in Congress for the past 2 years. Escalating medical costs have caused increased public demands for improved health insurance coverage, particularly against catastrophic health care expenditures. There is also growing awareness throughout our society of the advantages of preventive health care and the need to improve access to it.

Despite these clear public needs, congressional action in all three areas has been delayed by growing disenchantment with government regulation as a solution to social problems, fewer Government dollars with which to attack them, and increased reluctance to pump scarce resources into the Washington regulatory pipeline. In the health field, more and more experts are concluding that fundamental reforms of the basic structure of our health care delivery system are imperative if permanent solutions to these problems are to be found.

I believe escalating health care costs result not from a lack of regulatory controls on the industry but from the noncompetitive structure of the third-party health care reimbursement system. This system has been encouraged to spread by our Federal tax laws, which give generous deductions to individuals and employers for purchasing broad and inefficient health insurance coverage. To break this inflationary spiral, we need to encourage consumers to participate in health care pricing decisions and stimulate competition in the health insurance industry.

My proposal will change the nature of these tax incentives to encourage the patient to pay a larger share of short-term hospital care expenses, thereby bringing the patient back into pricing decisions. It will also reorient health insurance coverage to protect against the costs of high cost illness, and encourage better health through preventive care.

REDUCING HEALTH COST INFLATION

The public need

There is no question about the need to reduce the unacceptable escalation of medical costs in this country. In 1950, the average cost per patient day in one of America's hospitals was $15.62. By 1978, it had risen to $227.52, an increase of almost 1,400 percent. During that same period, consumer prices as a whole had risen by less than 200 percent. Thus, the cost of a day in a hospital from 1950 to 1978 rose by more than 7 times the rate of all other prices in the economy. Within the last 5 years, moreover, the cost of an average patient day in one of America's hospitals has almost doubled, whereas overall prices during the same period increased by less than 50 percent. Rising hospital costs account for more than 40 percent of all health expenditures and have thus been a primary cause of comparable increases in all health care costs.

The Federal Government has a direct impact on this problem because of its impact on the Federal budget. The Federal Government will spend about $54 billion in fiscal year 1980 on various health related programs. Of this amount, Federal expenditures for hospital care will be about $35 billion, an increase from 1969 of $28 billion or about 450 percent. By 1984, Federal taxpayer expenditures for hospital care will reach $48 billion, an increase of over 90 percent from their estimated 1979 level.

Government response to the problem

In recent years Congress has not been unaware of growing public alarm over rising health care costs. As the ranking Republican of the Senate Human Resources Committee and its Health Subcommittee, I have worked for years in searching for ways to attack it. One of our primary initiatives has been the Health Planning and Resources Development Act of 1974, which has attempted to encourage the states and local communities to make more effective use of our health care resources by reducing the duplication and proliferation of health

services, facilities, and equipment. In addition, I have authored legislation to promote the growth of Health Maintenance Organizations, which encourage more economical ways to deliver quality health care by emphasizing preventive and ambulatory services through internal cost containment mechanisms. Finally, recent medicare and medicaid legislation has attempted to discourage fraud and abuse and encourage greater efficiency in services reimbursed by the Government under these programs.

While I believe these congressional actions hold great promise, it must be admitted that their full impact will not be felt, nor their success known, for a number of years. Meanwhile, growing public concern over ever increasing rates of inflation requires more immediate action.

Recently, the Carter administration sent to Congress the third in a series of legislative proposals designed to reduce hospitals costs by Federal regulation. The bill would place hospitals under a form of price controls whenever their rate of expenditures rose by more than HEW-calculated standards. Thus, the administration's plan to reduce health care costs would focus on Federal revenue caps.

While I share the administration's goal of reducing hospital costs, I believe its proposed solution would do more harm than good. Aside from a disturbing number of technical difficulties in the way the program is designed, the administration's regulatory policy will do nothing to attack the fundamental causes of health cost inflation, which are rooted in the third-party reimbursement system. Establishing an HEW bureaucracy to control hospital expenditures will itself be inflationary. It will lead to anticipatory price increase and higher administrative costs. It will adversely affect quality of care by arbitrarily limiting national health expenditures and inject the Federal Government into medical decisionmaking. And it will preclude promising private sector efforts to attack the problem in a nonregulatory fashion, such as the voluntary effort and actions I will suggest here today.

The administration is attempting to build public support for this simplistic regulatory strategy by making it the centerpiece of its antiinflationary program. It argues that we do not have time to attack the more basic causes of health care inflation because the problem of general inflation requires more immediate action. Recent evidence, however, has shown that this line of reasoning is deceptive, since the President's cost containment bill will have only a negligible impact on the rate of inflation in the economy as a whole. This point was originally argued by Professor Martin Feldstein before our health subcommittee. A recent study by Data Resources, Inc. confirming his findings, estimates that the impact of the President's cost containment bill on inflation in the general economy over the next 5 years will be only one-tenth of 1 percent annually (see table 1). This is understandable since hopsital expenses represent only 3.5 percent of the gross national product.

TABLE 1.—RATES OF INFLATION IN THE ECONOMY WITH AND WITHOUT THE ADMINISTRATION'S COST CONTAINMENT BILL

[Annual percentage rates of change CPI—All urban consumers]

	1979	1980	1981	1982	1983	1984
No cost containment program	8.9	7.6	7.1	7.0	6.8	6.6
Administration cost containment program	8.9	7.6	7.0	6.9	6.7	6.5
Difference	0	0	−.1	−.1	−.1	−.1

Source: The Macroeconomic Implications of the Hospital Cost Containment Act of 1979, prepared by Data Resources Inc. (May 1979).

Thus, we should not be driven into a simplistic regulatory solution to a complex health care problem by the administration's argument. Health care cost inflation is a serious problem in its own right because of the devastating effects medical bills can have on those who bear the brunt of them. While the number of people who actually incur large medical bills is not large in number relative to the entire population, the fact remains that almost everyone in our society is a potential candidate for their devastating effects. As a result of this fear, many people are spending large amounts of money on inefficient health insurance protection. In addition, Government expenditures on health through medicare, medicaid, and other public programs are rising so quickly that precious resources are being diverted from other social problems. Thus, we should not be pushed into ineffec-

tive regulatory solutions in hopes that they will reduce inflation in the general economy. But we should look for effective long term solutions to health cost inflation because it squanders resources badly needed in other areas.

The fundamental causes of health cost inflation

Contrary to arguments made by the administration, escalating health care costs result not from a lack of regulatory discipline, nor from the unwillingness of the medical community to do something about them. They result from the fact that 90 percent of the Nation's hospital bills are paid by insurance companies or other third-party payors not directly involved in setting the price for that care. An arrangement in which the patient (or consumer) demands a level of service set primarily by the doctor (or supplier), with a third party picking up the tab, represents a "blank check" arrangement that is bound to be inflationary.

In addition, Federal tax laws which allow employers and employees to deduct cost of health insurance premiums have encouraged individuals to purchase as much insurance as possible for routine medical services. Over the last quarter century, the percentage of out-of-pocket expenses paid by the patient once he goes to the hospital has fallen from 50 percent to 10 percent. Patients, therefore, have little incentive to monitor the cost of services provided by the doctors and hospitals. By the same token, doctors and hospitals have little incentive to monitor costs since insurance companies or other third parties to the arrangement are paying the bills. Ultimately, the cost is borne by the patient in the form of increased insurance premiums, in turn increasing his demand for more insurance and more services and aggravating the inflationary spiral.

Another reason for health care cost inflation is a lack of competition in the health care industry. While the reasons are varied and complex, a basic cause is the fact that few individuals have the opportunity to make price-conscious decisions between alternative insurance plans. Generally, an employer makes the choice of a health plan on behalf of his employees. Where alternatives are available, employees do not always realize direct financial benefits for choosing more efficient plans. This lack of competition gives insurers little reason to aggressively control costs.

Clearly, Government-imposed price ceilings will not be an effective solution to this problem. What is needed instead are incentives for the various parties in this structure—patients, doctors, hospitals, and insurance companies—to monitor costs and participate more effectively in health care pricing decisions.

Proposed cost containment strategy

Mr. Chairman, I propose to attack the problem of health cost inflation by encouraging competition and encouraging the patient to participate in pricing decisions.

My bill will require that employers with more than 200 full-time employees, as a condition of deducting premium contributions from their gross income, offer their employees the choice of at least three health plans.

In addition, certain new tax conditions would apply to any employer regardless of size. Each plan he offers must be sponsored by a different organizational entity so as to ensure true competition. In addition, the employer would have to make the same dollar outlay for health benefits per employee, whether that outlay went entirely to the employee's insurance carrier or was divided between premium payments and rebates to the employee.

If an employee chose a plan whose premium cost was less than the employer outlay per employee, he would be entitled to receive the difference between the outlay and the cost on a tax free basis. This would insure that employees receive some direct financial reward for choosing lower cost, more efficient health plans. Throughout this process, the role of collective bargaining agents would be preserved.

In order to encourage the consumer to participate in health pricing decisions, my bill will also require that one of the plans offered by all employers, and by the Government to its employees, contain substantial cost-sharing provisions. At least one offering must contain a annual copayment rate for hospital services of at least 25 percent, effective until annual family medical expenses exceed 20 percent of adjusted gross income. Frequently, this plan will have the least expensive premium payments of those offered by the employer. Where the cost is less than the employer outlay, a tax-free rebate would result.

Requiring three health plans to be offered to employees by large firms will work to lower health costs in several ways. Since it is generally the employer who makes the choice of a health benefits plan for this employees, the forces of com-

petition are often precluded from operating within employee groups. If that choice is passed through to the employees themselves, more competitive alternatives will become available. Employees could compare notes and force insurance plans to improve benefits and lower premiums to accommodate their needs. This process will be encouraged by the availability of tax free rebates. Competition will also encourage health plans to provide clearer informational material to individual subscribers, thereby enhancing general understanding of the salient differences between various types of plans. "Multiple choice" marketing of health plans will force the insurers to monitor the cost, quality, and overall efficiency of doctors and hospitals in an effort to make premiums and benefits more competitive. It will thus encourage people to choose the lower cost health plan and thereby promote cost containment even where the patent does not directly pay for the service or is otherwise indisposed to be conscious of price. Finally, multiple choice creates a climate in which innovative health care plan with internal cost containment mechanisms will flourish. The "multiple choice" concept was originated by Dr. Walter McClure of Interstudy, and I believe it will be a major contribution to procompetitive efforts in the health care industry.

Encouraging employees to select a high coinsurance plan will also have significant results.

Studies done by noted health economists have shown that reinvolving the patient in hospital care pricing decisions will result in considerable savings. If third-party payors picked up 85 percent of the hospital bill instead of the present 90 percent, then the dollar value of ineffectual hospital care and testing eliminated by doctors and patients acting together would exceed the Congressional Budget's Office estimates of the administration plan's savings.

Such a modest change in health care financing would save more than the administration's plan because patient cost-consciousness will be aroused. Currently, for every 10 cents a patient had to pay, a third party paid 90 cents. If the patient paid 15 cents for every dollar's worth of care he received, the third party payor would finance 85 cents. The financial leverage facing the patient would be fundamentally altered. Instead of each $0.10 patient payment resulting in a $0.90 insurance side-payment, my plan would encourage a 25-percent patient payment and a 75-percent insurance company payment. Bearing a greater percentage of the direct cost, the patient would lower his demand for some health services. There are studies available, however, showing that this should not affect the quality of health care if it is appropriately linked to ability to pay. I have great confidence that patients and doctors working together will be better able to eliminate wasteful medical practices than the Department of Health, Education, and Welfare. One would certainly expect that those with the greatest amount of self-interest in cutting wasteful hospital expenses would do a better job than those far away from the scene. It is for this important reason that I have rejected the regulatory approach suggested by the administration and sought instead to find a way to increase patient cost consciousness.

Cost impact of proposed cost containment strategy

Table 2 summarizes the estimated annual savings from my plan to the Federal, State, and local governments, and to the private sector.

Table 3 states the estimated impact over the next 5 years, assuming gradually increasing acceptance of the 25 percent copayment option.

While equal employer contributions with tax deductible premium rebates has not been made available nationally as an incentive to encourage conservation of medical resources, empirical examples do exist where savings have been achieved through competition between various plans, copayments for medical expenses, and preventive coverage.

In 1978 the University of California offered several plans to its 80,000 employees. Included among them were first dollar coverage plans, health maintenance organizations (HMO's), and low-option plans with copayments and deductibles. The low-option plan requires a $100 deductible and a 20 percent copayment up to a level of $3,100 in medical costs, for employee premium savings over a basic and major medical package of $61 per month. Of the 80,000 employees in the University of California system, 23,000 prefer this plan even though there are no provisions for tax free premium rebates and they are losing an $11 subsidy per month from the university. As an institution, the university does not provide "self-insurance" for the first $700 of out-of-pocket payment which is required before the plan covers 100 percent of medical costs, so individuals are willing to bear the risk of paying $700 in order to save $61 per month.

TABLE 2.—*Annual fiscal impact of Schweiker comprehensive health plan*

	Billions
I. Federal Government:	
Savings from hospital cost containment [1]	—$2.5
Cost of medicare improvements	0.8
Reduction in tax revenue [2]	1.5
Net savings	0.2
II. State and local government:	
Savings from hospital cost containment [1]	—0.7
Reduction in tax revenue [2]	0.2
Net savings	0.5
III. Private sector:	
Savings from hospital cost containment [1]	—4.3
Reduction taxes	—1.7
Cost of preventive health programs [3]	2.0
Cost of catastrophic pooling program	1.0
Net savings	3.0
Summary of fiscal impact:	
Savings from hospital cost containment [1]	—7.5
Cost of medicare improvements	0.8
Cost of preventive health programs [3]	2.0
Cost of catastrophic pooling program	1.0
Net savings	3.7

[1] Assumes that 41 percent of population enrolls in 25 percent copayment plan.
[2] Government revenues fall because business deductions rise by $8 billion, reflecting the cost of new expenditures for catastrophic health insurance premiums and preventive health initiatives. Government revenues rise because itemizable deductions for medical expenses falls due to universal catastrophic health insurance.
[3] It is believed that preventive health measures will result in significant systemwide savings due to lower expenses required to treat illness diagnosed early and a reduction in the amount of production lost because of worker illness. But no savings are included as an offset against $2 billion in new preventive expenditures.

TABLE 3

ANNUAL HOSPITAL EXPENDITURES 1980-84

[In billions of dollars]

	1980	1981	1982	1983	1984	Total
No plan	93.6	104.9	117.4	131.7	147.9	595.5
Schweiker plan	91.2	100.4	110.4	121.6	134.1	557.7
Savings	2.4	4.5	7.0	10.1	13.8	37.8

HOSPITAL SAVINGS UNDER THE SCHWEIKER COMPREHENSIVE HEALTH PLAN 1980-84

[In billions of dollars]

Year	Total	Private sector	State and local government	Federal government
1980	2.4	1.4	0.2	0.8
1981	4.5	2.6	.4	1.5
1982	7.0	4.0	.7	2.3
1983	10.1	5.8	1.0	3.3
1984	13.8	7.9	1.4	4.5
Total	37.8	21.7	3.7	12.4

ASSUMPTIONS

1. Enrollment changeover to 25 percent copayment option: 1980 18 percent of privately employed population; 1981 29 percent of privately employed population; 1982 41 percent of privately employed population; 1983 53 percent of privately employed population; 1984 65 percent of privately employed population.
2. Estimates of national hospital expenditures in 1979 and 1984 without a policy change are those provided by the administration.
3. Hospital expenses between 1979 and 1984 grow at a constant rate during the period.
4. An employee who elects the 25-percent copayment option will order 20 percent less in hospital services than one who has an 18-percent copayment policy.
5. Doctors will treat medicare and medicaid patients in the same manner as they will treat privately funded patients. Since private patients will be cutting back on their purchases somewhat, doctors will treat publicly funded patients with somewhat lower resources than otherwise, too.

The State of Hawaii offers an instructive case of competition in health care plans. Hawaii has two dominant medical insurance plans, Hawaii Medical Service Association (HMSA) and the Kaiser Foundation Health Plan, Inc., an HMO. Competition between these two plans has required emphasis on apprpopriate utilization of services by its members and cost containment in all areas of health services. While HMSA had been functioning since the 1930's, the Kaiser Foundation only entered the Hawaiian market in 1958. Since the entry of Kaiser, HMSA has expanded its benefits and further emphasized cost containment in order to compete. In 1960 HMSA instituted first dollar coverage for such preventive services as biennial physical examinations, routine well-baby checkups, and immunizations. In addition Kaiser's presence in Hawaii prompted HMSA to develop its own HMO package. Competition from HMSA, on the other hand, has forced Kaiser to keep its premium rates competitive.

CATASTROPHIC HEALTH INSURANCE

My bill will insure that all Americans have "minimum catastrophic protection" to protect them against the cost of all medical expenditures (other than long-term nursing care) over 20 percent of annual family income. For the employed population, tax deductions for insurance premiums will not be allowed unless a plan contains this minimum level of protection. Additional Federal payments will finance catastrophic protection for the elderly under medicare; and a special insurance pooling arrangement will be used for small-firm employees, uninsurance risks, and those without access to health insurance.

Current health insurance needs

Until recently, there were large numbers of Americans without health insurance. This led to a host of private and governmental efforts to increase the general availability of health insurance coverage. As a result of such efforts, we find that today more than 80 percent of all Americans have access to some form of public or private health insurance coverage. Much of that coverage is inadequate, but the fact that most Americans have some form of insurance coverage is quite significant. It means that the primary challenge facing us today is to reorient existing insurance arrangements rather than supplant them with a Government-run insurance program.

While there are many areas for possible improvement in insurance coverage across the Nation, available statistics indicate that a primary need is to improve protection against the expenses of catastrophic illness. Statistics on the number of Americans without catastrophic coverage range from the administration's figure of 40 percent to the Health Insurance Institute's estimate of 12 percent. Clearly, millions of Americans now live with the fear that a serious injury or illness will lead to bankruptcy, yet a large number of insurance plans do not contain adequate coverage of these costs. As my colleagues are aware, no feature of national health insurance has more popular support or is demanded more often than improved protection against catastrophic health costs.

The need for catastrophic insurance is particularly strong among our elderly citizens who tend to have higher medical expenses than other segments of the population. Current medicare benefits, with high copayments and deductibles, a 150-day hospital confinement limit, and no upper ceiling on patient cost-sharing, give our elderly citizens little protection against very high hospital bills.

Many Americans, moreover, are without any health insurance coverage, not because they do not have access to health benefit plans, but because changes in circumstances have caused their coverage to lapse. Individuals who fall into this "gap" include the temporarily unemployed, children previously covered under their parents' health plans who lose coverage upon reaching the age of majority, and spouses and children covered under a family plan whose health coverage ceases due to the death of an insured head of household. Additionally, many employer plans do not cover spouses and family members.

Proposed catastrophic plan

My bill will insure the availability of catastrophic health insurance protection to the entire population without an additional Federal program and at a cost to the Federal Government of only $0.8 billion. This additional Federal cost will result almost entirely from adding catastrophic benefits to the medicare and medicaid programs. For the rest of the population, catastrophic coverage will be made available through some relatively simple adjustments in the existing private insurance market.

A. *For employed individuals and their families.*—Rather than establish a Government-run catastrophic insurance program, I propose to utilize the tax code to require health benefits plans of employers with more than 50 employees to contain catastrophic benefits. Under current law, employers may for tax purposes deduct from their gross income any contributions they make for employee health benefit plans. In addition, these employer contributions are not included in the employee's taxable income.

My bill would require that any health benefits plan would have to contain minimum catastrophic coverage if the employer and the employee were to continue to receive the benefit of these deductions and exclusions. For these purposes, minimum "catastrophic" coverage would be defined as complete coverage, without copayments, of medical expenses incurred annually by an individual and his family in excess of 20 percent of the family's adjusted gross income. Relevant medical expenses would include inpatient hospital care and certain other medicare-covered expenditures.

I have chosen a percentage of annual income as the catastrophic threshold rather than a fixed dollar level because I believe any determination of which expenses are catastrophic in nature depends on family income. A $10,000 hospital bill might not impair the well being of a wealthy family, but it would create unbearable financial strain for a family with a $15,000 income. For reasons of equity, then, catastrophic expenses should be measured in proportional terms, reflecting differences in the ability to pay a hospital bill of a given size.

Available information indicates that catastrophic benefits, when added to existing health insurance policies, are relatively inexpensive, depending on the level of underlying basic coverage. Therefore, most large employers would probably be able to absorb the cost of these additional benefits without undue hardship. However, my bill would not specify who would pay the cost of these health insurance premiums. That decision would be left to the collective bargaining process.

B. *For employees of small firms and of those without employer health plans.*—For those who work for small employers (fewer than 50 employees) and for those without access to any employer health benefits plan, my bill would use a "pooling mechanism" to provide catastrophic health insurance protection.

Toward this end, my bill would provide that insurance carriers would be required, as a condition of participating in federal health programs such as medicare and medicaid, to enroll such individuals in proportion to their business in any State. States would be encouraged to set up programs to keep track of whether insurance companies were meeting this obligation and to assign to carriers individuals without access to employee health plans. Since this mechanism would in effect make these enrollees members of larger groups, the cost of their premiums would in most cases be low enough for them to afford. However, my bill would specify that premiums charged such individuals could be no higher than a fixed percentage, e.g., 125 percent, above the rate charged to large group enrollees for similar protection in the same geographic area.

It is generally difficult for individuals who do not belong to large employee groups to purchase catastrophic or other health insurance protection at a reasonable premium. This is because large groups require lower marketing costs. They also enable insurance companies to estimate risks more accurately and spread those risks across a large number of individuals. Thus, in order to make catastrophic insurance available to individuals who are not members of large employee groups without resorting to a Government insurance program, a mechanism must be used to include small or nongroup enrollees in large insurance pools.

An additional function of this mechanism would be to relieve small employers of the additional paperwork and cost of administering a catastrophic health benefits plan. However, small employers would be required to assist their enrollees in contacting the state agencies administering the assignment program.

The pooling mechanism could not be used by individuals eligible for catastrophic insurance under government plans, such as medicare, medicaid, or veterans' health benefits.

The catastrophic threshold and definition of medical services included in it would be defined in the same way as it is for large employer health benefits plans.

C. *Medicare.*—Under current medicare law, an individual must not only pay a $160 deductible under part A and a $60 deductible under part B, but he must also continue to bear a portion of his hospital costs through ongoing copayments, regardless of how large his medical expenses become. These copayment rates include $40 per day for the 61st through the 90th day per benefit period and $80 per day for the 60-day lifetime reserve. Medicare will not pay hospital costs

after the 150th day. These limitations clearly do not provide adequate protection against the costs of catastrophic illness for our nation's elderly.

My bill would eliminate the 150-day hospital confinement limit and revise the current copayment provisions. An individual would have to pay 20 percent of the cost of hospital care regardless of how many days he was in the hospital. However, once co-insurance payments under part A and B reached 20 percent of income in any one year, all co-insurance requirements would cease.

The additional cost to the Federal Government of these provisions would be about $800,000 per year.

D. *Uninsurable risks.*—Any individual who could not get catastrophic insurance in the private market place at a reasonable cost because of poor health would be eligible to participate in the pooling mechanism outlined above. A maximum premium cost would be defined as a fixed percentage, e.g., 125 percent of large group rates in the geographic area. Any additional expenses would be borne by the insurance plan itself but should not inordinately raise premium rates since the number of individuals involved is relatively small.

E. *Temporarily unemployed spouses, dependents, and those who lose coverage due to change of circumstances.*—My plan would further condition employer deductions and employee exclusions on "extension of coverage" provisions. An individual would have to remain covered for at least 6 months after termination of employment if he had been on the job and enrolled in the plan for at least 30 days. In addition, spouses and children under the age of 25 would have to be covered by catastrophic benefits and remain covered for at least 6 months in the event of the death of the employee-policyholder.

HEALTH PROMOTION DISEASE PREVENTION BENEFITS

I believe that in addition to a cost containment mechanism and plans for catastrophic coverage, a health plan should contain a health promotion-disease prevention benefit package. Prevention is the most effective method for cost containment, and the cost of prevention itself is usually extremely low relative to the cost of medical care for the disease in question. Preventive measures are also indicated since for many diseases our therapies remain imperfect and total cures are not yet possible.

My plan includes six prevention benefits:

1. Maternal care;
2. "Well-baby" clinic services;
3. Childhood immunizations;
4. Hypertension screening;
5. Cervical cancer screening; and
6. Periodic health examinations.

The National Center for Medical Statistics reports that between 1930 and 1945 medical advances permitted the average life expectancy to increase by almost 6 years; during the 1945 to 1960 interval life expectancy increased by approximately 4 years; and most recently between 1960 and 1975 the increase was less than 3 years. Conversely, the cost of health care and hospitalization has increased exponentially in recent years. The total most of illness, which includes estimates of the short- and long-term medical cost of disease as well as the wages lost to illness and the effect on gross national product, has increased dramatically. In 1963 the total cost of illness was $93.5 billion whereas in 1972 it was $188.8 billion. In summary, a dollar spent on medical care is buying less and less in terms of national health.

Two types of preventive measures offer great promise for containing health costs and improving both the length and quality of life. Primary prevention measures when applied to the healthy, general population prevent the development of certain diseases. Secondary prevention measures are screening procedures that detect the presence of early disease in the population, thereby permitting early treatment and preventing serious morbidity and mortality from the disease. At a time when Federal budgetary austerity is limiting the amount of resources available for national health missions, we must be diligent in our efforts to insure that these limited means are used to improve health in the most effective manner. It is interesting to note that in 1976 the Federal expenditure for all prevention and health promotion programs including environmental programs were only 2.6 percent of the total Federal expenditure for health care and research.

Prevention and promotion measures, aside from the traditional public health procedures that deal with sanitation and immunization, are a relatively new and underdeveloped approach to health. A number of preventive interventions, such

as alterations in the environment, socioeconomic status or family structure, are beyond the scope of our current health care system or are not presently amenable to legislative action. In other health care areas we have not yet developed sufficiently reliable or proven prevention techniques for inclusion in a general health plan. For example, behavioral based health problems such as smoking, alcohol or drug abuse, and violence, are difficult to prevent by the available health education methods. Nevertheless, it makes no sense to wait for all of the answers, we should move ahead with preventive programs of proven value.

The six preventive health benefits in my proposal must be provided in the insurance plans offered by employers who seek special tax status, as well as in plans offered under the State-administered pooling arrangements. These benefits offer a combination of primary and secondary preventive measures.

First, the health insurance plans will be required to offer maternal care, that is, medical examinations, treatment and counseling for pregnant women, delivery services and post-partum care. Infant mortality in the United States is excessive: Over 50,000 infant deaths occur each year. One of several responsible factors is inadequate pre- and post-natal care. This tragic problem is also addressed by the second benefit in my plan: the provision of newborn care and well-baby clinic services during the first year of life. These measures are necessary to prevent and treat the nutritional and infectious problems that are a major health problem for infants and children. In addition, well baby services permit the detection of congenital deformities and diseases and allow the early application of corrective procedures to prevent lifelong disability. Also included in the benefit package are vision and hearing examinations for children between the ages of 2 and 6 years. The third benefit directed to child health is the provision for childhood immunizations including DPT, polio, measles, mumps and rubella. The value of this program for the prevention of death, suffering and deformity has been proven over several decades. In the early 1950's, 20,000 Americans were afflicted each year with poliomyelitis and the consequent burden of illness in dollars and quality of life was enormous. During the 1970's, following the use of polio vaccines, the total number of polio victims has been less than 100. Whooping cough, diptheria, tetanus, and smallpox have been nearly eradicated by immunization. The incidence of measles has declined from 442,000 cases in 1960 to 24,000 cases in 1975. The importance of these statistics is illustrated by the fact that 1 of every 1,000 children with measles will die and in 1964 rubella caused 20,000 permanent congenital defects in the offspring of infected mothers. However, we must take note of a disturbing trend; namely, that participation in immunization programs is declining. If this trend is not reversed the unexposed and nonimmunized children will be at a risk for major and costly epidemics of these diseases.

The final three prevention benefits are directed to the adult population. Hypertension screening will be provided over the lifespan starting with teenagers. Cardiovascular disease is the leading cause of death and contributes the major burden of illness in this country; hypertension, in turn, is one of the most common and damaging forms of cardiovascular disease. It is estimated that over 25 million Americans have high blood pressure and that at least 40 to 45 percent of these are receiving adequate treatment. Hypertension was calculated to contribute $16 billion to the cost of illness in 1975. The estimated annual savings to the national economy by successfully treating all hypertensives would be approximately $8 billion. Since the cost of detection and treatment programs are estimated at about $5 billion, this translates to a net yearly benefit of $3 billion. The second adult prevention program provides screening for cervical cancer in women by means of the pap smear test. Cancer detection and control studies indicate that the best cancer prevention investment, in terms of initial dollar effects on a cost-effective ratio, is the detection of cervical cancer. Finally, I propose to provide periodic health examinations and counseling every 3 to 5 years for the adult population. Counseling services include education about health promotion measures (e.g. diets, methods to stop smoking or drinking, and exercise programs) as well as the explanation of therapeutic programs for diseases discovered during screening (e.g. blood pressure control programs or management of diabetes). Although the cost effectiveness of periodic exams in the well population is still controversial, the continuing advent of new diagnostic and screening techniques and continuing therapeutic advances should progressively enhance the potential benefits of periodic examinations.

A relative lack of previous experience with national efforts at providing prevention programs makes it very difficult to cost account this prevention-promotion package. Many people in the well population, particularly the young, are already

receiving some of these services, but for the most part they are paying for this out of pocket or are receiving benefits as part of an HMO plan. The provision of these services as benefits in a health insurance plan would insure utilization of a wider scope of prevention programs by a larger segment of the population. Estimates provided by the private health insurance industry indicate a per capita cost of between $2 to $10 per year for adults and approximately $10 per year for children. I estimate that the total yearly cost to the private sector for this preventive package will be approximately $2 billion. The provision of counseling services as an adjunct to the medical and screening services contained in the package would probably cost an additional $7 per capita.

If these preventive health measures were followed nationwide, they almost certainly would pay for themselves. First, there is the obvious savings from the early diagnosis of a problem with minimal financial outlay, thereby eliminating large therapeutic and disability expenses in the future. Second, preventive health programs eliminate some of the major reasons for lost production in our economy. Lost production from sick leave exceeds that from labor strikes by an overwhelming factor. Finally, there is the very human factor behind preventing illness. When the incidence of illness falls, fewer Americans must suffer its debilitating physiological and psychological effects. I feel these three savings make an overwhelming case for preventive medicine.

Cost-effective studies are underway for prevention programs and clear effectiveness has been demonstrated for programs such as maternal care, immunization, and hypertension screening. One must bear in mind that short-term savings in dollars are not likely with preventive measures. The payoff is long term through the prolongation of life (avoidance of premature death) and improvement in the quality of life. My proposal recommends using the savings from hospital cost containment to finance this innovative preventive health program. Increasing patients' cost consciousness in the manner that I have outlined earlier will lower national hospitalization expenses by approximately 6 percent annually.

CONCLUSION

In sum, Mr. Chairman, I believe that in national health policy we are faced with three primary interrelated needs—cost containment, catastrophic health insurance, and preventive care—which must be addressed with a unified, comprehensive program. My bill will attempt to do just that.

The fundamental cause of rampant health cost inflation and lack of catastrophic and preventive health insurance benefits is a noncompetitive third party reimbursement system weighted too heavily toward first-dollar hospitalization coverage. Scarce resources and disenchantment with Government regulation make it unlikely that yet another public program will be the solution.

In this situation, we can use tax incentives to offer Americans a trade-off: If they are willing to pay slightly more in co-payments for low cost medical care, they can save enough money to obtain catastropic protection and preventive care. In addition, they can stop the health cost inflationary spiral without new government regulation. We can also use tax incentives to help restore competition to health care by giving our citizens a greater variety of health insurance choices and insuring that they will save money on premiums if they choose more efficient providers of care.

I believe this approach to be more realistic, more effective and clearly less costly, than the Government regulation route. I look forward to working with the members of this committee to perfect the details of the proposal and to enact a nonregulatory approach to insuring that all Americans have access to quality health care at a reasonable cost.

Now, if you would, Senator Ribicoff, I would like for you to preside for a few minutes while I take my turn at bat.

Senator RIBICOFF [presiding]. Senator Long.

STATEMENT OF HON. RUSSELL B. LONG, U.S. SENATOR FROM THE STATE OF LOUISIANA

The CHAIRMAN. I am going to try to abbreviate my statement. I will ask that it be printed in the record in its entirety.

Senator RIBICOFF. Without objetcion, the entire statement will go in the record as if presented.

[The prepared statement of Senator Long follows:]

STATEMENT OF SENATOR RUSSELL B. LONG

The Finance Committee and its Members have, over the years, devoted a substantial amount of time and effort in the consideration of various National Health Insurance proposals.

We have had the unique ability to evaluate those proposals on the basis of the good and the bad experience encountered with the now huge and costly Medicare and Medicaid programs. And, now I believe it is time to act. In fact, in my opinion, action to extend vitally needed health insurance protection is overdue.

Some 6 years ago Senators Ribicoff, Talmadge and I, along with many other Members of the Senate, first introduced a program designed to improve the financing of health care for all Americans.

The proposal we sponsored then, and which we continue to sponsor, includes catastrophic health insurance protection for all Americans, reform of our medical assistance program for the low-income population, and standards for basic private health insurance policies. I still believe that, in the long run, that is the approach which will be adopted.

But we now have realities confronting us which cannot be ignored—realities which were not present when we first offered our proposal, and which I believe must be taken into account at this time. These realities include a continuing level of inflation which we must act to moderate and not aggravate through an enormous increase in Federal spending levels. Under these circumstances of high inflation and a need for budgetary restraint, priorities have to be assigned to what we do in the way of national health insurance initiatives.

The first priority, and the most urgent of priorities, is to assure Americans that they will not be wiped out financially by the overwhelming costs of serious and prolonger illness. Survey after survey, and poll after poll, has shown the concern of the majority of Americans with the need for catastrophic health insurance.

Just recently, a report prepared for the General Mills Co. by the distinguished survey firm of Yankelovich, Skelly and White, Inc. found, and I quote: "Most American families are worried about catastrophic illness—but not about the more mundane but possibly serious 'ordinary' illnesses. Fear of cancer is the overriding concern of most families, followed by fear of accidents and heart trouble. Only 11 percent mention 'everyday' illnesses as a principal health worry."

Time after time we hear of the ruinous costs of prolonged illness. Again and again we hear of serious injury all but wiping out lifetime savings and property.

I think there is general consensus among the Members of this Committee, as well as the Carter Administration, of a need for action in this area.

I think we are in general agreement that the basic approach to providing catastrophic health insurance should be through requiring that employers provide, through private health insurers, coverage for their employees meeting basic requirements as to adequacy. I believe there is a consensus concerning the need to provide assistance to small employers and other employers where the costs of mandated catastrophic health insurance coverage exceeds amounts which they can reasonably be expected to afford.

We may have some differences as to the amount of the deductibles which would apply. We may have differences as to effective dates. For my own part, I believe that we should not waste any time in providing this vitally needed protection. I believe, and I will urge that catastrophic health insurance protection be provided to working Americans and their families by not later than July 1, 1980.

I should point out that, while I have my own ideas concerning the nature of the catastrophic insurance program, my position is not frozen at all. I look forward to receiving, and hopefully supporting, the constructive suggestions of my colleagues. But, let me stress that catastrophic health insurance is a program of protection for those many, many millions of middle-income Americans who have a real sense of being left out of the legislative process.

These are the people who seem to be paying the most and getting the least out of Government. These are the people who are not only paying their own way, but paying for the other fellow as well. These are the millions of Americans we should protect from the fear—and all too often the reality—of bankrupting medical expenses.

Now I also believe that we will be able to make some significant improvements in the programs for low income Americans. I think that the present Medicaid program has inequities which we might be able to relieve in good part.

In this regard, I am now working to see what reasonable and budgetable improvements can be made in our health insurance coverage for the poor. Here too we are encountering unavoidable considerations of how much new money we can spend. I am hopeful that we on the Committee will be able to work out significant and affordable improvements for the low income population.

I think we will be able to come to general agreement in this area.

I also believe that we will be able to agree upon significant improvements in the existing medicare program for older and disabled Americans. I think we will be able to agree on a need to assure that everegone has access to private basic health insurance such as Blue Cross and Blue Shield, regardless of health conditions and with premiums which are reasonable in relation to the benefits paid out.

There will obviously be those who want to go beyond what I have described. There are those who believe we should do everything for everyone from the cradle to the grave.

There are those who believe that, while we put less than a cradle-to-grave approach into effect now, we should at the same time, provide now for automatic expensions of coverage and costs in future years.

Quite simply, I don't think the Nation can afford—nor does it want—womb-to-tomb health insurance coverage.

Quite simply, I don't think we should bind future budgets and future Administrations to what may be inappropriate or unaffordable expenses for health insurance. I have sufficient faith in the judgment of future Congresses and future Presidents as to what will be appropriate action at those times.

Again, we currently appear to have a concensus for action on catastrophic health insurance.

Again, I think that consensus should be translated into early action by this committee an dthis Congress.

I look forward, during the next few weeks, to hammering out a committee bill with catastrophic health insurance for Americans as the centerpiece, with improvements in protection for the poor, and assurance of the availability of adequate private health insurance to those who have difficultly purchasing the coverage now.

I think, as always common sense and a common sense of concern will prevail in the Finance Committee.

The CHAIRMAN. Mr. Chairman and Members, 6 years ago Senator Ribicoff and I joined by Senator Talmadge introduced a program to finance health care for all Americans, and it placed an emphasis on catastrophic health insurance, but it also sought to provide health care for the low income people. Now, a lot of people have passed on to meet their Maker in those 6 years, and a lot of middle income families have been wiped out while we have been talking about trying to do something. I hope very much that we will in this Congress, and I hope in this session, move to at least do the most urgent things, those which claim the highest priority, and recommend them from this committee.

Now, the realities are pretty much as Senator Danforth has pointed out, that we are limited in the amount of money we have available, and being limited, we can't do as much as we would like to do if we had unlimited resources to work with. There was a study by Yanklivitch, Skelly, White, Inc., asking what people were concerned about, and they concluded that most families are worried about catastrophic illness, but not about the more mundane but possibly serious ordinary illnesses. The fear of cancer was the overriding concern of most families, followed by fear of accidents and heart trouble.

Only 11 percent mentioned everyday illnesses as their principal health worry.

Time and again we hear of the ruinous costs of these prolonged illnesses. I think there is a consensus among members as well as the Carter administration that we should act in this area. I think we

are also in general agreement that the basic approach to catastrophic insurance should be by requiring that employers provide, using private health care insurance to the maximum extent possible, coverage for their employees to meet the basic requirements. I believe that there is a consensus concerning need to provide assistance to small employees and others where the cost of mandated catastrophic health insurance would exceed the amount which they could reasonably be expected to afford.

Now, we may have some differences about the amount of deductibles, and we may have differences as to the effective date, but it seems to me that we should not waste time before providing what we believe is the most necessary and essential protection of them all, and that would be catastrophic health insurance. If would seem to me that it should begin not later than July 1 next year.

I would point out that while I have my own ideas concerning the nature of catastrophic insurance, my position is not frozen. I look forward to receiving and hopefully supporting the constructive suggestions of other members of this committee, those from the administration and others who can make suggestions as to how we can meet various details of providing adequate health insurance to those we wish to protect.

Now, it would seem to me that the people who are most deserving of protection are those who have been paying for a great number of years to support this Government, those who have been paying their own way and paying the other fellows' way as well, and these are the millions that should be protected from the fear that is too often a reality of a bankruptcy medical expense.

I also believe that we will be able to make some significant improvements to low income protection for Americans. In this regard, I am now working to see what reasonable and budgetary improvements can be made in our health care coverage for the poor. Here we are encountering unavoidable considerations of how much new money we can spend, and I hope that we on the committee will be able to work out a significant and affordable program for the lowest income population.

The latest estimates of the Department of Health, Education, and Welfare indicate that the bill which I introduced along with Senators Ribicoff and Talmadge would actually cost more than the administration plan, whether you have hospital cost containment in both plans or don't have hospital cost in both plans, for the simple reason that our plan would do more for the low income and the near poor than the administration's plan would do. I want to welcome the administration to the position of being accused of being the pennypincher, the one who is not willing to spend money to help the poor.

We have been proposing all along to do more for the poor than they are proposing doing, but the question is, how much of this can we afford?

Now, there are some aspects of this matter that no one here at this moment can provide the best answer to, but I do think that if we work together, we can pick out the best that everyone has to offer on this committee, that which the majority of us seem to find to be the best answer to the problem. I would urge that we have some further conferences with the medical authorities and with the insurance companies as well as with the administration experts, and everyone who has

something to contribute, and I would hope that we would get our nose to the grindstone as soon as possible and try to grind out a bill that we would hope the majority of the Senate would approve.

Senator RIBICOFF. Mr. Chairman, I want to take this opportunity to commend you for your leadership. If people would have realized 6 years ago what they are coming to realize today, that 50 percent of something is better than 100 percent of nothing, we would have had health insurance in place on an incremental basis. We would have had 6 years of experience with catastrophic, and then we could have gone ahead with another phase.

So, we are 6 years behind. From my experience with this committee, it is my feeling that this Committee is a cross section and reflects the basic thinking of this country, and I am confident that we are going to be able to work out a bill with the collective wisdom of the entire membership that will have the overwhelming support of the U.S. Senate for the entirety of its bill to be able to withstand amendments that would emasculate or make this bill impossible.

Now, it is expected that this committee will take the leadership. As I read it, generally, while legislation of this kind must be initiated in the House, I think the House is waiting for the initiative to be taken by the Finance Committee and the Senate before they follow. This is a great opportunity, Mr. Chairman, for you, as you have in the past, to supply the leadership under your chairmanship for a rally landmark piece of legislation that will do so much for the people of this country. I thank you for your testimony.

Senator Dole?

Senator DOLE. I have no questions, except I think we were discussing earlier, we have had some very excellent testimony from, I think, a panel of witnesses, Mr. Kilpatrick of Connecticut. They have been very helpful, as have Mr. Melman and others, in supplying information to the committee to see if we can do what we want to do with the money we have and accomplish the things the Chairman has pointed out.

It seems to me that once we can, if we are persuaded, Republicans and Democrats alike, of differing philosophical views, that we have certain limits, but that we can operate within those limits and come up with some program that would provide benefits to those the Chairman has outlined, then I think we are going to have a consensus that Jack Danforth talked about.

I do believe that as I look at our program, we probably do not have enough focus on the third part of our plan, the so-called residual market, the poor and the near poor, because of the cost. If there is some way we can work out an accommodation in that area, along the lines suggested by Senator Moynihan, that is probably what increases the cost of the Long bill, though I think the administration estimate was not on the latest Long version, was it? It was on the initial version. I think the 760 would be less costly, considerably less costly.

Senator RIBICOFF. Senator Moynihan?

Senator MOYNIHAN. Well, just to congratulate the Chairman for giving us this unaccustomed opportunity that just occurred, and to say that the original Long-Ribicoff bill did do something which it seems to me is essential, and that is, it really does commence to federalize medicaid by putting a cap on State expenditures and as low benefit States go up, providing encouragement to do that but not con-

tinually—there is just too much of a disparity. We are one country, and people ought to have the same level of medical care in all parts of it, particularly if we are going to be thinking in these terms.

I was much encouraged by that, and will very much hope this becomes part of legislation. I would like to hear if the Chairman continues to feel that way. I am sure he does.

The CHAIRMAN. It is purely up to the committee. As far as I am concerned, I am willing to support that. Now, we have the budget procedures, and we have these limitations, and so on that type of expenditure we will have to phase it in as we can find the money to pay for it. I would hope that we can make that the first step to find some money for that purpose, and then to go ahead and expand it from there, but I would hope, though, that we would do something.

Now, as the Senator so well knows, on this Finance Committee we are pretty good about moving and getting action, meeting problems. Sometimes we will start out by saying, if someone has an idea, do we want to do anything about this or nothing? We will have a show of hands, and if the majority say do nothing, we do nothing; if the majority say they want to do something, then we decide, how much do we want to do, a little or a lot? In any event, we will start from that point and go forward, and if the committee wants to act, it has been very effective, and I think it will be, and I hope it will continue to be, with the best advice we can find to guide us.

Senator RIBICOFF. Senator Danforth?

Senator DANFORTH. No questions, Mr. Chairman.

Senator RIBICOFF. Senator Durenberger?

Senator DURENBERGER. Yes; I think it was about 3½ hours ago, Mr. Chairman, that the witness expressed a great deal of frustration about the 6 years of effort and no piece of legislation, and far be it for me with 5 months of experience to provide any advice to someone who has been here 31 years, but my experience in the campaign would indicate to me that often we are given more points for the things we don't do but we talk about and we point out than the things that we actually do. I am constantly impressed by the flow of information that comes across my desk about all of the things that are happening out there despite the lack of legislation, but because of the fact that Senator Long and others have been dealing with zeroing in on the priorities that we have.

My own community has reduced hospital costs from 16 percent increase down to 9.5. We have seen the rise of HMO's. You read about for profit hospitals springing up and saving people money all over the place. There are all kinds of exciting things happening out there, because Chairman Long and you, Senator, and others have spent a lot of time talking about the problem and trying to develop a consensus.

So, all I have to say is, I am appreciative of all that effort you have put in, and I wouldn't be discouraged by the lack of a bill.

Senator RIBICOFF. Senator Long, you can resume the chair.

The CHAIRMAN. I would suggest, Senator, that you conclude the hearing, at least for this morning.

Senator RIBICOFF. Well, the hearings will be closed, subject to further call by Chairman Long.

[Whereupon, at 12:35 p.m., the committee was adjourned, subject to the call of the Chair.]

PRESENTATION OF MAJOR HEALTH INSURANCE PROPOSALS

THURSDAY, JUNE 21, 1979

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met at 9:10 a.m., pursuant to notice, in room 2221, Dirksen Senate Office Building, Hon. Russell B. Long (chairman of the committee) presiding.

Present: Senators Long, Talmadge, Ribicoff, Bentsen, Moynihan, Baucus, Boren, Bradley, Packwood, Roth, Chafee, Heinz, and Durenberger.

The CHAIRMAN. We will be pleased to have the Senator from Minnesota, Mr. David Durenberger, to introduce the witness.

Senator DURENBERGER. Thank you, Mr. Chairman.

I probably have not known Alain Enthoven as long as you have and other people in this community. I have been aware of some of the things he is concerned with in the health care area because we have been practicing them in our own State of Minnesota, principally as a result of employers being deeply involved and concerned about what was happening to health care and the cost of health care.

Over the last 3 or 4 years it has been principally major employers in the Twin Cities community who have started to make change in the health care delivery system, in the quality of care and in competitive alternatives provided their employees for choosing health care. According to statistics I could give you, they are able to reduce through that kind of a competitive system the cost of care.

As far as I know, Professor Enthoven did not participate in any way in developing the Minnesota plan but he has been practicing the theories which Minnesota has developed for some time.

He is currently professor management at the graduate school of business and a professor of economics of health care at the school of medicine at Stanford University.

He also has some other practical experience. He was Deputy Comptroller and then Assistant Secretary of Defense during the 1960's. Subsequent to that he was president of Litten Medical Products and he has also served on the board of directors of several hospitals including the Georgetown University Hospital here in Washington.

In addition to teaching, Dr. Enthoven is a consultant for the Kaiser Foundation Health Plan.

The concepts which he is about to provide to this committee I think provide the Congress and the administration with a choice. Either

we continue down the path of more Government controls and tinkering with all of our reimbursement mechanisms which in my opinion and in our practical experience in my State have done nothing more than encourage waste or we try to find a more appropriate path out of this and, I think, competitive incentives is the path.

I am very pleased, Mr. Chairman, that you have given Professor Enthoven the opportunity to testify today.

The CHAIRMAN. Dr. Enthoven, I had the privilege of hearing some of your views on this subject and I was impressed. Now that I know your credentials I am more impressed.

We would be pleased to hear your statement, sir.

STATEMENT OF ALAIN C. ENTHOVEN, PROFESSOR OF PUBLIC AND PRIVATE MANAGEMENT, GRADUATE SCHOOL OF BUSINESS, AND PROFESSOR, HEALTH CARE ECONOMICS, STANFORD UNIVERSITY

Mr. ENTHOVEN. Thank you very much, Mr. Chairman. I want to thank you for the privilege of appearing before this committee. I am speaking as a private citizen expressing my own views and not necessarily those of Stanford University or any of my consulting clients.

In order to keep my remarks brief, Mr. Chairman, I will just hit the highlights in this statement and then with your kind permission submit backup materials for the record.

The main cause of the unnecessary and unjustified increase in costs of health care as well as inequity in its distribution is the complex of perverse incentives inherent in our dominant financing system for health care: Fee for service for the doctor; cost reimbursement for the hospital; and third party insurers to protect consumers with premiums usually paid largely or entirely by employers or Government.

This system rewards providers of care with more revenue for giving more and more costly care whether or not more is necessary or beneficial for the patient. It leaves insured consumers with little or no incentive to seek a less costly health care financing or delivery plan. There are many cost increasing forces and virtually no reward for economy.

The third party insurance mode of finance into which we have fallen, borrowed from casualty insurance, is a totally inappropriate way to finance medical care in this modern world of high technology.

Mr. Chairman, medical care insurance just should not be viewed like collision insurance for your automobile. If you smash your fender there is pretty much one way to get it fixed. You get three bids and you find out how much it should cost and then you know what it is. It is not open ended. They pound it out and that is it.

That just is not the way it is for example with chronic stable angina, chest pains caused by clogging of the coronary arteries. There we have built a $1 billion a year industry called coronary artery bypass graft surgery and the doctors are still arguing about whether it is a good idea or not.

The only way we can solve the problems of cost, access, equity, and quality is through fundamental reform of the health care delivery system and the only way we can do that is through a system of

rational economic incentives, that is, rewarding people for providing better care at lower cost and fair economic competition in the private sector.

In a system of fair economic competition among various types of health plans, each covering comprehensive health care services, consumers who joined health plans that did a good job of controlling costs would pay lower premiums or receive better benefits and health plans that did a poor job would lose customers and risk being driven out of business. The health care system would be transformed gradually and voluntarily from today's system with built-in cost-increasing incentives to a system with built-in incentives for consumer satisfaction and cost control.

Mr. Chairman, I believe from today's patterns, it would be possible to cut costs substantially without cutting the quality of care. I demended that proposition in last year's Shattuck lecture to the Massachusetts Medical Society and I have left a copy for the record.[1]

Quality and economy often go hand in hand. The busy surgeon will be more proficient and able to charge lower fees and still make a good living.

The essential principles of a system of fair market competition are these. First, multiple choice. Once a year give each family the opportunity to enroll in any of the qualified health plans operating in his area.

Two, a fixed dollar subsidy. The amount of financial help each consumer gets toward the purchase of his health plan membership, from medicare, medicaid, employer, or tax laws, would be the same whichever plan he chooses. The family that chooses a more costly health plan would pay the extra cost itself so it would have an incentive to choose wisely.

Third, same rules for all competitors. A uniform set of rules would apply to all health plans to assure that they are all competing to provide good quality care at reasonable cost and not profiting by such practices as preferred risk selection or deceptive inadequate coverage.

Fourth, doctors in competing economic units. Physicians would be organized in competing economic units so that the premium each group charged would reflect its own ability to control costs.

These principles could be embodied in a universal system of comprehensive health insurance. I proposed such a system called "Consumer Choice Health Plan" in September of 1977 and described it in an article in the New England Journal of Medicine, which I am leaving for the record.[1] Such a program could be financed at a low level or a high level by the Government. The essential financing vehicle would be a refundable tax credit or voucher usable only as a premium contribution toward the qualified health plan of your choice.

These principles could also be embodied in a set of low cost incremental steps that would contribute greatly to the competitive restructuring of the delivery system while costing the Government practically nothing. I am submitting a memorandum of such proposals for the record.

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[1] See Mr. Enthoven's prepared statement.

On June 7, 1979, Mr. Al Ullman, the distinguished chairman of the Ways and Means Committee of the House of Representatives, put forward a set of proposals based on these principles.

Mr. Chairman, these principles are of demonstrated practicality and effectiveness. For example, multiple choice and fixed dollar employer contribution are an integral part of the Federal employees health benefits program in successful operation since 1960 and now serving 10.5 million people.

The State of California and my own employer, Stanford University, offer their employees a similar choice. Comprehensive health care organizations with built-in incentives for economy have done very well in this fair competition.

A comparison of the Federal employees plan and medicare illustrate the simplicity of the concept. The Federal employees health benefits plan law is 8 pages long and the regulations are 16 pages. I have read the regulations and I understand them. The medicare law, the last time I counted, was 102 pages long and the regulations are 400 pages of fine print.

The CHAIRMAN. In other words the first simple thing to do to reduce cost and gain simplicity is to substitute the Federal employees plan for the medicare plan.

Mr. ENTHOVEN. That is right, Mr. Chairman. If you show signs of being interested in that idea, I am going to sell short my Xerox stock.

The CHAIRMAN. Doctor, when we first considered medicare I proposed that we take the Federal employees plan so you and I were together before we knew it.

Mr. ENTHOVEN. The administrative cost per claim processed in the Federal employees plan was 22 percent below that in medicare. That is what appropriately structured competition in the private sector can do for you.

Mr. Chairman, these principles are not in widespread application today and to that can be attributed most of the problems in our health care economy.

Most people have no choice. When they come to work or they become 65, they are stuck with the employer presenting them with a single plan, or the Government says you are on medicare. If they do have a choice the employer or medicare pays more if they choose a more costly plan.

For example in my county, most city employees have a choice between Blue Cross, with a typical family premium of $125 and Kaiser with a family premium of $85. The employer pays the whole thing either way. In other words, the employers are saying to the most costly fee for service doctors, "It does not matter what your costs are, we will pay them."

Medicare systematically pays more on behalf of beneficiaries who stay with fee for service than on behalf of those who choose group practice HMO's. For example, in 1970, medicare paid $202 per capita on behalf of those who joined Group Health of Puget Sound and $356 per capita or 76 percent more for a sample matched by age and sex and location for those who choose fee for service.

As you know, Mr. Chairman, it is awfully tough to compete in a market in which employers and Government will pay such large subsidies to your competitors.

We do not have equal rules. HMO's are very tightly and I think too tightly regulated by the law and HEW while the rest of the health insurance is free to experience rate, use complex benefit packages with trickly exclusions, et cetera.

The medical profession has successfully defended the principle that every health insurance plan must offer "free choice of doctor" which effectively rules out economic competition among doctors. It says that if I am insured it does not matter whether I go to the most expensive or the least expensive doctor, it is all paid by my insurance. The right of "free choice of doctor" ought to be augmented by the right of each family to agree to get all its care from or on referral through a limited set of doctors in exchange for lower premiums or better benefits.

Mr. Chairman, these principles could be put into operation at little or no cost to the Government. Here is one way to do it. Employer contributions to health benefits are excluded from taxable incomes of employees and a part of individual premium payments are tax deductible. This favorable tax treatment is costing the Federal and State governments roughly $13 billion this year in forgone tax revenues. In these laws the Government has an ideal lever to make the market achieve public purposes more effectively. It can set requirements and minimum standards for employee health benefits programs as a condition for favorable tax treatment.

For example, require the employer to offer the employee three distinct choices. Require that the employer premium contributions be the same amount whichever plan the employee chooses.

Require that all health insurance plans that qualify for favorable tax treatment cover basic benefits as defined by the HMO Act as a minimum uniform standard or some other uniform standard of benefits. Make them include catastrophic expense protection. Catastrophic expense protection is a good idea. Every family should have it. It should be done on a private sector basis rather than on a legal entitlement basis.

Include continuity of coverage provisions such as automatic coverage of newborns and the right of unemployed, widows, divorcees, and so forth to convert to individual coverage at group rates.

The same provision should be embodied in a freedom of choice provision in medicare such as the one just introduced by Congressman Rangel under which any beneficiary can direct adjusted average per capita cost to medicare for people in his actuarial category be paid as a fixed premium contribution on his behalf to the HMO of his choice. This could be the first step in the ultimate total reform of medicare along the lines of the Federal employees health benefits program. That is, determine a set of per capita and flat per capita subsidies to people depending on their actuarial category and say, here is the subsidy and here is the menu of competing choices.

Mr. Chairman, where tried, competition has been an effective contributor to cost control. Senator Durenberger sees it work in Minnesota. I am sure Senator Matsunaga sees it work in Hawaii where they have a very good system of health plan competition. Congressman Ullman sees it work well in his home district.

On the other hand, direct controls on prices and capacity have failed and are bound to fail. I spelled out some of the reasons for this

in an article in the Harvard Business Review and in a letter to Congressman Waxman which I have submitted for the record.[1]

The administration's hospital cost containment proposal rewards the fat and punishes the lean. Its proposed system for grouping hospitals by peer groups is unworkable. There is no satisfactory way of controlling for case severity. I do not know about other hospitals, Mr. Chairman, but Stanford University Hospital has no peers.

Such price controls with their inevitable cost passthroughs inevitably become a system of cost reimbursement. The Nixon administration's economic stabilization program apparently slowed the growth of hospital wages but failed to produce economic cost savings.

Certificate of need has failed. It has been tried, thoroughly studied, and failed. The leading experts cannot agree on standards for the appropriate number of beds not to mention for more esoteric technologies.

With the possible exception of New York in fiscal crisis, there is not the political will to close unneeded hospitals by direct Government action. They could be closed by the impersonal forces of the competitive market.

Mr. Ullman put it this way and I quote:

> Government simply cannot regulate the entire industry effectively. Once the accelerator is stuck, putting on the brakes may slow the car but the damage is extensive.

The time has come, Mr. Chairman, to stop tinkering at the fringes of a system with fundamentally wrong incentives and to subject the dominant system of fee for service cost reimbursement and third party intermediaries to fair economic competition from alternative delivery systems and then let the systems that do the best job for the consumers win in the marketplace whether or not they are spelled MOH or whatever you want to call them.

Thank you, Mr. Chairman.

The CHAIRMAN. It is my impression, based on the experiences of an HMO trying to organize in my State, that the medical establishment frowns on HMO's and for good reason. I think the established doctors feel that an HMO in their area might cause them to make less money.

I would think that if someone went out and got busy, however, younger doctors could be interested in getting together and forming a clinic to offer service and bid for the business in the community.

How would you promote competition? How would you get the competition started if you were trying to advance your concepts in such a situation?

Mr. ENTHOVEN. Mr. Chairman, that is correct that the medical establishment frowns on it because they do not want economic competition between doctors.

The CHAIRMAN. Lawyers do not either.

Mr. ENTHOVEN. That is different. I am not a lawyer.

The CHAIRMAN. It is all right to compete for the business; however, the law provides that you cannot advertise in the newspaper and so advertising has to be done very subtly.

The Federal Trade Commission says they should compete.

Mr. ENTHOVEN. Mr. Chairman, I think the first best thing to do would be the following; the biggest barrier for a new health plan to

[1] See attachments to Mr. Enthoven's statement.

get going is that it has to be sold first to the employer and then to the employee and then it is only going to be attractive to the employee if the employee gets to keep the savings. That is why I am recommending that we say employers above a certain size have to offer three competing alternatives to their employees. You have to do what Stanford University does or what the Federal Government does or what Control Data does and other leading companies in Minnesota do.

The CHAIRMAN. Can employees accept that individually or do they accept it as a unit?

Mr. ENTHOVEN. I was thinking that you give them at least three choices and then, individually, each employee examines the choices once a year and make a choice.

The CHAIRMAN. Each individual employee?

Mr. ENTHOVEN. Yes; that is the way the system works.

The CHAIRMAN. Is that how it is with the Federal plan?

Mr. ENTHOVEN. Yes; Mr. Chairman, that is how it is with the Federal plan. I was covered by the Federal plan when I was Assistant Secretary of Defense in the Johnson administration. Once a year I got little booklets describing the different plans in this area. I had a choice of Aetna, Blue Cross-Blue Shield, Group Health Association and now there are Georgetown University Community Health Plan and George Washington University Health Plan. You get these booklets and the Federal Government as the employer says, we are going to contribute $58 a month toward the plan of your choice, you read the books, take your pick and tell us which one it is and we will deduct the rest from your paycheck and send it in.

The CHAIRMAN. If you as an individual want to have the Blue Cross plan and that costs more, you would pay more.

Mr. ENTHOVEN. That is right.

The CHAIRMAN. One the other hand, if you had the Kaiser plan available to you, that would cost you less.

Mr. ENTHOVEN. That is right.

The CHAIRMAN. The employer is going to contribute to a flat amount in any event and then you would decide how many frills you wanted. If you wanted to have the plan that starts with first dollar coverage, you would pay the difference.

Mr. ENTHOVEN. Exactly. The plan that I am on at Stanford, the university says to me, Alain we will contribute $55 per family per month toward the plan of your choice.

The CHAIRMAN. Is that the plan we now have for our Federal employees?

Mr. ENTHOVEN. Yes; we have had that since 1960.

The CHAIRMAN. That is the plan we Senators are going by right now.

Mr. ENTHOVEN. Are you on that also?

The CHAIRMAN. I think I am on it, yes, sir. I am a pretty busy guy so I have not read my own policy. My impression is that I am on it. In fact, I originally tried to put medicare on the same basis.

Mr. ENTHOVEN. It works. In California as an example, in northern California about half of the Federal and State employees in Kaiser's northern California service area belong to Kaiser. They are given the choice of that or Blue Cross or Aetna and so forth. Year by year the plans with built-in cost controls have gained in market share.

At Stanford University we have a choice between three plans. The Palo Alto Clinic prepaid plan is one.

The CHAIRMAN. Is that an HMO?

Mr. ENTHOVEN. It is like an HMO. It is not an official Government HMO but it is like an HMO. It is a prepaid group practice. There is the Kaiser plan and a Blue Cross insurance plan.

The couples and families get the flat dollar amount. The individuals get the whole thing paid. Among the couples and the families about one-third take the Palo Alto Clinic plan and about one-third take the Kaiser plan and about one-third take Blue Cross. If you take the more expensive Blue Cross plan, you pay more copayments and a higher premium.

Senator PACKWOOD. Dr. Enthoven, I used to negotiate labor contracts and in my State of Oregon, Kaiser-Permanete provides health coverage and jobs to many persons. I discovered just a month or two ago the plan itself is the tenth biggest employer in Oregon which gives you an idea of the scope of its size. Whenever a union would sign a contract with an employer where Kaiser was to be the principal carrier, Kaiser would require there be an option for the employees to opt out.

Is that still customary?

Mr. ENTHOVEN. That is still their general rule. They insist on the principle of choice.

Senator PACKWOOD. I thought it was a show of confidence in Kaiser's own plan that they say we will not sign one unless the employees who do not want to use our plan have a right to opt out and the employer to pay an equivalent amount to wherever they want to go. This is very close to what you are saying.

Mr. ENTHOVEN. Exactly. They insist on dual choice. Their doctors are wise and they say, we do not want patients who are in here involuntarily. It is better for us and them if they have made a free informed choice and have chosen us in preference to a valid alternative.

Senator PACKWOOD. Let me ask you something further. You have had a lot of experience with Kaiser yourself. I was always intrigued in talking with them and going through their hospitals that their statement was they really did not run their hospitals any cheaper than any other hospital. They just did not hospitalize as many people.

Mr. ENTHOVEN. That is correct.

Senator PACKWOOD. How in your estimation have they succeeded where other plans have failed in getting so many employees voluntarily to take their annual physicals? I remember Kaiser bringing mobile health facilities to big plants and doing them there. They had a psychological way of achieving it that other plans do not achieve. How do they do it?

Mr. ENTHOVEN. I wish I could be more helpful on that, Senator. I know they believe very much in preventive medicine and health maintenance and trying to keep you well and the system of payment of course rewards that.

I am not acquainted with the specific techniques for how they do it.

Senator TALMADGE. Doctor, how does the Federal employees plan bring competition into the marketplace?

Mr. ENTHOVEN. Senator, it brings competition in this sense, that the typical Federal employee is given a choice of several different compet-

ing alternatives and the Federal Government as an employer says, we will contribute for a family about $58 per family per month and we give you this choice.

Senator TALMADGE. That is much higher than most other plans, is it not?

Mr. ENTHOVEN. No.

Senator TALMADGE. $58 a month is over $600 a year.

Mr. ENTHOVEN. It depends on the location, Senator. In the State of California or around where I live, all the county and municipal employees get the whole thing paid for. Many of the big unions get the whole thing paid for, whatever they do. In some cases I understand with the autoworkers it is typically something like $1,800 a year paid for by the employer tax free.

Senator TALMADGE. Let's get back to the Federal employees plan. As I recall, I elected for the high option. If I get ill I can pick out any hospital I want, isn't that so?

Mr. ENTHOVEN. Senator, in actuality what happens is generally you pick a doctor and he picks out the hospital.

Senator TALMADGE. How does that introduce competition?

Mr. ENTHOVEN. If I can describe how it has worked in California, Federal employees in California, Blue Cross high option costs more than Kaiser and you have to make copayments as well. Year after year what has happened is given a free choice, an increasing percentage of the Federal employees in northern California around where I live say, I see a better deal in the Kaiser plan than I do in Blue Cross so I am going to switch.

Senator TALMADGE. Is there any other way to introduce competition into the marketplace except HMO's?

Mr. ENTHOVEN. Definitely. I think one of the most interesting plans has been developed by the Safeco Life Insurance Co. in Seattle. You might say it is a different way of paying the doctor. They sign up in Seattle, they do it in northern California, in small towns as well as large cities, they sign up doctors who are called primary care physicians. If you join their prepaid plan, you as a beneficiary, you pick the participating primary care doctor of your choice. You say, I will agree to get all my doctoring and medical care from or through, that is on referral and under the control of my Dr. Jones.

The doctor in turn signs a contract where he agrees to be that person's doctor for a flat monthly retainer fee. The monthly retainer fee is actuarially adjusted. It is higher if you are an older person in a higher actuarial category and it is lower if you are younger and healthier.

Senator TALMADGE. In other words it is analogous to a salary rather than a fee for service.

Mr. ENTHOVEN. Or analogous to a retainer. He is an independent professional but he has a retainer. Money from the insurance premium flows into an acocunt which that doctor manages for all of the referral care and the hospitalization for his patients.

Senator TALMADGE. How are you going to introduce competitive forces into the marketplace with respect to hospitals?

Mr. ENTHOVEN. The main customer for the hospital, Senator, is the doctor and the health plan. If the doctor has a financial interest in

holding down the hospital cost then he will get interested in holding down the hospital cost.

Senator TALMADGE. In other words you are going to control the hospital cost through the doctor?

Mr. ENTHOVEN. Yes; because he is the one who calls the shots. Let me go on with the Safeco plan to say that plan is now offered as one of the multiple choice options, for example, in the State of Washington to the State of Washington employees. They can pick Blue Cross, Safeco, or Group Health Cooperative of Puget Sound. Seattle First National Bank does the same thing.

With Safeco, they have been doubling enrolled memberships every year and their hospital use looks like an HMO. They hospitalize their people something like 400 days per 1,000 per year instead of the 800 that is typical of Blue Cross-Blue Shield.

Senator TALMADGE. The real key to your plan is the cooperation of the doctor?

Mr. ENTHOVEN. Rewarding the doctor for the economical use of other health care resources. Senator, the gross income of doctors is only 20 percent of the grand total of health care costs. While sometimes doctor fees are excessive, that is not the really important problem of health care costs.

If we take the Willie Sutton principle, you know, that is where the money is, it is mainly in the hospital. The key is to get the doctor interested in holding down the hospital cost. That was the success of the Kaiser plan, the way they built the plan, the doctors are interested in holding down the hospital costs.,

Senator TALMADGE. Under the Kaiser plan, does Kaiser provide the hospitals?

Mr. ENTHOVEN. Yes; they have their own hospitals. To give another example in my area, a new individual practice association is starting up where the doctors are at risk for the hospital costs. The first thing this plan did was to send letters to the hospitals in the area with typical orders for typical diagnoses. They said, this is a lady 45 years old who is going to have an appendectomy and we ordered these tests on this day in the hospital and tell us what the bill will be for that.

For a bunch of different cases they got the bills back from the different hospitals and looked at them. They went back to some of the hospitals and said, we think you are a neat hospital but your extra cost is not worth the extra charge. Either you are going to have to cut your costs back or we will not be able to use you any more.

One friend of mine, Senator Talmadge, Paul Ellwood, once explained it to me. He said hospitals do not have patients. Hospitals have doctors and doctors have patients. That is, the doctor is the customer of the hospital and you want to make the doctor conscious of the hospital cost. Today most of my friends who are doctors say they have no idea what the hospital costs are.

Chairman LONG. Senator Baucus?

Senator BAUCUS. Thank you very much, Mr. Chairman.

Doctor Enthoven, frankly I find your proposal very refreshing. We first discussed this yesterday morning. We have a Long bill, a Talmadge bill and a Kennedy bill. Do you have an Enthoven proposal that is a little more detailed than that which you presented this morning?

Mr. ENTHOVEN. It is very kind of you, Senator. I am not a member so I am dreaming that we will have a new Long bill with some of these competitive principles.

I did design a national health insurance proposal called "Consumer Choice Health Plan" which I described in the New England Journal of Medicine and I submitted a copy of that for the record today.[1]

Chairman LONG. We will insert that into the record.

Mr. ENTHOVEN. Last February, I prepared a memorandum for Mr. Ullman called "Low Cost Incremental Proposals to Improve Competition in the Marketplace." I submitted that for the record also. I spelled out therein more detail the kinds of ideas that I have referred to, that is to say, why not use the leverage of the tax system to require employers above a certain size to offer their employees three competing alternatives and to offer their employee a flat dollar amount as a contribution.

I will have in the record for you, Senator, outlines of these two proposals.

Senator BAUCUS. Do you have it in bill form at all? Has anybody put this together?

Mr. ENTHOVEN. No.

Senator BAUCUS. In your judgment how long would that take?

Mr. ENTHOVEN. I am not experienced in that so I am not sure.

Senator BAUCUS. What feaures of the present bills that are under consideration do you find most palatable and which do you find you are in disagreement with?

Mr. ENTHOVEN. I generally use as the criteria for looking at any proposal these four principles I talked about. Does it give the family multiple choice? Is there a fixed dollar contribution or does it pay more on behalf of people who choose more expensive health plans? Are there equal rules applicable to all competitors? Does it get the doctors organized into competing economic units?

I find in many of the bills that people are still thinking too much in terms of kind of the third party insurance mode, health insurance being like automobile insurance.

I think one of the most important things is not to have an insurance plan that subsidizes fee for service and cose reimbursement against efficient organized comprehensive plans.

Senator BAUCUS. Do you have your proposals sufficiently precise that you are able to cost them out and identify the premium cost and the benefits?

Mr. ENTHOVEN. I did that back in the summer of 1977 in working on the consumer choice health plan. If you bought the full proposal which would make the world look for everybody like it looks for the Federal employees health benefits program and the subsidy level, the tax credit or voucher, was about $800 a year for a family of four in 1978 dollars, I think the net cost to the Federal budget would be about $26 billion. That is an approximate estimate. It might be $30 billion or something of that order.

On the other hand, if you bought a low cost version of the plan and set the tax credit level at say $400 for a family that was not poor and then raised it on a sliding scale for low-income families, I estimated

[1] See Mr. Enthoven's prepared statement.

the net cost to the Federal budget would be on the order of $6 billion.

An important part of it is we would trade in today s tax subsidies for a new form of tax subsidies.

Senator BAUCUS. On either of the two alternatives the annual increases would then be increases at the rate of inflation. Is that correct?

Mr. ENTHOVEN. That would be necessary. I would recommend that once the Congress determined the subsidy level that it tie it to the All Services Consumer Price Index and just let it work automatically going up each year.

Senator BAUCUS. Thank you very much.

I have no more questions, Mr. Chairman. Thank you.

Senator DURENBERGER. Mr. Chairman. I just want the Senator from Montana to know that there will be a Durenberger bill as soon as we get a draft.

Senator BAUCUS. I suspected as much.

Chairman LONG. Senator Bradley?

Senator BRADLEY. Thank you, Mr. Chairman.

Mr. Enthoven, your plan has the employer paying a fixed amount toward the employee's health insurance. There are many unions in this country which have negotiated 100 percent coverage. This would imply a reduction in benefits for those union members.

My question is how do you answer their concern, that they are facing the possibility of reduced coverage under your plan?

Mr. ENTHOVEN. I recognize that we do have a problem, Senator. For those people who have their health plan 100 percent paid by the employer today, if the employer then starts paying less than 100 percent, they are going to lose something. That causes a problem.

I have been working with some employers in our area and talking to some large national industrial employers and suggesting let's say if your employees have a choice between the Blue Cross plan at $125 and the Kaiser plan at $85 and some of them take one and some take the other, perhaps what you should do is agree on saying, we will pay the $125 either way but if you take the less costly plan, we will make it up to you as you choose, in cash or in other health benefits.

One employer in California uses what is called a cafeteria style benefits plan. The employee is given a fixed amount of money with which to spend on health insurance, dental insurance, retirement contributions, and a variety of other things like that. The employee just designates where it goes.

If the employer chooses a less costly health plan, he is rewarded in some other way.

That would be one way of doing it without throwing people for a loss.

Another way that the county supervisors in one of our local counties do, they said they felt they really should change and what they would do is grandfather the existing employees but new employees as of a certain date would go onto the new system of a flat contribution.

Senator Baucus, if I can come back to your question for a moment. I do want to say that there is a trend in various proposals that are being made now to adopt these principles. In the new Kennedy plan, there is competition and choice. In the administration's new proposal which I have not had a chance to study in detail but I read the President's

message, I saw that the President recommends that we require that the employer contribution be a fixed amount equal with respect to the health plan.

There is a trend in that direction.

Senator BAUCUS. What kind of provision under your plan is is made for the person who wants the best neurosurgeon in the country and he happens to live in California and the best neurosurgeon is in Baltimore? How is he covered under your plan?

Mr. ENTHOVEN. There are two possibilities. One is a good health maintenance organization, unless it is very large, is not going to be able to afford to do all of its fancy specialized care itself. What it is likely to do I think in the competitive marketplace is to do what the Kaiser plan in Hawaii does. For many years the practice of the Kaiser plan in Hawaii was if a patient needed heart surgery, and since Kaiser-Hawaii was not big enough to perform open heart surgery, the air fare was paid for the patient and spouse to fly to California where Dr. Shumway at Stanford would perform the heart surgery and Kaiser-Hawaii would pay for it.

One of the important things about this whole business is as I mentioned briefly in my statement, usually the best surgeon is also the most economical surgeon. That is, economy and quality go together. The best surgeon is very proficient. He does not make mistakes so he gets a good result the first time and so forth.

I think what you would find is that good competing health plans would want to get their referral care from well-qualified specialists.

It would still be the case in this plan, unless you chose a free choice of doctor plan which I think would be more expensive, that you would have to agree that you would get your care through or on referral from the doctor group. If you wanted to fly to Baltimore and your doctors did not agree to that, you would not be covered.

Senator BAUCUS. Let s say I am an employee and I have been given the options but I did not know anything about it or let's say I am poor and I never heard of this and I get sick and I arrive at the hospital emergency room. How could I be covered and how would that be financed?

Mr. ENTHOVEN. You mean if you had not made a choice?

Senator BAUCUS. Yes.

Mr. ENTHOVEN. Under the consumer choice health plan, as I recommended it, every family would have a tax credit or a voucher useable as a premium contribution toward the plan of their choice. I recognize that some families would simply fail to make an election. That unused money, I would recommend, would go into a fund. There would be a kind of standard fall back plan for those families who failed to enroll.

At the time of illness when they showed up at the hospital, they would be told, for instance, if the subsidy level was $800 a year, "you are automatically enrolled in this insurance plan that has a premium of $800."

There are alternative devices which could be used. For example, in California, the Culinary Workers' Union has a dual choice between Kaiser and Blue Cross. Some of the culinary workers failed to make a choice. The union, Kaiser, and Blue Cross have agreed that money which has not been spoken for is paid to the two plans as a retainer

fee. They agree if a culinary worker shows up unenrolled, they will enroll him on the spot.

I think that is a workable system. It works nicely.

Senator BAUCUS. Thank you very much, Mr. Chairman.

The CHAIRMAN. Do I understand from what you said, doctor, that in that particular case, if the worker is not insured that he can wait until he is ill and needs the hospitalization and then decide which plan he wants?

Mr. ENTHOVEN. The worker was not free not to pay the premiums because the premiums were contributed by the employer into the health and welfare fund.

I think it is awfully important, Senator, that we not have a system where people can choose not to pay the premiums until they get sick. That is one problem with free standing catastrophic.

The CHAIRMAN. It would be a pretty poor risk to allow a guy to sign up when he gets sick.

Mr. ENTHOVEN. That is why in the system I described the unused money was paid as a retainer fee to Kaiser and Blue Cross to compensate them for taking the risk. In effect they have a system for predicting how many people will go to Kaiser and how many will go to Blue Cross who have not enrolled. In effect the union is saying, we are going to pay their premiums for them even though they did not enroll.

The CHAIRMAN. It would seem to me that the logical answer would be if you do not want to put up any of your own money you are stuck with the low cost option.

Mr. ENTHOVEN. Exactly.

Senator BAUCUS. On that point, as I understand the Kennedy proposal, he would use the Internal Revenue Service to be the collection agency for the "premiums" in this case and where someone did not sign up and suffered some catastrophic illness and showed up at the emergency room, he would get the same coverage he would ordinarily get if he did sign up but the Internal Revenue Service would go back and collect back premiums like it does now collecting back taxes from those taxpayers who have not paid their income taxes.

In effect the Internal Revenue Service would collect back premium taxes that were not paid.

Mr. ENTHOVEN. Something like that makes sense. It is important not to reward people for not insuring. It is just like what Senator Long was saying. It does not make sense to say you do not have to insure until you get sick.

I am all for a freedom of choice market kind of solution here but there are some kinds of freedom that we cannot allow if we want to make the system work and one is that people can get a free ride on it and not contribute to the insurance until they get sick.

Senator BAUCUS. Thank you.

The CHAIRMAN. Senator Heinz?

Senator HEINZ. Thank you, Mr. Chairman.

Mr. Enthoven, are you familiar with Congressman Ullman's speech of June 7 on his health proposal?

Mr. ENTHOVEN. Yes; I am.

Senator HEINZ. Do you think that proposal, which includes some or many of the things you have talked about today, goes far enough,

too far, or are there things lacking? Where does it fall short of introducing elements of real competition into the health care industry that are absolutely vital?

Mr. ENTHOVEN. I think Mr. Ullman's proposals were excellent and would have a major impact on our health care economy. I think it would be wise to supplement them with some further requirements on a qualified health plan. By that I mean I think we ought to have a standard benefit package which we could call basic benefits that every qualified health plan has to cover. That is for several reasons.

One is we could standardize a lot of fine print. We could outlaw what some doctors call "Swiss cheese insurance policies." That is, they say we will insure you unless you get sick. It would make it much easier for the consumer to make comparisons. A plan could have add-ons on top of that but we standardize one some basic benefits. I think that would be a wise thing to do. It would improve competition and it would improve the quality of people's protection.

The next thing is, I think it would be wise as a condition of tax favor treatment to require that the private plan provide the family with catastrophic expense protection.

Third, I think we should require what you might call continuity of coverage propisions. We have a scandalous situation in this country where people who have been paying their premiums for many years get sick and therefore cannot work any more and lose their health insurance just when they need it most or the breadwinner dies or there is a divorce or my child is no longer my dependent and therefore no longer covered.

We ought to say in all those cases that people who were members of a covered group plan have the right to convert to individual coverage at group rates.

Senator Long, in the Long-Ribicoff bill, had a number of standards and in the Dole bill I noticed also there are standards for private health insurance plans including continuity of coverage provisions.

I think those could be done at little cost. You are saying that the family pays the premium and would greatly improve the workings of the marketplace.

Senator HEINZ. Have you any idea why Congressman Ullman left out what is probably the key element, which is the benefit package, the standardized benefit package, or do you think his substitute of kind of the bottom line of the federally qualified HMO as a means of qualifying for the deduction was his way of doing that?

Mr. ENTHOVEN. Congressman Ullman, as I understood it, was not trying to use just the HMO's as the chosen instrument. He wanted to see a much broader class of qualified health plans and he referred to a prepaid plan that was not an HMO. I really cannot speak for Mr. Ullman. I think he was trying to emphasize a point that we have to change the basic incentives so he was putting his emphasis, you might say, on those aspects that emphasized fiscal restraint.

In his speech he emphasized that he felt the Congress just could not pass legislation that would greatly increase the costs.

I am very hesitant to speak for him because I do not know for sure but do not believe that he is in any sense opposed to what I talked about. I think it was just a matter of where he felt the emphasis was needed.

Senator HEINZ. There was quite a debate yesterday on elements of catastrophic coverage and about what is the threshold at which catastrophic begins but there was also a lot of debate, and I guess a clear resolution of when a catastrophic illness ends or how long it goes on.

That is to say if you have medical bills that are piling up at a high rate, how long are those bills going to be paid if you have some really unfortunate situation and let's say you have a child who is on a respirator and needs all kinds of expensive equipment, which I understand is about $40,000 a year. Those were the figures that some of my constituents from Philadelphia gave me, based on their knowledge.

How long do you cover? How do you handle those situations under catastrophic coverage? Is it lifetime coverage? Is it annual coverage with renewals?

Mr. ENTHOVEN. That is an excellent question, Senator. I am glad you asked. As I listened to that discussion yesterday, I felt it is unfortunate that people are kind of trapped mentally in the insurance model of the program where if you are the insurance company getting the bills afterwards, the only thing you can do to control costs is to disallow things or say we will not pay or we have this rule or that rule. I was thinking in that particular case, you are bound to have a very perverse incentive, that is to keep being catastrophically ill, you have to have $500 of expense per quarter. The patient is going to tell that to the doctor and the doctor is going to see to it that you have $500 of expense. That does happen.

I have talked to doctors and they tell me the patients explain their insurance and what they need.

If instead you are in a comprehensive care organization, let's say if you are a member of the Med Center Health plan in Minneapolis and you are on their prepaid plan. That whole thing just does not arise. You have signed a contract with them which says they will provide all the medical care you need without limit. That does not arise.

The way the cost control comes in is not by playing games with these 500 days or $500 but by the judgment of the physician, is more care going to do more good. The physician knows if he makes a practice of giving an awful lot of care that is doing no good it is going to waste a lot of money and it is going to drive up the costs of the health plan.

I believe a lot of so-called catastrophic medical expense is the patient may be very sick but more medical care will not do more good.

Senator HEINZ. If somebody elects a non-HMO, nonprepaid, nonindividual practice association plan but somehow finds himself on a standard indemnity "pay-after-you-are-sick-and-through-the-nose" kind of plan, what happens then?

I understand everything you say.

Mr. ENTHOVEN. In the private sector now we have a lot of major medical which will pay up to $250,000 or up to $300,000 or in some cases even higher limits. The tendency is to go on paying or to set some high limit. The weakness of that, of course, is there is no built-in cost control or use of judgment whereas medical care is inherently a matter of judgment.

Senator HEINZ. That is right. Suppose someone opted for the high option?

Mr. ENTHOVEN. In the competitive world what would happen, Senator, I think those plans would have to build those costs into their

premiums and the plans lacking in cost controls, their premiums would get higher and higher and finally they would either build in cost controls that are acceptable to people or else they would get driven out of business. The world would be transformed into competing systems of built-in cost controls.

Senator HEINZ. Your bottom line on the initial question is we should have the kind of catastrophic protection that we should mandate starts with a particular threshold and that is it period.

Mr. ENTHOVEN. Yes.

Senator HEINZ. Once you are a catastrophe, the health plan takes care of you.

Mr. ENTHOVEN. Yes.

Senator HEINZ. Is there a threshold on an annual basis?

Mr. ENTHOVEN. No.

Senator HEINZ. Once you hit $2,500, that is lifetime for catastrophic spell of illness?

Mr. ENTHOVEN. What I recommended was that you have some annual limit per family like $1,500 or $2,500 per family per year. After they have paid that out of pocket the health plan pays the rest.

I talked about the Safeco life insurance company plan. Once I was addressing a group of financial executives and someone in the back of the room stuck up his hand and said, I am the executive vice president of Blue Shield of Pennsylvania and you are describing our consumer choice something or other plan. We got together afterwards. It turned out that Blue Shield of Pennsylvania is pioneering a very similar plan. Good things are happening in Pennsylvania also.

Senator HEINZ. I hope no one here is surprised.

The CHAIRMAN. I know that I will never sue a doctor for malpractice. I know because as a lawyer I know a little about the business and my brother-in-law is a doctor. I know enough doctors who are friends to where I think I understand their problem. A doctor does not deliberately make a mistake. Doctors do not deliberately engage in malpractice.

An example that I know of is a good doctor friend who was very busy running from place to place and he made a mistake. He is a fine doctor and it was too bad. He took care of my wife and my children and he is just a fine doctor. I will never sue a doctor for malpractice.

By the same token, I do not like having to pay the expense of somebody else having the right to sue that doctor for malpractice. Do you think it might be appropriate in choosing what option you want to either claim the right to sue for malpractice or waive it?

Mr. ENTHOVEN. Yes, Senator. In fact what happens in California. if you join the Kaiser plan and I think it is in both northern and southern California now, part of your choice is that you agree to an arbitration system instead of the tort system in the courts. I think there is a final resort to the courts if you are not satisfied with what the arbitration panel decided but that you agree that the arbitration panel's findings are admissible in the court.

In effect, the member who has voluntarily chosen that plan has also voluntarily agreed to arbitration. In the tort process as I understand it. more than 80 percent of the costs go into the legal fees and all of the rest of it and less than 20 percent to the compensation of the victims.

If you could have an efficient arbitration system, that could be very economical.

The CHAIRMAN. If you set up the arbitration system and you fixed it so the lawyer could not take that case on a contingent fee, and require the person to deal with the doctor directly and not the insurance company and make it so it is inadmissible to say what the arbitration award was, I would think you are not going to have very many lawsuits. What tends to stimulate those lawsuits so much is a young lawyer who does not have much business getting ahold of a case like that and just hustling like a bird dog after quail to go out and take the chance that he will make a lot of money by pursuing that litigation. Oftentimes a lawyer has to almost talk people into suing especially if they have very substantial award coming to them by arbitration.

That type of approach would be well worth considering making a part of this. The suggestion is that you agree to arbitration if you think there is malpractice. If the arbitration does not award you and if you go into court to sue, I would like to say that the lawyer cannot take it on a contingent fee basis so you could lose money as well as make money.

Mr. ENTHOVEN. Another important thing about malpractice, Senator, I believe that generally speaking the health care industry is very weak in quality controls compared to manufacturing industry in which I worked and there is a lack of adequate quality controls. We see appalling cases of gross negligence in the newspaper frequently. I think one thing about organized systems of care where the physicians are working together and they are sort of in it together and they have a concern over their reputation, then they police each other.

Near where I live in California we have El Camino Hospital and doctors and they formed their own insurance exchange where they mutually insure each other. When their own money was on the line, they started imposing on each other restrictions and controls the likes of which the Government would never dream of imposing on them. It was things like if a doctor did a particular operation and made a mistake more than some allowable number of times, the doctors on the board of the insurance exchange would just say, you are no longer covered for that operation.

They started policing themselves and clamping on the quality controls. El Camino Hospital has an excellent record in that respect. They just went at it systematically.

In an organized system you can start putting in quality controls.

The CHAIRMAN. If you are a surgeon you are only permitted to make the same mistake once or twice and after that you are not permitted to perform that operation again.

Mr. ENTHOVEN. That is right. That is just what they do. Depending on what they think the fault was, they might say, you cannot do that operation any more period or you cannot do it unless you have a board certified specialist from your field in there with you doing it or whatever remedy they feel is appropriate to stamp out the cause of the medical injuries.

Senator PACKWOOD. Doctor, I have a number of questions. I missed your opening statement although I have read it. I want you to take me through it from A to Z again as I ask the questions so I am sure I understand it.

If the Congress mandates a basic level of coverage, both catastrophic and basic, would that be the minimum package that would have to be offered?

Mr. ENTHOVEN. Yes. That is exactly what I am talking about. I think I would recommend that it be allowed to be offered subject to significant copayments and deductibles in order to hold the premium down to a level that would be affordable.

Senator PACKWOOD. The benefit structure, you would have to offer that?

Mr. ENTHOVEN. Yes.

Senator PACKWOOD. That is the minimum package. Above that you may have two or three other packages. Are you saying that above that the employee ought to pay?

Mr. ENTHOVEN. I have not even recommended that there be a particular level of employer versus employee contribution. I think that should be a matter of mutual agreement between employer and employee in different circumstances. I have not recommended mandating a particular level of employer contribution.

Senator PACKWOOD. We are going to get into the argument of those who cannot afford to pay, and who is going to pay for them, and are they going to be denied adequate coverage because they cannot pay and their employer will not pay.

Mr. ENTHOVEN. I think for low income people we ought to have a system of subsidies on a sliding scale with income so that we preserve work incentives. If your income is low enough, you get the whole thing paid.

I think an excellent model for the care of low income people is Project Health in Multnomah County, Oreg.

Senator PACKWOOD. I agree.

Mr. ENTHOVEN. The low income people get the multiple choice of competing private plans and the Government agency acts as the broker and subsidizes them. I think that is the way we should do it. A lot of good things come out of Oregon.

Senator PACKWOOD. The founder of that did so well that North Carolina took him off as their director of health.

Mr. ENTHOVEN. Yes, he is a good man.

Senator PACKWOOD. I used to be on Senator Kennedy's Health Subcommittee and I traveled around the country with him on these shows that we had about health insurance. We would have a perpetual series of witnesses who had broken their backs and run out their insurance and sold their house, their dog and their gun and went bankrupt. It was just one witness after another.

If the basic package is moderate enough that it does not cover catastrophic costs and we face this same problem with people running out their insurance, I want you to explain to me how your system of retroactive payments cover that so we do not again have this series of witnesses with the same litany of excessive health costs that they cannot afford.

Mr. ENTHOVEN. First, every qualified competing private health plan should be required to provide catastrophic expense protection.

Senator PACKWOOD. That would be part of the basic plan?

Mr. ENTHOVEN. Yes. If it is too expensive for low income people, you have a Project Health model.

Senator PACKWOOD. Catastrophic is covered perpetually and continually so we never again have to face the argument of these witnesses coming in having run out their insurance.

Mr. ENTHOVEN. Yes.

Senator PACKWOOD. Tell me about the person that can opt out. Can he opt out even of his basic minimum coverage if he chooses he does not want it?

Mr. ENTHOVEN. I think he should not be able to opt out of paying for it, Senator. You should have a system so that the money that is paid in, if he did not actually make a choice, is sitting there available to finance a plan into which he is sort of automatically enrolled.

Senator PACKWOOD. Can he opt out prospectively? Can he say no, I do not even want the basic coverage, do not take any money out of my paycheck, do not put any money down for me, I do not want any coverage?

Mr. ENTHOVEN. I do not believe you can make a system of insurance workable if people can do that and then get back in when they are sick.

Senator PACKWOOD. I did not understand the explanation you had about collecting from someone who chose not to have coverage. Would you please explain.

Mr. ENTHOVEN. Are we talking about a comprehensive national health insurance plan or just modifying the system we have today?

Senator PACKWOOD. I think we are talking about mandated benefits.

Mr. ENTHOVEN. Benefits provided by the employer?

Senator PACKWOOD. Not necessarily. I think we are going to come to them being partially provided by the employer but then if they are provided by the employer, I want to know if the employee can opt out at all or whether he has to at least have the minimum coverage, whether it is paid fully by the employer or partially by the employer and the employee.

Mr. ENTHOVEN. I think everybody ought to have the minimum coverage. Senator, we have some 34 to 44 million people in this country who have duplicative coverage often because both spouses are working. I think one of the things we would like to do is unduplicate that and say one family and one health plan. A working spouse should have the right to say, "I choose not to get my insurance from you, Mr. Employer, because my wife has a good health plan with her employer."

Senator PACKWOOD. Let me ask you something further on this basic benefit. I have never understood why industrial accident insurance or why those who write it do not have the same experience as health insurance.

In Oregon, we have an option in industrial accident insurance of insuring with the State, of self insuring if you were sufficiently viable or private insurance. That option came into existence about 10 years ago. It used to be a State monopoly. Private insurance has done quite well. There is a minimum basic benefit package compelled by the law and you cannot undercut it.

It has been quite common for employers to shop around among the different private insurance companies and indeed one would come in and say we will be happy to beat Travelers and we will come in every 2 weeks to the plant and help fill out the forms and what not. That

does not seem to be as common among health insurance providers. I am curious as to why not.

Mr. ENTHOVEN. There are a lot of factors that have gone into it. I think one of the factors is the medical profession has been extraordinarily astute at selling the rest of us a set of what they call ethics that are economically self-serving and that prevent competition. They like things like fee-for-service which means they will only discuss fees with you when you are sick and not in a good position to negotiate.

In Oregon, some of these battles were fought out on the so-called "free choice of doctor plan." They tried to defend the idea that every insurance plan provides you can go to any doctor that you want. In fact there is a famous legal case back in Oregon on that.

In 1977 in Michigan Blue Shield tried to put in a restriction which said if you agree to go to those doctors who accept our cost controls then you can have better benefits, by limiting a free choice of doctor. The doctors in Michigan threatened to boycott Blue Shield for trying to block competition.

We have to get people to understand and to see through this thing and to understand what has been our trouble and then support some active procompetitive policies by the FTC and the rest of the Government.

Senator PACKWOOD. Dr. Enthoven you are making the doctors appear to be the stumbling block. I am not going to comment one way or the other. I have often wondered why a Blue Cross or a Mutual of Omaha, that may have 100,000 or 200,000 as a universe that they are insuring, does not go to a hospital and say, "on January 1 of every year we will pay you $10,500,000 and in exchange we want a guarantee of 45,000 man-days of beds a year."

I would think a hospital would jump at the opportunity and make their cost savings out of it if they could. Why does that not happen?

Mr. ENTHOVEN. They have to include in the policy that the policyholder understands and agrees he will go to that hospital.

Senator PACKWOOD. Kaiser succeeds in doing this.

Mr. ENTHOVEN. Yes.

Senator PACKWOOD. They have a very low rejection rate and the people seem perfectly happy with Kaiser.

Mr. ENTHOVEN. Yes.

Senator PACKWOOD. When I was negotiating those contracts with firms with 5,000 to 6,000 employees, we would not have 2 to 3 percent that would reject it.

Mr. ENTHOVEN. Blue Cross was set up by the hospital associations with a similar idea to what the doctors have, that is they wanted to assure payment to hospitals and avoid economic competition among hospitals.

What I am trying to do is recommend a set of rules that will bring about economic competition. We have to do just what you are saying.

Senator PACKWOOD. I find your ideas and your statement the most refreshing I have run across in all my years on the Finance Committee and you and I kind of come to the same conclusions, that there is no reason why economic competition in the health delivery industry cannot work. It will work.

Mr. ENTHOVEN. It does work. I live in it myself. I deliberately choose once a year. I get all of my care from the Palo Alto Clinic doc-

tors. They know if they let their premium get up too much higher than Kaiser's that all those nice professors from Stanford Business School next year will choose the Kaiser plan instead of their plan. The economic competition keeps them under the gun.

Senator PACKWOOD. Plus the fact that those few professors influence thousands of others who will follow them.

Mr. ENTHOVEN. We really do have working examples of competition in Senator Durenberger's home area, in Hawaii, in northern California, and the result is people are hospitalized about half as much. In parts of Oregon, in Clackamas County where Kaiser and PACC compete head to head, it is very tough competition.

Senator PACKWOOD. Is PACC the old Oregon Physicians Service where the Clackamas County doctors got together and did exactly what you described about their retainer system?

Mr. ENTHOVEN. It is not OPS but it is Physicians Association of Clackamas County. They have an individual practice association and they compete against Kaiser. A lot of people have the choice. Believe me it is not fun. Those PACC doctors have to sweat blood to get the costs down. They are very tough on each other but they do it in order to serve up a good, efficient package for their enrolled members.

Senator PACKWOOD. Thank you very much. I find your testimony excellent.

Mr. ENTHOVEN. Thank you, Senator.

Senator MOYNIHAN. We would all like to associate ourselves with that thought, Alain. It was very refreshing and it may have changed the course of these hearings.

Senator RIBICOFF. I have a couple of questions and I apologize for not being able to come earlier.

What is the compensation average a year of the doctors in your clinics out in California?

Mr. ENTHOVEN. I do not know, Senator. I have read the national average studies. I do not have a good fix on that. My impression is plans like the Kaiser plan and the Palo Alto Clinic plan do not compete economically by getting lower cost doctors. That is they pay competitive salaries.

Senator RIBICOFF. They have no difficulty getting men of outstanding qualifications?

Mr. ENTHOVEN. Last year I am told that the Kaiser plan had seven applicants for every vacant physician place.

Senator RIBICOFF. In how many communities in the United States at the present time are there organizations similar to these clinics that could go into delivering health care?

Mr. ENTHOVEN. It is a little hard for me to know how to quantify that. I believe there are possibilities in many communities in this country. I think there is in Cleveland, Boston, and Chicago, many communities that could repeat what Minneapolis has done and if we got the rules set right so they had to do that.

Senator RIBICOFF. You feel that if the rules were set right, there would spring up all over the country clinics of this caliber?

Mr. ENTHOVEN. Yes; we can observe that organized delivery systems like HMO's and similar plans have been created in this country by unions, universities, consumer cooperatives, insurance companies,

the Blues, and industrial companies. There have been all kind of sponsors.

In Senator Durenberger's hometown, one of the multispecialty group practices created there is now in competition. A consumer cooperative started and then a multispeciality group practice and then a hospital thought, we are going to lose our business so we had better get with it and they teamed up with a group of doctors and they formed their plan.

Senator RIBICOFF. What is the premium that you personally pay a year in Palo Alto?

Mr. ENTHOVEN. It is $93 per family. I have a three-way choice as a Stanford professor. Kaiser for a family is $85. Palo Alto Clinic is $93 a month. I forget what Blue Cross is, but it is more.

Senator RIBICOFF. How many members in your family?

Mr. ENTHOVEN. Senator, I have six children. I am subsidized by society and I just pay the rate for a family. They have individual, couples, and family premium. I am paying the family premuim.

Senator RIBICOFF. That would take care of your catastrophic illness and all your expenses, medical and hospital?

Mr. ENTHOVEN. Yes; in that plan they make you pay a quarter of the doctor bill up to a certain limit although next year they are going to switch to an HMO and I think they are going to have a copayment of something like $4 for a doctor visit and then everything else is paid for. That is because they feel they would like to give people a little bit of an incentive to think it over as to whether they need to go to the doctor.

Senator RIBICOFF. Your premium is about $1,200 a year?

Mr. ENTHOVEN. Yes; I think when they become an HMO they are saying it will become $110 a month. That is comprehensive care.

Senator RIBICOFF. How do you suggest the unemployed, the poor, and those on welfare, be brought into the system?

Mr. ENTHOVEN. What I was saying to Senator Packwood was in Multnomah County, Oreg., they have a model called Project Health which I think is an excellent model for the kind of thing we are talking about. The county acts as the broker. If you are a low income person, they advertise on television and say, if you are having trouble getting health insurance, come into us. The people are means tested to see if they are qualified for this low income protection. If they are, they are given a multiple choice of six competing private sector comprehensive health plans including Oregon Physicians Service, Providence, Kaiser, Cascade, et cetera. They take their pick and they are enrolled in that plan. Project Health pays their premium and turns around to them and says, we will require of you, Mr. Beneficiary, a contribution that depends on a sliding scale on which plan you chose and on your income. If your income goes up, we expect you to contribute more and if your income goes down, you contribute less. If you choose a more expensive plan, you have to pay more but because you are poor, we are not going to make you pay the whole difference.

Senator RIBICOFF. What has been the experience in the setting up of those plans with organized medicine? Have they fought them? Have they accepted them? Have they cooperated?

Mr. ENTHOVEN. I think the attitude has changed enormously in the past ten years or so. There was a time when organized medicine fought

that kind of thing bitterly. I think that has changed enormously. The younger doctors see the merit of this and are much accepting and even older doctors more and more come to realize that in this modern technological age you just have to have organization.

I do not think what you might call opposition of organized medicine today is nearly the factor it once was. The American Medical Association formed a national commission on the costs of medical care. They recommended as the best approach to the solution of our Nation's problems of cost and equity what they called the competition of alternative delivery systems.

Senator RIBICOFF. Thank you very much.

The CHAIRMAN. Thank you very much, Mr. Enthoven. You have made a very fine contribution here. I think you will find some evidence of it in the legislation that will emerge from the committee.

Mr. ENTHOVEN. Thank you very much, Mr. Chairman. It was a privilege to be allowed to appear.

[The prepared statement and attachments of Mr. Enthoven follow:]

STATEMENT OF ALAIN C. ENTHOVEN, MARRINER S. ECCLES, PROFESSOR OF PUBLIC AND PRIVATE MANAGEMENT GRADUATE SCHOOL OF BUSINESS, AND PROFESSOR OF HEALTH CARE ECONOMICS, SCHOOL OF MEDICINE, STANFORD UNIVERSITY

Mr. Chairman, thank you for the priviledge of appearing before this committee. I am speaking as a private citizen, expressing my own views, and not necessarily those of my employer, Stanford University, or any of my consulting clients.

In order to keep my remarks brief, Mr. Chairman, I will just hit the highlights in this statement, and then, with your kind permission, submit backup materials with supporting details for the record.

The main cause of the unnecessary and unjustified increase in cost of health care—as well as inequity in its distribution—is the complex of perverse incentives inherent in our dominant financing system for health care: Fee-for-service for the doctor, cost-reimbursement for the hospital, and third-party insurers to protect consumers, with premiums usually paid largely or entirely by employers or Government. This system rewards providers of care with more revenue for giving more and more costly care, whether or not more is necessary or beneficial to the patient. It leaves insured consumers with little or no incentive to seek a less costly health care financing or delivery plan. There are many cost-increasing incentives and forces. There is virtually no reward for economy.

The third-party insurance mode of finance into which we have fallen, borrowed from casualty insurance, is a totally inappropriate way to finance medical care in this modern world of advanced technology. It rests on a number of demonstrably false assumptions such as these:

1. The patient is either sick and needs the doctor, or he is well.
2. The doctor knows just the right thing to do.
3. There is one correct method of treating each illness—a professional standard.
4. Providers of care are not responsive to financial incentives.
5. More care is better than less.

In fact, Mr. Chairman,

1. The need for and efficacy of much medical care is marginal, small, in a grey zone of uncertainty.
2. Medical care is dominated by uncertainty.
3. There are often several medically equivalent ways of treating a particular illness, some of which cost more or less.
4. Providers of care do respond to financial incentives. Physician services account for about 20 percent of health care costs, but physicians control or influence most of the rest. The key opportunity for cost control is to find ways of rewarding physicians for economical use of health care resources.
5. More care is often no better than less. Much is useless. As Senator Moynihan put it yesterday, too much care can be bad for your health.

Medical care insurance shouldn't be viewed like collision insurance for your automobile. If you smash your fender, there's pretty much one way to get it fixed. You get three bids and you'll know how much the repair should cost. It isn't open ended. That just isn't the way it is, for example, for chronic stable angina. There we have built a billion dollar a year industry called coronary artery bypass graft surgery, and the doctors are still arguing about whether it's a good idea.

Mr. Chairman, I believe that the only way we can solve the problems of cost, access, equity and quality is through fundamental reform of the health care delivery system. And the only way we can do that is through a system of rational economic incentives (that is rewarding people for giving better care at less cost) and fair economic competition in the private sector.

In a system of fair economic competition among various types of health plans, each covering comprehensive health care services (including traditional insurance and fee-for-service as one option), consumers who joined health plans that did a good job of controlling costs would pay lower premiums or receive better benefits. Health plans that did a poor job would lose customers and risk being driven out of business. The health care system would be transformed, gradually and voluntarily, from today's system with built in cost-increasing incentives, to a system with built-in incentives from consumer satisfaction and cost control.

Mr. Chairman, I believe that, from today's patterns, it would be possible to cut costs substantially without cutting the quality of care. I defended that proposition in last year's Shattuck Lecture to the Massachusetts Medical Society, a copy of which I am submitting for the record. Quality and economy often go hand in hand. The busy surgeon will be more proficient and able to charge less to make a good living.

The essential principles of a system of fair market competition are these four:

1. *Multiple choice.*—Once a year, each consumer would be offered the opportunity to enroll for the coming year in any of the qualified health plans operating in his area.

2. *Fixed-dollar subsidy.*—The amount of financial help each consumer gets toward the purchase of his health plan membership—from medicare/medicaid, employer or tax laws—would be the same whichever plan he chooses. The family that chooses a more costly health plan would pay the extra cost itself. Thus it would have an incentive to choose wisely.

3. *Same rules for all competitors.*—A uniform set of rules would apply to all health plans to assure that they are all competing to provide good quality care at a reasonable cost, and not profiting by such practices as preferred risk selection or deceptive inadequate coverage.

4. *Doctors in competitive economic units.*—Physicians would be organized in competing economic units so that the premium each group charged would reflect its ability to control costs.

These principles could be embodied in a universal system of comprehensive health insurance. I proposed such a system—called Consumer Choice Health Plan—in September 1977, and described it in an article in the New England Journal of Medicine, a copy of which I am submitting for the record. Such a program could be financed at a low level or a high level by the Government. The essential financing vehicle would be a refundable tax credit or voucher usable only as a premium contribution toward a qualified health plan.

These principles could also be embodied in a set of low-cost incremental steps that would contribute greatly to the competitive restructuring of the delivery system while costing the Government practically nothing. I am submitting a memorandum of such proposals for the record.

On June 7, 1979, Mr. Al Ullman, the distinguished chairman of the Ways and Means Committee of the House of Representatives put forward a set of proposals based on these principles. I am submitting a copy for the record.

Mr. Chairman, these principles are of demonstrated practicality and effectiveness. For example, multiple choice and fixed dollar employer contribution are an integral part of the Federal Employees Health Benefits Program, in successful operation since 1960, and now serving 10.5 million people. The State of California and my own employer, Stanford University, offer their employees a similar choice. Comprehensive health care organizations with built-in incentives for economy have done very well in their fair competition. For example, about two thirds of the Stanford couples and families choose either the Kaiser or the Palo Alto Clinic prepaid plan in preference to the traditional insurance plan. A simi-

lar result is occuring in the Minneapolis-Saint Paul area where many of the leading employers offer a fair multiple choice of all or most of the seven competing HMOs there.

A comparision of the Federal Employees plan and medicare illustrate the simplicity of the concept. The FEHBP law is 8 pages long, and the regulations are 16 pages long. The medicare law—last time I counted—was 102 pages long, and the regulations are 400 pages of fine print. The administrative cost per claim processed in the FEHBP was 22 percent below that in medicare. That's what appropriately structured competition in the private sector can do for you.

Mr. Chairman, these principles are not in widespread application today—and to that can be attributed most of the problems in our health care economy today.

1. Most people have no choice. When they come to work, the employer presents them with a single plan.

2. If they do have a choice, the employer or medicare pays more if they choose a more costly plan.

For example, in my county, most city employees have a choice between Blue Cross, with a typical family premium of $125, and Kaiser, with a family premium of $85. The employer pays the whole thing either way. In other words, the employers are saying to the most costly fee-for-service doctors "it doesn't matter what your costs are, we'll pay the whole thing."

Medicare systematically pays more on behalf of beneficiaries who stay with fee-for-service than on behalf of those who choose group practice HMOs. For example, in 1970, medicare paid $202 per capita on behalf of those who joined Group Health of Puget Sound, $356 or 76 percent more for those who chose fee-for-service.

It's tough to compete in a market in which employers and Government will pay such large subsidies to your competitors.

3. We don't have equal rules. HMOs are very tightly—too tightly—regulated by law and HEW, while the rest of health insurance is free to experience rate, use complex benefit packages with tricky exclusions, etc.

4. The medical profession has successfully defended the principle that every health insurance plan must offer "free choice of doctor"—which effectively rules out economic competition among doctors. The right of "free choice of doctor" ought to be augmented by the right of each family to agree to get all its care from, or on referral through, a limited set of doctors, in exchange for lower premiums or better benefits.

Mr. Chairman, these principles could be put into operation at little or no cost to the Government. Here is one way to do it. Employer contributions to health benefits are excluded from taxable incomes of employees, and a part of individual premium payments is tax deductible. This favorable tax treatment is costing the Federal and State Governments roughly $13 billion this year in foregone tax revenues. In these laws, the Government has an ideal lever to make the market achieve public purposes more effectively. It can set requirements and minimum standards for employee health benefits programs as a condition for the favorable tax treatment. For example:

1. Require the employer (above a certain size) to offer the employee three distinct choices.

2. Require that the employer premium contributions be the same amount which ever plan the employee chooses.

3. Require that all health insurance plans that qualify for favorable tax treatment:

(a) Cover basic benefits as defined in the HMO Act as a minimum uniform standard. (They can keep the premium down by higher deductibles. This would standardize a lot of fine print, make plans easier to compare, and rule out a lot of tricky exclusions.

(b) Include catastrophic expense protection (i.e., a limit such as $1,500 or $2,500 on the family's annual out-of-pocket costs for basic benefits). Catastrophic expense protection is a good idea; every family should have it; but it should be done on a private sector basis rather than a legal entitlement basis.

(c) Include continuity of coverage provisions such as automatic coverage of newborns, and the right of unemployed, widows, divorcees, etc., to convert to individual coverage at group rates.

The same provision should be embodied in a "freedom of choice" provision in medicare, such as the one just introduced by Congressman Rangel (H.R. 4444) under which any beneficiary can direct that the "adjusted average per capita

cost" to medicare for people in his actuarial category be paid, as a fixed premium contribution on his behalf, to the HMO of his choice. This could be the first step in the ultimate total reform of medicare along the lines of the FEHBP. (A copy of my statement on this bill is attached for the record.)

Mr. Chairman, where tried, competition has been an effective contributor to cost control. Senator Durenberger sees it work in Minnesota. I am sure Senator Matsunaga sees it work in Hawaii. Congressman Ullman sees it work well in his home district.

On the other hand, direct controls on prices and capacity have failed and are bound to fail. I have spelled out some of the reasons for this in an article in Harvard Business Review and in a letter to Congressman Waxman, both of which I am submitting for the record.

The Administration's hospital cost containment proposal rewards the fat and punishes the lean. Its proposed system for grouping hospitals by peer groups is unworkable. There is no satisfactory way of controlling for case severity. And Stanford University Hospital has no peers! Such price controls, with their inevitable cost pass throughs, inevitably become a system of cost reimbursement. The Nixon Administration's economic stabilization program apparently slowed the growth of hospital wages, but failed to produce economic cost savings.

Certificate-of-need has failed. It has been tried, thoroughly studied, and failed. The leading experts cannot agree even on standards for the appropriate number of beds, not to mention for more esoteric technologies. With the possible exception of New York in fiscal crisis, there isn't the political will to close unneeded hospitals by direct Government action. (But they could be closed by the impersonal forces of the competitive market.)

Mr. Ullman put it this way: "Government simply cannot regulate the entire industry effectively. Once the accelerator is stuck, putting on the brakes may slow the car—but the damage is extensive."

The time has come, Mr. Chairman, to stop tinkering at the fringes of a system with fundamentally wrong incentives, to subject the dominant system of fee-for-service, cost-reimbursement, and third-party intermediaries to fair economic competition from alternative delivery systems—and let the systems that do the best job for the consumers win, in the marketplace, whether or not they're spelled MOH or whatever it is.

ATTACHMENTS

Shattuck Lecture, New England Journal of Medicine, June 1, 1978.

Health Care Costs: Why Regulation Fails, Why Competition Works, How to Get There From Here, National Journal, 5/26/79.

Consumer Choice Health Plan, New England Journal of Medicine, March 23 and 30, 1978.

Recommended Low-Cost Changes to Existing Laws to Enhance Competition Among Health Care Financing and Delivery Plans, February 10, 1979.

Speech by Representative Al Ullman before the National Journal Conference on Health Policy, June 7, 1979.

Consumer-Centered vs. Job Centered Health Insurance, Harvard Business Review, January, February, 1979.

Letter to the Honorable Henry A. Waxman, May 15, 1979.

Statement by Alain C. Enthoven, Ph.D., before the Subcommittee on Health Committee on Ways and Means, U.S. House of Representatives, in support of H.R. 4444, June 18, 1979.

SPECIAL ARTICLE

SHATTUCK LECTURE — CUTTING COST WITHOUT CUTTING THE QUALITY OF CARE

ALAIN C. ENTHOVEN, PH.D.

THE invitation to give the Shattuck Lecture posed a problem for me. How could an economist from California relate to Dr. Benjamin Shattuck, colonial physician in Templeton, Massachusetts, and the distinguished line of Shattuck physicians that followed him? Then I discovered Lemuel Shattuck (1793-1859), not a physician, but a businessman, a founder of the American Statistical Association and principal author of the Report of a General Plan for the Promotion of Public and Personal Health, published in 1850.[1] Lemuel's interest was not primarily in how the medical profession could lift itself above quackery, a problem very much on the mind of Dr. George Cheyne Shattuck when he addressed the Society in 1866.[2] Lemuel was interested in how the people of Massachusetts could most effectively use their resources to promote the health of the population, a problem he considered too large to be left exclusively to physicians. He proposed a broad program of practical measures, to be refined with the help of better statistics, and justified by cost-effectiveness analysis. When I read Lemuel's Report, I knew I had found my Shattuck. I felt comfortable about coming here as I realized that Lemuel Shattuck had demonstrated that one does not have to be an M.D. to be able to speak intelligently about health policy.

Lemuel was concerned that the Commonwealth was spending far too little on health. Today, of course, our concern is that we appear to be spending too much.

The rapid increase in the cost of health care has become a serious problem. Government will do what it must to bring this spending under control; its financial commitment is now too large for it not to. The main line of public policy has been to attempt direct economic controls: certificate of need, price controls, Medicare and Medicaid reimbursement limits and, recently, the proposed Hospital Cost Containment Act of 1977. Generally speaking, studies have shown that such controls are ineffective.[3,4] Even if they were to be made effective, there is nothing in them, or in the history of economic regulation in general, to suggest that they would promote more efficient or equitable delivery of services.[5]

The main alternative to increasing direct economic regulation is to change the basic framework of financial incentives within which the health-care industry operates. Today's system of fee for service for the physician, cost reimbursement for the hospital, and third-party intermediaries to protect the consumer rewards providers of care for cost-increasing behavior and leaves the insured consumer little or no incentive to consider the cost of care. The alternative is to create a system in which consumers and providers can benefit from seeking out and joining health-care financing and delivery plans ("health plans") that are economical in the use of resources. Such a system would rely on incentives and competition to promote economy and equity. I have proposed such a system of health-care financing, called Consumer-Choice Health Plan.[6] More recently, the AMA-sponsored National Commission on the Cost of Medical Care recommended a similar strategy for cost control.[7]

The Shattuck Lecture gives me an opportunity to respond to two questions physicians often ask about such competitive market approaches to cost control:

The first is, "How can we organize to control cost? Are you saying that we must join an organization like Kaiser-Permanente or Harvard Community Health Plan? Or would we be able to continue practice in our own offices on a modified fee-for-service basis?"

The second is, "How can we cut cost without cutting the quality of care?"

These are not easy questions. The answers require balancing different values, which will be weighed differently by different people. And there is much uncertainty about many of the relevant facts. In this spirit, I offer suggestions for consideration, not definitive answers.

ORGANIZING FOR IMPROVED EFFICIENCY AND COST CONTROL

In the system of fee for service, cost reimbursement and third-party intermediaries that dominates health-care financing today, the question of efficient use of resources does not even arise. The problem of how best to spend a given amount of money for the health care of a population is not posed. Providers are not required to set priorities, look at alternatives and make hard choices. From the point of view of the provider, there is an apparently unlimited amount of money. This system rewards cost-increasing behavior with more revenue; it punishes cost-reducing behavior with less revenue. Such a system must produce inflation in prices and waste in the use of resources.

By contrast, an economically rational health plan will have built-in incentives for cost effectiveness. It will reward people for finding ways to deliver better

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care at less cost. The source of funds will not be open-ended. Rather, in such a plan, physicians will accept responsibility for providing comprehensive health-care services to defined populations, largely for a prospective per capita payment, or some other form of payment that rewards economy in the use of resources. Physicians control or influence most health-care spending. The key issue in health-care costs is not physicians' fees; it is how to motivate physicians to use hospital and other resources economically.

Physicians and other health professionals are motivated by nonfinancial goals, including a desire to cure the sick and to achieve professional excellence and the esteem of peers and public. But their use of resources is inevitably shaped by financial incentives. Those who survive and prosper must do what brings in money and curtail what loses money.

In the design of health plans with built-in incentives for cost effectiveness, physicians are not limited to a single blueprint. Today, there are several successful or promising models in existence. And one of the objectives of the Consumer-Choice Health Plan is to stimulate the development of more good ideas.

Prepaid Group Practice

The best known type of health plan with built-in incentives for economy is prepaid group practice. The main examples include the Kaiser-Permanente Medical Care Program, the Group Health Cooperative of Puget Sound and the Ross Loos Medical Group. And an important recent entry is the Harvard Community Health Plan. The essential principles are that a group of physicians, working together, agree to provide comprehensive health-care services, for a fixed prospective per capita payment, to a defined population of members who have enrolled as the result of a free choice. There are many variations on the theme, depending on their origins and sponsorship and the conditions in which they operate. Prepaid group practices have been sponsored by industrial companies, physician partnerships, consumer co-operatives, insurance companies and Blue Cross, universities and others. The physicians may be salaried, as in the Harvard Community Health Plan, or receive capitation plus a share of the program's net income as a group, and salary and bonuses as individuals, as in Kaiser-Permanente, or the physician partnership may own the plan as in Ross Loos. The prepaid group practice may or may not own its own hospitals. The physician group may include a broad range of specialties, or it may emphasize primary care, referring elsewhere patients who need care by specialists not in the group.

There is convincing evidence that prepaid group practices are effective in holding total per capita costs (premium and out-of-pocket) to levels well below those for comparable people with health insurance cared for under fee for service. Luft reviewed and reanalyzed the many comparison studies done since 1950 and concluded that the cost reduction was on the order of 10 to 40 per cent.[10] The cost savings are mainly attributable to much lower hospitalization rates and to greater economy and efficiency of operation. They cannot be explained away by out-of-plan utilization, differences in age and sex composition, previous health status or government subsidies.

For example, one large study compared the costs to Medicare of beneficiaries in six prepaid-group-practice plans with the costs of a control group on fee for service matched for age, sex and area. The average cost of the former was 74 per cent of the latter.[11] Medicare beneficiaries who regularly get their care from prepaid group practices are free to get the same benefits from fee-for-service providers outside their plan; in this study, the costs of the outside services were identified and charged to the costs of the group-practice beneficiaries. Another large study, by Gaus, compared days in hospital and surgical admissions for Medicaid beneficiaries enrolled in eight prepaid-group-practice plans with those of beneficiaries in matched control groups who got their care from fee-for-service providers.[12] The group-practice beneficiaries averaged 340 days in the hospital and 24 surgical admissions per 1000 persons per year, as compared to 888 days in the hospital and 50 surgical admissions per 1000 persons per year in the control groups. This study investigated prior health status as perceived by the beneficiaries and number of chronic conditions, and it found no statistically significant difference between the members of prepaid-group-practice plans and the control groups. As for government subsidies, federal assistance to health-maintenance organizations has been both recent, small and more of a burden than a help.[13]

The prepaid-group-practice model offers many advantages for economy and quality. The method of payment gives the organization a prospective budget. Its physicians and managers must seek to get the most effective medical care out of limited resources. The method of payment also virtually eliminates the administrative burden of billing and collecting from patients for each service. And an economical division of labor frees the doctor from business management and allows him to concentrate on medical care.

Secondly, practice in a multispecialty group has advantages independent of the method of payment. These advantages include ease of consultation, which can be a convenience for both the physician and the patient, a single unified medical record, which allows each doctor to see what the others are doing to and prescribing for the patient, and the stimulation and reassurance of mutual professional support. Ellwood has found evidence that "good multispecialty group practices manage to provide good medical care with less hospitalization" whether on a fee-for-service or a prepayment basis.[14]

Thirdly, a major contributor to cost in the fee-for-service sector is unneeded facilities: hospital beds, surgery suits, radiation-therapy units and the like. The hospital-based prepaid-group-practice plans have a strong financial incentive to match carefully their facilities to the needs of the populations that they serve. And they operate roughly half the beds per capita (adjusted for age and sex) as their fee-for-service counterparts.

Fourthly, prepaid-group-practice plans have economic and professional incentives to match their specialty mix to the needs of their enrolled populations. The goals of proficiency and economy are best served by a limit on the number of surgeons to those who can be kept fully employed doing surgical procedures and by primary care performed by primary-care physicians. Prepaid group practices employ relatively more primary physicians and fewer surgeons than are in the population as a whole.[15]

Fifthly, group practices offer advantages in terms of opportunities for quality control. They can control the quality of their members and have incentives to do so. They can review the qualifications of a physician before he joins, and take action to correct poor performance afterward. They can adjust the professional activities of each physician to the tasks that he is currently well qualified to perform without threatening his livelihood. In the group-practice setting, there is no financial incentive for a physician to practice beyond his competence.

However, it is also clear that the model has serious limitations. In the first place, it takes much time and cost to get one started. The experiences of Georgetown University and Harvard Community Health Plans and others suggest that several years and several million dollars in investment and operating losses are required before a new prepaid group practice will reach the financial break-even point.

Secondly, to join one, patients must change their physicians, something many will be reluctant to do. Thus, prepaid group practices seem to grow fastest in areas and among population segments characterized by high mobility in which people are required to find new physicians anyway.

Thirdly, many patients apparently do not prefer this style of care. Some perceive it as impersonal, institutional or inconvenient. However, it is really not known how many prefer the prepaid-group-practice to the individual-practice style of care because most Americans have not been given the choice on an equal basis.

Fourthly, and even more important, it is evident that this style of practice, although attractive to some physicians, is quite unattractive to many others, who see it as posing unacceptable limitations on their professional independence.[16]

In a national system of fair market competition, prepaid group practice would be an effective competitor. But, because of these limitations, it is not likely to dominate the scene. There would be a good deal of room for other kinds of organization.

Individual-Practice Associations

Another type of health plan with built-in cost controls is the individual-practice association or "fee-for-service health-maintenance organization." Its prototype is the San Joaquin Foundation for Medical Care, established in 1954 in response to the threat of entry by Kaiser–Permanente. There are many variations on this theme. The essential principles are these. The physician continues to practice in his office on a fee-for-service basis. However, as part of a group, the physician agrees to provide comprehensive health benefits to an enrolled population largely for a fixed prospective periodic payment.

To reconcile fee-for-service with the fixed payments, the physicians agree to the following arrangements.[17] First of all, they agree on a maximum fee schedule. When they render a service to a member of the plan, they bill the plan, not the member. Secondly, they accept peer review of the appropriateness of services. This has led individual-practice associations to develop a number of management tools for cost control, including criteria for patient care such as model treatment systems and peer review before hospitalization. Thirdly, the association either pays hospital costs or teams up with an insurance carrier that offers a hospital insurance policy. The premium for the policy reflects the hospital use of those enrolled in the individual-practice association: the less the hospitalization, the more left over for the doctors. Finally, the physicians accept varying degrees of financial risk. If the money runs low, they may agree to accept a pro rata reduction in fees. In some plans, physicians are also liable for costs of inappropriately ordered hospital use or for hospital costs in excess of the budgeted amount.[18]

The individual-practice model offers some substantial advantages. The first is that, as compared to a prepaid group practice, an individual-practice association can be established more quickly and with a smaller initial investment. Secondly, it requires a minimal change in the established physician's practice style. Physicians can remain in fee-for-service solo practice with existing doctor-patient and hospital-staff relationships. Patients may be able to keep their doctors when enrolling in an individual-practice association. However, despite the apparent ease of start-up, these associations have not grown in number or membership as fast as prepaid group practices. As of the July, 1977, census of health-maintenance organizations, 65 per cent of all prepaid plans representing 90 per cent of total membership were prepaid group practices.[19] Thirdly, fee-for-service practice has positive aspects that should not be overlooked in the present concern with cost. It does reward the doctor for working harder and for being more attractive to his patients.

Apparently, individual-practice associations have not so far succeeded in controlling costs. Gaus, Cooper and Hirschman compared days in hospital and surgical admissions for Medicaid beneficiaries enrolled in two individual-practice associations with beneficiaries in matched control groups getting their care from uncontrolled fee-for-service providers.[17] The data revealed no statistically significant differences between the individual-practice beneficiaries and the control groups. This study is the only one with matched control groups. However, its value is limited by such factors as small sample size and the fact that hospital admissions for the Medicaid beneficiaries in Sacramento in the fee-for-service control group were also subject to the Sacramento Medical Care Foundation's Certified Hospital Admissions Program. Studies of total per capita costs for California state employees found that the costs for individual-practice associations were 24 to 27 per cent higher than those for the Kaiser-Permanente program. Luft concluded that "there is no evidence that costs for enrollees in Individual Practice Associations are any lower than for people with conventional insurance."[18]

Egdahl recently sought evidence of the ability of independent-practice associations to reduce hospital use. His investigation was seriously limited by lack of good data, a condition that he is working to correct, and by a lack of comparisons with suitable control groups. Nevertheless, he did find that "three IPA-type plans studied in detail achieved a striking decrease in hospitalization of their patients after introduction of the plan, or in contrast to a comparison population."[19] I believe Egdahl's research points to the correct conclusion: these or similar fee-for-service organizations can control cost if they must. Competitive necessity is the key factor. For example, Hawaii Medical Service Association, a community-sponsored Blue Shield type of plan with built-in cost controls, competes effectively with the Kaiser-Permanente Medical Care program in Hawaii. Both have hospital-use rates (for patients under 65 years old) below 400 days per 1000 per year, and premiums among the lowest of all the comprehensive plans participating in the Federal Employees Health Benefits Program.

Cost control of individual-practice associations is weakened by the fact that the physicians are paid fees for service. In a sense, the format of the individual-practice association assumes that abuse or overutilization is the cause of the cost problem. Peer review curbs the excesses, but it does not do much to motivate a reduction in the costs generated by the majority of doctors whose practices are near the norms.

Individual-practice associations have a propensity to sign up 75 to 100 per cent of the physicians in private practice in their service areas — many more than the number needed to serve their enrolled populations.[18] One main reason for this excess is marketing: the association cannot tell the prospective enrollee that he will be able to keep his own doctors unless most of the doctors belong. And marketing is a critical problem for any health plan starting up. Another reason is political: to gain physician support and neutralize opposition.

But this means that the individual-practice association accounts for a comparatively small percentage of most physicians' practices, which limits its ability to influence their behavior. (Or, if its controls influence physician behavior with patients who are not enrolled in individual-practice associations, as some claim, it does not enhance the association's competitive position.) It also means that the association includes the physicians who generate high costs as well as the economical ones. And it means that the association cannot realize the benefits of matching the specialty mix of its physicians to the needs of its enrolled population. Thus, individual-practice associations face a dilemma: one of their main strengths is connected to a serious weakness. I doubt if they will become effective competitors unless they become selective in their physician membership.

Moreover, signing up most of the physicians in an area invites charges of anticompetitive behavior. The tradition of county-medical-society sponsorship of individual-practice associations makes this situation worse. The individual-practice association then appears to be a restraint of trade for the purpose of fixing prices and blocking competitive entry by other health plans.[20] This position will not be viable in the long run. If competition is not genuine and effective in controlling cost, the government will surely step in and regulate.

Individual-practice associations should carefully select their physician members on the basis of quality, commitment and cost consciousness. They should also reasonably relate the numbers and specialties of their physicians to the needs of their enrolled populations. They should avoid county-medical-society sponsorship. And they should leave the market open to competitive entry by other health plans. The model is flexible enough to make such adaptations.

The Health-Maintenance Program

A third and much more recent model has been called by its originators a "health-maintenance program." Its prototype, the Wisconsin Physicians Service Health Maintenance Program, begun at Wild Rose, Wisconsin, in 1970, now covers about 150,000 people.[21] A similar system was inaugurated in 1974 in Woodland, California, by the SAFECO Insurance Company of Seattle in collaboration with the Woodland Clinic.[22] It has been extended to other areas in California and Washington, and now covers roughly 9000 people. Thus, these plans are both small and new. The value of studying them is for the innovative quality of their ideas rather than for the duration and breadth of their experience.

In the SAFECO plan, a member of a covered group

is given a choice between a conventional third-party insurance plan, with cost sharing (i.e., coinsurance), and a prepaid health plan, with essentially no cost sharing. A beneficiary who chooses the prepaid plan agrees to get all his care from or through (i.e., on referral by) the participating primary-care physician of his choice. (Except for emergencies, services not ordered or referred by the primary-care physician are not covered.) If the beneficiary is not satisfied with his doctor, he may select another participating physician and remain in the prepaid plan, or he may switch to the conventional insurance plan.

The participating primary-care physician (or group of physicians) agrees to provide directly all primary-care services, and to arrange referrals and supervise all other care, including specialist services and hospitalization, for each of his (or their) enrolled beneficiaries. For his services, this physician (if he has 50 or more enrollees) is paid a negotiated age-sex-adjusted monthly capitation payment. An account is set up for each participating physician from which the bills for all referral services are paid. Money flowing into this account is based on the gross premium revenue associated with the doctor's patients, less an allowance for the insurance company's costs, and less the capitation payments. The physician must see and approve every bill. The doctor receives or pays back 50 per cent of the annual surplus or deficit in this account, with a limit on his share of the deficit equal to 5 per cent of his capitation revenue, but with no limit on the surplus. To protect physicians from the costs of catastrophic illness, the costs of patients whose annual expenses exceed a limit are excluded from these calculations, and paid by the insurance company from its reserves. A medical director, assisted by a board of participating physicians, monitors utilization, hospitalization and prescription patterns. Questionable patterns of use are reviewed for possible corrective action. The company reports hospital use of about 300 days per 1000 per year, about half the rate in the community as a whole.[22]

As with the other models, there is room for considerable variation on this theme. In the Wisconsin Physicians Service Program, the primary-care physicians are paid on a fee-for-service basis, not capitation.[21] The Wisconsin plan includes specialists; the SAFECO plan is built on primary-care physicians. The Wisconsin plan is sponsored by physicians and endorsed by the county medical societies. The SAFECO plan is sponsored by an insurance company. The formulas for sharing in the savings can vary.

The health-maintenance-program model offers some attractive features. It makes the individual primary-care physician knowledgeable and accountable for the total health-services costs of his enrollees. It gives him an incentive to increase productivity — e.g., by using nurse practitioners for well-baby visits. It gives him incentives to emphasize prevention of illness and instruction of patients in self-care. It makes the primary-care physician the "general manager" of his patient's medical care, a much needed role in today's complex health-care system.

The health-maintenance program can be started with a minimum of investment and a minimum of disruption of established practice patterns and relationships between doctors and patients, hospitals and other doctors. SAFECO's cost to establish its plan in four areas over a four-year period was less than $500,000.[22] The program can start small, with a few doctors and families, and can be extended gradually into a whole system including specialists and hospitals.

The health-maintenance program creates a market for specialty and hospital services in which the buyers are experts — i.e., physicians able to judge quality, need and appropriateness of services all in relation to cost. Primary-care physicians can see what specialists are charging, and reflect judgments about quality of services in deciding what they should be willing to pay.

The SAFECO model is a partnership between an insurance company and physicians in which the company contributes its skills of organization, administration, underwriting and marketing, and its capital. And the plan can be tied into existing group-insurance arrangements. Thus, it is one way in which the established health-insurance industry can participate in the restructuring of the health-care delivery system.

The health-maintenance program has many of the advantages of the individual-practice association without its most serious defect — i.e., that in the individual-practice association the individual doctor is paid fee for service and has no knowledge of or incentive to control total per capita cost of services for his enrollees.

There are potential disadvantages. Are the cost-control incentives too strong? Will they lead to inadequate service? There might be a problem of preferred-risk selection — i.e., a doctor could benefit financially by discouraging high-risk patients from continuing their enrollment with him. There may be an economic incentive for the physician to take his capitation patients for granted and seek the extra revenue obtainable from serving fee-for-service patients. But there are safeguards against such abuses, the most important of which is the freedom of the dissatisfied patient to change doctors or health plan. And the design of such a plan can be modified to correct problems.

There is potential for abuse under any system of health-care organization and financing — including fee for service or a National Health Service. A physician who wants to take advantage of the incentives of the health-maintenance program, or any other scheme, can surely do so. If there is an optimal set of incentives, I do not know what it is. There is no

a priori basis for deriving one. The only way to find good incentive schemes is through experience in a system of fair market competition among alternative health plans. And any payment system, including fee for service, must ultimately place some reliance on the ethics of physicians.

Other Models

There are other models: some in actual operation, some only proposed. Newhouse and Taylor proposed variable cost insurance.[23] Ellwood and McClure proposed health-care alliances.[24] The essential idea in both is that beneficiaries agree to get their care from a defined set of providers (or on referral by them); the premium for their insurance policy reflects the cost-generating behavior of these providers. In a competitive situation, the providers will be under pressure to control costs. I believe there are other interesting possibilities that have not yet been conceived because we do not have a system of fair market competition that would create a demand for them.

Each of these models is flexible. The variations on each of these themes are many and important. Participating in an organized health plan with built-in cost controls need not be an uncomfortable strait-jacket for the physician. There are enough models to suit the tastes of many — perhaps most. Moreover, in a world of competing health plans, there would be substantial room for individual fee-for-service practice. Some consumers, because of their life-style or tastes, will prefer ordinary insurance and will be willing to pay the higher cost associated with it. Moreover, all the organized systems would refer some of their patients to physicians outside their plan for specialty care, which may be on a fee-for-service basis.

Cutting Cost without Cutting the Quality of Care

As physicians join such organized health plans with built-in cost controls, they will confront the question, "How can we cut the cost without cutting the quality of care?" I believe that lower cost does not need to mean lower quality of care. On the contrary, in many cases quality and economy work together. In other cases, spending can be reduced substantially with no discernible loss in benefit to the patients. Determining the effect of different patient-management policies is extremely complicated, and can be discussed in detail only on a case-by-case basis. What I can offer here are a few insights and suggestions, not a complete catalogue of methods of medical-care cost reduction.

Curtailing "Flat-of-the-Curve Medicine"

A basic principle of economics is the law of diminishing marginal returns: as one input is applied to a production process in successively larger amounts, the resulting increases in output will each be successively smaller. The marginal return — i.e., the increase in output associated with a unit increase in input — may even become zero or negative. As an empirical generalization this law fits many (though not all) situations in the production of goods and services, national defense and environmental protection.

For medical examples of diminishing marginal returns, one should think of the relation of health outcome to more in-hospital days for a patient with a given diagnosis, or the relation of the probability of a correct diagnosis to the number of diagnostic tests, or the relation of health status for a given population to the percentage of the population to which an elective surgical procedure is applied.

I believe that a great deal of "flat-of-the-curve medicine" is being practiced in the United States today — that is, applications of health-care resources yielding no discernible or valuable health benefit. Admittedly, the evidence is suggestive, not conclusive.

Lembcke observed wide variations in the per capita rate of primary appendectomies in different hospital service areas of New York.[25] He found that a lower per capita rate of operations for appendicitis was not associated with higher appendicitis death rates. If anything, he found the contrary. His data suggest that patients in areas with a high rate of appendectomy would have been no worse off if the rate of operations had been reduced to that in the areas with a low rate.

More recently, Wennberg and Gittelsohn found wide variations in the per capita consumption of various health services in 13 different service areas of Vermont, despite the similarity of the populations in terms of rates of illness, income, racial and social background, insurance coverage and per capita physician contacts. They found a twofold variation in the overall age-adjusted per capita rate of surgical procedures, with much wider variations for some operations. There was also wide variation in use of nonsurgical procedures: among Medicare enrollees, total laboratory services per capita varied by 700 per cent. Wennberg observed, "There is no evidence that the latter (i.e those living in high cost areas) have greater medical need, or indeed, that more health is produced...in terms of their health status, it is not possible in my opinion to argue that Vermonters in more expensive areas are better or worse for the effort."[26] Other studies have documented similar variations elsewhere.[27]

As mentioned earlier, there have been many comparisons of hospital use by members of such groups as federal employees and their families, some of whom get their care through fee for service paid by insurance, and some of whom get their care through prepaid-group-practice plans. The latter are hospitalized, typically, some 30 to 50 per cent less. The fact that those cared for by prepaid group practices are there as the result of a free choice suggests that,

at least in their judgment, the lower rate of hospitalization was not associated with lower quality of care.

Another indication of "flat-of-the-curve medicine" is provided by the results of second-opinion surgical consultation programs such as the one directed by McCarthy for several unions in New York City.[28] In some of the programs, a second opinion was voluntary, and in others it was mandatory. In the voluntary programs, 34 per cent, and in the mandatory programs, 17 per cent, of the recommendations for operation were not confirmed by the second opinion.

I am careful to avoid the term "unnecessary surgery" in discussing such findings, although that term will inevitably be used in political discussion and by the media. I am quite prepared to believe that in most of the cases not confirmed by a second opinion, the patient had a real ailment to which the recommended operation was addressed. Moreover, I believe that most physicians sincerely want to do the best thing for their patients, and that the surgeons recommending these operations honestly believed that they were in the best interest of their patients. The findings of Bunker and Brown about high surgical rates among physicians' families would support this view.[29] And in some cases, medical management may cost as much as surgical care, so that avoidance of surgical procedures may not save much. But these second-opinion results do suggest that in many cases, the risks and benefits to the patient are quite closely balanced. If two surgeons, both well qualified and honestly seeking what is best for the patient, come to different conclusions about the advisability of an operation, generally speaking its net benefits must not be large or obvious. One might say that some of the operations are examples of "flat-of-the-curve" medical care.

Another example of "flat-of-the-curve" care was reported by Hutter and his associates.[30] Their prospective randomized controlled study found "no apparent additional benefit to the patient with an uncomplicated definite myocardial infarction from a three-week as compared to a two-week hospital stay." McNeer and his colleagues recently reported a similar result with hospital discharge at one week.[31] Unfortunately, the samples in both studies were small, and McNeer's description of methods makes no mention of randomization. But if their conclusions hold up under further study, the cost savings could be very large. Similar conclusions about the hospital treatment of many diseases must have been reached by physicians who have formed individual-practice associations, developed model treatment systems with criteria for length of stay and substantially reduced hospital use.[18]

It is apparent that there is a great deal of bias in favor of more care, and more costly care, whether or not it helps the patient. This situation is quite understandable in terms of the values of patients and physicians. The insured patient and his anxious family have every reason to seek whatever care might do some good. And it seems unnatural for the physician to stand back and not do all he could to cure disease and alleviate suffering. And the bias is increased by the fear of malpractice suits. We now need to introduce some correction to this bias. We are facing a new situation. The costs are becoming too large. To use Fuchs' phrase, "...medicine should consider the possibility of contributing more by doing less."[32] And the places to begin doing less are where the curves relating benefits to costs are flat.

Regionalization

In the production of many specialized services, average total cost per unit decreases substantially as the number of units produced per year increases. In such cases, economies can be achieved if production is consolidated into facilities producing at an efficient volume.

For example, my student, Steven Finkler, recently estimated the costs of open-heart surgery as a function of annual volume, based on an examination of all the relevant costs for a typical mix of operations at a large medical center in California in 1976.[33] He found that at 50 patients per year, the cost per patient would be about $21,100; at 500 patients per year, the cost would be about $8,700. The average costs per unit decrease with volume mainly because many of the costs of a heart-surgery center are fixed.

Finkler then examined the distribution of open-heart operations in California. In 1975, nearly 15,000 operations were performed in 91 hospitals, for an average of 163 per hospital. In 48 hospitals, there were 100 or fewer operations. Finkler estimated what the total costs would have been if every hospital had produced its reported volume at the unit costs he had calculated and then what they would have been if all the heart procedures had been done in 30 centers doing about 500 operations each. He estimated that consolidation would have saved about $44 million per year in California alone.

Additional savings to be expected from proficiency based on experience are not reflected in these estimates. Moreover, other things equal, the quality of care is likely to be much better in the hospital that does 500 operations per year than in the one that does less than 100.[34] Quality and economy are not always opposed; here is a case in which they go together.

Other services that exhibit decreasing unit cost with increasing volume include clinical laboratories, computed tomography, maternity and neonatal intensive care. Pettigrew's estimates of the costs of an efficient minimum-capability maternity unit imply $1,245 per admission at 500 admissions per year and $653 per admission at 1200 admissions per year.[35] Evens and Jost estimated the technical cost per tomographic ex-

amination at about $157 at a volume of 40 patients per week, and $89 at 80 patients per week.[36]

Regionalization is not a new idea, but its practical implementation is not widespread. If most people got their health care through organizations that actively sought out the best combination of cost and quality of specialized services for their enrollees, and if today's system of cost reimbursement for hospitals were replaced by a system of competitive pricing, I believe that competition would bring about a desirable degree of regionalization on a voluntary basis. (For them to be able to compete, the teaching and research costs of university medical centers would need to be separately identified and subsidized on their own merits.) The resulting improvements in economy and quality would be large.

Cost-Effectiveness Analysis

Physicians should encourage and participate in the development of cost-effectiveness analysis for medical decision making. And they should learn to use it. By cost-effectiveness analysis, I mean a synthesis of principles of economics, statistics, probability and decision theory applied to the complex and uncertain problems of medical decision making. The goal is to elucidate all the costs, risks and benefits of alternative courses of action so that decision makers can be well informed in applying the necessary judgments. Such analysis, properly conceived, should be an aid to judgment, not a substitute for it.

Such an analytical approach to decision making should be formal — that is, written down in precise terms, with the logical steps of the argument exposed to view. Quantitative aspects should be treated quantitatively (rather than with adjectives). The analysis should be empirical, with standard definitions and criteria for measurement, broadly based data and the best statistical methods. Decision analysis should be open and explicit. It should be presented in such a format that it can be reviewed critically from many perspectives. Such an approach allows the experiences of many physicians to be pooled, so that the individual physician does not have to rely excessively on his own experience. It can allow value judgments by patients, public officials and others to be introduced and considered. And an open, explicit analysis can be debated and corrected much more easily than an intuitive, implicit analysis.

Analytical aids to decision making have been developed and applied extensively in such fields as industrial management, natural-resource development, environmental protection and national defense. In 1850, Lemuel Shattuck defended his General Plan for the Promotion of Public and Personal Health with an economic analysis.[1] But there was virtually no progress in the application of cost-effectiveness analysis to health care in the 100 years after that.[37] There are several reasons for this lack. In the first place, the total costs, in relation to income, were not nearly so large as they are today. Secondly, it is often exceedingly difficult, if not impossible, to put a meaningful numerical value on the benefits of medical care. Thirdly, people understandably resist what appears to be "trading dollars for lives." Fourthly, the system of fee for service, cost reimbursement and third-party financing gives providers little or no incentive to consider costs. However, in recent years there has been a considerable development of cost-effectiveness analysis for medical decision making, much of it at Tufts and at the Center for the Analysis of Health Practices at the Harvard School of Public Health.[38-40]

The development of cost-effectiveness analysis is needed because of the extreme complexity of medical-decision problems. I recognize that these decisions require difficult judgments in the face of uncertainty, with wide variations in the responses of different patients, and often a wide variety of diagnostic and therapeutic choices, each having a large number of components with different probabilities of producing different outcomes in different people. The trade-offs among these variables must be considered. And decisions must be made in a timely way, in the face of pain, suffering and risk of death. That the medical profession has dealt with all this as well as it has is a most impressive achievement. But I believe that physicians need help from other disciplines in the development of a set of aids to decision comparable to those developed in other fields.

The need for such help is illustrated by the findings of my Stanford colleague, Dr. David Eddy, who recently did a study of the clinical policy-making process in mammography, which included a thorough review of the literature through 1975. Among other problems, he found numerous errors in probability reasoning such as confusing the conditional probability that a woman will have a positive mammogram, given that she has breast cancer (the sensitivity or true-positive rate), with the conditional probability of cancer, given that a woman has a positive mammogram (predictive accuracy).[41-43] The two probabilities are quite different, and confusing them can have very harmful consequences. Eddy also found a general pattern of single-minded pursuit of breast-cancer detection to the exclusion of such relevant considerations as the false-positive rate and the costs, risks, and discomfort of biopsies generated by false-positive results, radiation hazards, the costs of the procedure and the evidence of effectiveness. This type of reasoning is found in many recommendations to use mammography annually to screen relatively young, asymptomatic women. The recommendations may or may not prove to be wise. My concern here is not with the specific conclusions, but with the quality of the supporting rationale.

In 1850, Lemuel Shattuck observed of the medicine of his time, "The great error has been in forming theories upon observations or statements, without

duly inquiring whether they have been sufficiently numerous, and have been carefully and truthfully made, upon a uniform and comprehensive plan, or whether they are otherwise imperfect."[1] The medical literature of the 1970's still shows an inadequate awareness of the principles of statistical inference. One still finds comparisons in which the control group was not selected randomly, and sample sizes too small to support the conclusions drawn.

The art of medicine has drawn heavily from the physical and biologic sciences. Physicians should now draw the decision sciences into their synthesis.

Controlled Introduction of New Technology

The history of medicine includes many innovations that were initially greeted with enthusiasm, and then subsequently dropped for lack of evidence that they were beneficial.[44] Although new drugs can be introduced for general use only after thorough testing according to careful experimental designs, new operations and other new technologies often move quickly into widespread application without the benefit of similar controls. Only a minority of medical innovations are tested by a randomized controlled trial.[45,46] Investigator enthusiasm for new procedures appears to be much greater in the uncontrolled studies than well controlled studies.[45] And only a minority of innovations prove to be preferred to standard existing treatment when evaluated by a randomized controlled trial.[46]

Although recognizing the many difficulties in planning and executing a randomized controlled trial, and recognizing that such trials do not answer all the questions and settle all the arguments, I believe that many more innovations should be evaluated by this means. In any case, innovations in medical technology should be thoroughly evaluated early, before being put into widespread use. Public officials have good reason for concern when they see, for example, that the number of coronary-artery bypass grafts has grown to more than 70,000 operations a year at a cost of roughly $1 billion while the medical profession is still debating the merits of the procedure.[47,48] The debate is healthy. But it is entirely reasonable for those concerned with public finances to believe that it would have been better if the procedure had been limited to perhaps a few thousand per year, done in a few centers under careful experimental protocols, including long-term follow-up observation, until the indications for the operation and its efficacy had been clearly established.

A similar point can be made for computed tomography. In a very short time, we will have installed 1000 computed-tomography scanners, with an annual cost of roughly $300 million, without established guidelines for its use.[49] Although tomography is a marvelous innovation that will doubtless improve care and save much cost in some applications, there is no evidence that Americans would not be just as healthy with, for example, half as many scanners. Again, early controlled evaluations leading to guidelines for use of computed tomography might have saved tax and premium payers a great deal of money.

Government regulation can exacerbate the problem of uncontrolled introduction of new technology by rewarding those who move quickly to buy a new device before proof of efficacy and evaluation of cost-effectiveness, and punishing those who take a more deliberate approach.[50] Such perverse incentives need to be corrected.

But private action by physicians is also needed. They should forbear in the introduction of costly new technology until a controlled evaluation has been done. Bunker, Hinkley and McDermott have recently recommended the creation of an "Institute of Health Care Assessment" to provide independent evaluation of surgical procedures, to act as a "central reviewing authority capable of sophisticated statistical and economic analysis and empowered with authority and resources necessary to initiate and coordinate appropriate trials."[51] Similar evaluation of other new technologies and of many existing practices is needed. Physicians would find the process far more satisfactory if the evaluation were done on a private and voluntary basis by the profession than if it were done by the government.

Although my purpose in making these recommendations is to suggest ways of controlling costs, I also believe their adoption could improve the quality of care.

Other Methods

These are only a few of the ways in which physicians could respond to a financing system that rewarded economy in care without cutting quality. I believe that we could find many other possibilities if the incentives were appropriate. Observation suggests many things that could be done in a less costly but equally effective way. If our financing systems were not biased against it, we could make greater use of home care. And, if incentives for physicians and patients were appropriate, we could make more use of self-care.[52] Bear in mind that health-care spending will inevitably be brought under control. Control could be effected voluntarily by physicians in a system of rational incentives, or by direct economic regulation by the government. I believe the incentives approach to cost control would produce an outcome far more satisfactory to doctors and patients. Physicians are by far the best qualified to make the difficult judgments about need and cost effectiveness. So I hope the medical profession will accept the challenge.

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ATTACHMENT #3

INCENTIVES AND INNOVATION IN HEALTH SERVICES ORGANIZATION

(Or if HMOs are such a good idea, why don't we have more of them?)

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ADDRESS TO THE ANNUAL MEETING
INSTITUTE OF MEDICINE
NATIONAL ACADEMY OF SCIENCES

WASHINGTON D.C.
October 26, 1978

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INCENTIVES AND INNOVATION IN HEALTH SERVICES ORGANIZATION

(Or if HMOs are such a good idea, why don't we have more of them?)

ALAIN C. ENTHOVEN, Ph.D.

THE COST-EFFECTIVE ORGANIZED SYSTEM

Let us accept, as a hypothesis for the sake of discussion, that the following characteristics describe a good health services delivery organization, or "health plan" responsive to the needs of our times.

1. A group or association of physicians accepts responsibility for providing comprehensive health services to a defined population.

2. The enrollees belong as the result of a free choice among this and similar health plans. Thus there is a competitive incentive for the health plan to see to it that its personnel give good, caring, willing service to patients.

3. The system provides health maintenance services to the extent that they are efficacious; at least it is effective in providing immunizations, prenatal care, and screening of demonstrated value.

4. The health plan has built-in cost controls. The physicians accept responsibility for the total per capita cost for the care of their enrollees, and they use their best judgment as to how to give the best value. They systematically consider such trade-offs as, for example, substituting ambulatory care or home care for costly inpatient care in order to allocate resources to improved accessibility.

5. The physician specialty mix, facilities, and other resources employed are matched to the needs of the enrolled population.

6. There is built-in quality control through peer review, ease of consultation, and follow-up on patient satisfaction. Specialized procedures are done by specialists whose annual volumes of such cases are sufficient to maintain proficiency.

7. There is continuity of health plan membership.

8. The health plan keeps a unit medical record for each patient, so that a new doctor on a case can quickly and reliably ascertain what else has been and is being done for the patient. Unnecessary duplicate tests and conflicting prescriptions can be avoided.

One might be tempted to call this "the ideal Health Maintenance Organization." I am reluctant to use the term "HMO" because of all its political and bureaucratic connotations. Let us instead call it an organized system with built-in controls on quality and cost, or "an efficient organized system" for short.

I do not want to imply that any earthly institution meets all these heavenly ideals. But I do believe that we have in existence in this country some reasonably good approximations. The question Dr. Hamburg asked me to address today is, "If the efficient organized system is such a good idea, why don't we have more of them? What disincentives are retarding this apparently desirable innovation in health services organizations?"

Of course, it is possible that the efficient organized system is not a good idea. Perhaps it is merely a health policy thinker's dream, and not something practical. But I do believe it is a good and timely idea. Of course, there is much diversity in consumer and provider

tastes, so it would be unwise and ineffective to attempt to force people into any single model of health care organization. People would resist such a change if imposed involuntarily. Moreover, there are many ways an efficient organized system might be put together, and we certainly do not know enough about the subject to be able to specify the right or only or best way to do it. But, if this is a good idea, why doesn't it come about naturally? Why doesn't it win out in the marketplace?

I believe the answer is very simple: we don't have a fair competitive marketplace. Rather, we have a marketplace that is shaped by the concepts and interests of fee-for-service medicine, and that is strongly biased against efficient organized systems.

THE INSTITUTE OF MEDICINE POLICY STATEMENT

In 1973, a committee of the Institute of Medicine studied the obstacles to a fair market test of the HMO concept, and recommended eliminating them.[1/] The list included:

A. Legal obstacles, including state Blue Cross/Blue Shield statutes limiting medical service plans to those controlled by doctors or that are open for membership to all or a majority of providers; corporate-practice rules and laws against for-profit health service plans; subjecting HMOs to regulation intended for and appropriate to insurance companies; certificate-of-need laws, one effect of which "whether or not intended, may be to protect existing facilities from competition of such newcomers as HMOs;"[2/] and state laws and regulations restricting innovations in manpower use.

B. Professional obstacles including professional training; and discrimination or exclusion of HMO doctors from hospital staffs.

C. Capital needs including needs for startup assistance and limits on their ability to generate capital internally through retained earnings based on superior efficiency.

D. Marketing problems, including the problems of marketing to employee groups that already have one insurer (e.g. the employer objects to the extra bookkeeping, and the insurer objects to the competition); consumer inertia (based on a preference to maintain their satisfactory relationships with their family physicians) and lack of information.

E. Organizational problems including legal mandates to provide services so comprehensive as to price them out of certain markets, exposure to actuarial risk and arbitrary limits on the manner in which they can reinsure, limited availability of management skills, and legal mandates on governing board membership.

The list was not short. And the Committee noted many of the ways in which the HMO Act of 1973 failed to clear away the obstacles. Many of those obstacles persist, even after the HMO Amendments of 1976. But the Committee's list was not complete. There are powerful economic barriers to a fair market test for efficient organized systems in such federal programs and policies as Medicare, Medicaid, and the tax laws.

ECONOMIC BARRIERS: MEDICARE

Medicare is based on fee-for-service and cost-reimbursement. Thus, it systematically pays more on behalf of people who choose more costly systems of care. There is a provision for paying Health Maintenance Organizations on a quasi-capitation basis, but it is very complex, dis-

criminatory against HMOs and their members (i.e. the government keeps half the "savings"), retains elements of cost reimbursement, and has not been put into operation to any appreciable extent. For example, in 1970 Medicare paid $202 per capita (on a cost-reimbursement basis) on behalf of beneficiairies cared for by cost-effective Group Health Cooperative of Puget Sound, but paid $356, or 76 per cent more, on behalf of similar beneficiaries (i.e. an age-sex matched sample) in the same area who chose to get their care from the fee-for-service sector. On average, for six group practice prepayment plans around the country included in the study from which these data come, Medicare paid 36 per cent more on behalf of similar beneficiaries who chose fee-for-service.[3/] And it is in the nature of Medicare cost-reimbursement that this subsidy to fee-for-service will increase as the cost differential widens. Medicare beneficiaries could get their care from the less costly provider, but they were not allowed to keep for themselves the savings generated by that choice, either in lower premiums or better benefits.

It simply is not fair competition if the government systematically pays large subsidies to one type of competitor.

We could have fair economic competition to serve Medicare beneficiaries if Medicare subsidized their purchases of health insurance or membership in an efficient organized system through a periodic fixed dollar payment, and if they were given a choice from all the available health plans meeting federal standards operating in their area. In other words, we should have a "freedom of choice provision" for Medicare whereby beneficiaries could direct that their Adjusted Average Per Capita Cost (to Medicare) be paid as a premium contribution to the plan of their choice. That would enable efficient organized systems competing to serve Medicare

beneficiaries to pass on their savings to the beneficiaries in the form of better benefits--such as catastrophic illness protection--and lower premiums.

Medicare has other harmful economic effects that help to block fair competition. It helps to create an open-ended demand for sub-specialty care in the metropolitan areas attractive to physicians. It enables such specialists to earn a good living charging high fees and carrying relatively light workloads, thus creating a disincentive for such physicians to join efficient organized systems.

Medicare (and Medicaid) cost-reimbursement blocks fair market competition in the hospital market. One wonders, for example, how a hospital with a 40 per cent occupancy rate can afford to exclude prepaid group practice doctors seeking staff privileges, or how it can afford to refuse to sell its facility to a growing HMO that needs it. And the answer is that Medicare and Medicaid--and the other third-party intermediaries--will allow that hospital to allocate its overhead over the 40 per cent occupancy and recover all its costs from the intermediaries.

MEDICAID

From the point of view of those who are eligible, Medicaid pays all the cost of covered benefits. But again, most Medicaid providers are paid on a fee-for-service and cost-reimbursement basis. Medicaid usually has limits on fees for individual services. But providers can increase their Medicaid revenue by prescribing a greater volume of services for the same medical condition. Thus, Medicaid gives consumers and providers no economic incentives to use resources wisely.

We could have fair economic competition to serve Medicaid eligibles if they were given a choice of competing health care financing and

delivery plans offering comprehensive services, and a voucher, like a "health insurance premium stamp" (analogous to food stamps) to pay all or most of the average cost of a comprehensive plan. In such a system, a government agency would serve as advisor, advocate and broker for the beneficiaries. Project Health in Multnomah County, Oregon, would be a good model for this.

TAX LAWS

The Internal Revenue Code excludes employer contributions to health insurance from the employee's pay subject to income and social security taxes. This encourages employee pressure for more employer-paid health benefits. If the employees take an additional dollar of gross compensation in cash, they get to keep roughly 60 to 70 cents after tax; if they take it in health benefits, they get the full dollar. The tax shelter aspect motivates employers and unions to exhaust this opportunity for tax-sheltered pay. This is becoming even more important as inflation and increasing social security taxes are pushing employees into higher tax brackets. Benefits for more than two-thirds of the workers in private industry health plans are paid entirely by employers.[4/]

As insured benefits become more comprehensive, and the relative efficiency of the HMO over the fee-for-service sector improves, the premium for the fee-for-service plan comes to equal that of the HMO, then to exceed it by an increasing margin. In some cases, the employer or health and welfare fund keeps the premium contribution the same but lets the HMO offer better benefits. This is better than some alternatives, in that it does allow the HMO to pass on to consumers the benefits of its superior efficiency. But after a point, the marginal utility of extra benefits

to each consumer will be worth less than the cash equivalent to the cost of the extra benefits. The extra benefits then become less valuable as a competitive weapon than would be premium reductions passed on to consumers. In other cases, the employer or health and welfare fund keeps the benefits roughly equivalent and pays a larger premium to the fee-for-service plan. Then the employer pays a subsidy of increasing relative amount on behalf of those who select the more costly delivery system. When the employer must pay 100 per cent of equivalent comprehensive benefits either in the fee-for-service sector or from the HMO, the employee is deprived of an important financial incentive to choose a less costly health plan. The autoworker in California who chooses membership in a prepaid group practice plan that provides comprehensive benefits for $77 per month, rather than the Blue Cross plan that costs $101, doesn't get the savings because General Motors must pay the whole cost either way. In the auto industry, and in many industries in California, this situation is becoming the rule rather than the exception. Thus, some collective bargaining agreements force the employer to subsidize the employee's choice of a more costly health plan. The law does not effectively require the employer contributions on behalf of different plans to be equal. And the Internal Revenue Code, in effect, allows more tax-free compensation on behalf of the worker who chooses the more costly plan.

It should not be surprising that HMOs have grown slowly when one considers that such powers as the United States government and the auto industry pay large subsidies to the fee-for-service sector on behalf of people who choose not to join HMOs.

I believe that companies and unions should find it in their enlightened long-run self-interest to agree on an employer

contribution large enough to pay all or most of the premium of a good quality cost-effective comprehensive health plan, and then leave it to the worker who wants the more costly fee-for-service free-choice-of-doctor plan to pay the difference himself. Since the employee--not the employer or union--chooses the provider, it seems reasonable to let him bear the costs or realize the savings associated with his choice. That way, labor and management could cease to subsidize the most costly element of the delivery system, and they would take a large step toward creating fair economic competition.

But whether or not they can agree on that, it makes little sense for the IRS to participate in the subsidy to the more costly health plan. Wouldn't it make more sense to say that above a certain level, the employer contribution is taxable income? Better still, replace the exclusion of employer contributions from taxable income by a refundable tax credit that is not greater if the family chooses a more costly health plan. As well as correcting the cost-increasing incentive inherent in today's tax laws, the use of a refundable tax credit would also channel more medical purchasing power to lower income groups.

The Health Maintenance Organization Act of 1973 requires employers to offer their employees the option of joining one group practice HMO and one individual practice HMO if such federally qualified organizations are operating in their area. This was a small step in the right direction. But it is very far from creating the competition we need. It leaves the health plan market segmented. For example, some employers might offer one HMO in addition to their conventional insurance plan

while others offer a different one, so that the HMOs rarely or never meet each other in direct competition. Each can become, say, 25 to 30 per cent more efficient than its fee-for-service competitor and then settle into an equilibrium in which its costs rise at the same relative rate as in the fee-for-service sector.[5/] We need competition among HMOs as well as against fee-for-service plans in order to give them an incentive to keep improving efficiency.

Another important effect of the tax law is, in effect, to limit the employee's health insurance options to the plan or plans offered by the employer or labor-management health and welfare fund. Employers have seen health benefits as a way of attracting qualified employees to their company, or as a way of discouraging unionization. Union leaders have seen health benefits as a prize to be won at the bargaining table, and as a way of making the union the worker's benefactor. Both emphasize benefits specific to the employer or union; this medical purchasing power is not used to create a market of competing provider groups in the community. The tax law should be changed so that employer contributions are usable toward any qualified health plan.

While marketing to employee groups instead of individuals certainly aided the spread of health insurance, the link between jobs and health insurance adds greatly to the time and cost required to market a new health plan. The health plan must first sell the employer and/or union and negotiate a benefit package to meet their special requirements, and then sell the plan to the employees. New alternative delivery systems such as individual practice associations would have a far easier time getting started if they were merely required to satisfy the criteria of one regulatory agency, and if they were then allowed to participate in a

government-run open enrollment in which membership was made available to all persons in their market area.

THE HMO ACT

The HMO Act of 1973 was supposed to help HMOs. It would have been more accurately characterized as the "Anti-HMO Act." It did more to hurt than to help. It placed many costly burdens on HMOs (in premium rating, benefit packages, enrollment practices, quality assurance, data reporting, etc.) but did not place these burdens on the HMOs' competitors. The Act tried to help HMOs by singling them out; it should instead have sought to place equal rules on all competitors, rules designed to produce a socially desirable competition.

HEW ADMINISTRATION

In 1976, the Comptroller General listed HEW's administration of the Act high among the "factors that impede progress in implementing the Health Maintenance Organization Act of 1973."[6/] It noted such factors as fragmented responsibility for administration, inadequate staff, inadequate financing, and delay in issuance of regulations. Secretary Califano has acted decisively to unify the HMO program's administration and to correct some of the other problems. But a recent GAO report indicates that many of the problems remain.[7/] HEW has reduced the backlog of HMOs awaiting decision on their qualification applications. But the required detail and complexity of the applications still appears to many to be excessive. The GAO observed "HEW plans to reduce the average waiting period for a decision on an application from 180 to 120 days. Qualification delays have not only affected HMO

development adversely, but have also increased program costs."[8/] The delays drain precious working capital, and actually impede the marketing of HMOs because employers wait for the HMO to become qualified before offering it so that they can be sure it will satisfy their dual choice requirement.

Making HMOs a federal program has given them that disastrous quality of public programs that they can't be allowed to fail. As HMOs fail financially--and some of the federally supported HMOs are failing[9/]--this puts pressure on the qualification process to demand ever more detailed documentation, to be sure that HMO developers have a plan for every contingency, and to be sure that HEW is protected from criticism in case of failure. The whole conception is a mistake. Like any other type of business, some HMOs will be run well, others badly. The ones that are poorly managed should be allowed to fail. The process of natural selection purges the incompetent and encourages the others to manage effectively. Moreover, there is no reliable objective way to tell in advance, from an examination of paper plans, whether an-as-yet non-existent organization will be run effectively or ineffectively. Federal qualification doesn't seem to be a good indicator of quality; lack of federal qualification surely doesn't indicate lack of quality. The same is true of financial viability. The whole idea of the federal qualification process needs to be reconsidered. Is it cost-effective? Just what does it accomplish that justifies the extremely heavy burden it places on starting HMOs--even HMOs not seeking federal money? I believe that it would make more sense to leave much more of the "qualification process" to the competitive marketplace.

PREMIUM RATING

The law requires HMOs to practice community rating, i.e. charging the same premium for the same benefits to all members in a service area, regardless of employer. Before the HMO Act, HMOs generally practiced community rating because it fit with their social philosophy of risk spreading and not charging more to persons in greater need of medical care. Also it meant less paperwork. And, because of their built-in ability to control costs, it was not a serious competitive liability.

Insurance carriers, on the other hand, for the most part practice experience rating, that is setting a premium based on the particular medical expense experience of each employee group. They were forced to do this by competition. Employers of low-risk groups can seek out an insurer who will offer them a low premium based on their favorable experience. If insurers fail to respond, the employer can often self-insure, using the insurer for "administrative services only" (ASO).

In a market in which insurers and HMOs are free to set premiums as they think best, this variation in rating practices might be acceptable. If persistence in community rating, with its built-in cross-subsidy from low-risk to high-risk groups, put HMOs at too great a competitive disadvantage, they too could experience rate and quote lower premiums to low-risk groups. The problem is that the HMO Act requires HMOs to community rate, but does not place the same requirement on insurers. This fragments the market: in the low-risk groups, the HMO, whose dues must reflect the costs of the high-risk as well as the low-risk groups, must compete against a premium based on the favorable experience of the low-risk group. That is a disincentive for people in low-risk groups to join the HMO, and an incentive for people in the high-

risk groups to join HMOs. In a system of fair market competition, the same rules regarding premium rating methods must be applied to all competitors.

ENROLLMENT PRACTICES

The premium rating issue is intimately related to the question of enrollment practices. Even with mandatory community rating, a HMO or an insurer might seek to reduce its costs by agreeing to open its enrollment only to low-risk groups. Thus, mandating community rating without open enrollment could work against the goal of universal coverage. In any case, for fair market competition, the rules with respect to enrollment practices must be the same for all health plans. It makes no sense to say that one type of health plan must practice open enrollment while others need not, unless the goal is to abolish that type of health plan. Of course, the "Anti-HMO Act" of 1973 was very counterproductive in that regard, and the "Anti-Anti HMO Act" of 1976 limited the damage without correcting it completely. If we want fair market competition in a system of universal coverage, we must require open enrollment of all health plans. The best models I know for this are the government-run annual open enrollments in the Federal Employees Health Benefits Program (FEHBP) and in the California State public employees' health benefits system.

BENEFIT PACKAGES

A similar problem occurs with respect to benefit packages. The recent GAO report put the point nicely. Noting that the HMO's premiums must be competitive with those of the other health plans being offered, the GAO

observed, "Consequently, a qualified HMO automatically faces a serious threat for its survival. By law, it generally must provide more comprehensive benefits than competitors, but must charge about the same prices as competitors."[10/]

In a system of fair market competition, there would be a uniform definition of comprehensive benefits required to be covered by all competing health plans eligible for any subsidies through the tax laws or any other public program.

OTHER

This list of economic barriers to fair market competition is long, but not exhaustive. There are others. For example, the tax laws governing not-for-profit corporations give substantially more favorable treatment to hospitals than to HMOs.[11/] This seems ironic to those who believe that we have too many hospitals and too few HMOs.

But the list of barriers is long enough to make the point: cost-effective organized systems have not failed in a fair market test. They simply have not had a fair market test; they have been systematically blocked by public policy responsive to the dominant provider interests.

HOW TO HELP HMOs: GRANTS AND LOANS OR A FAIR MARKET TEST?

Have these barriers to fair market competition not been offset by generous federal grants and loans to HMO's? The answer is no. The grants have been small, slow in coming, and surrounded by numerous complex conditions.

I believe that it is a serious mistake to try to offset the barriers to fair market competition by special grants and loans. Already, the

miniscule subsidy program has done great damage. It has created the illusion in the fee-for-service sector that HMOs are a latter-day creation of HEW, an intrusion into the private sector, and the entering wedge for socialized medicine. This is particularly ironic in view of the fact that we had large, growing, cost-effective organized systems--now HMOs--on the West Cost before there was a Department of HEW, not to mention a HMO Act, and they made it to their present position of strength and success despite the systematic and determined opposition of government. When you consider the barriers they have had to overcome, their mere survival, not to mention success, is quite a tribute to the quality of the idea.

I believe special subsidies to HMOs are a mistake because they confuse the far larger and more important issue of establishing conditions for truly fair-market competition. If Medicare, labor and management would contribute equally on behalf of people who join HMOs instead of systematically paying more on behalf of people who choose more costly fee-for-service, that would be worth far more to HMOs than any politically realistic level of public subsidies. And it would leave HMOs and their competitors to the stern discipline of the marketplace instead of beholden to public officials for special favors. The idea of special subsidies to HMOs makes every piece of legislation that bears on them a grab bag for special favors--a political contest that the dominant established interest groups are likely to win. Creating special favors for some inevitably creates political pressures for countervailing favors for others. And, on a very muddy field, we all lose track of where the 50-yard line is. It would make more sense to agree on a fair-market test. Efficient organized systems can win in a fair marketplace. They can't win in a political football game.

PRINCIPLES FOR NATIONAL HEALTH INSURANCE

Finally, let me relieve the anxieties of those whose loyalties lie with one or another proposal for national health insurance, and who fear that I might abuse my position on this nonpartisan platform by saying something in favor of a national health insurance proposal other than the one they favor. The thought crossed my mind only long enough to be rejected.

Instead, following the admonition "when in Rome, do as the Romans do," let me propose some Principles of National Health Insurance as seen from the point of view of efficient organized systems:

1. A system of NHI that requires that the beneficiary's premium contribution be equal (including zero as one example) whichever plan the beneficiary selects would deny efficient organized systems one of their strongest selling points. that is, comprehensive benefits at a lower premium to the beneficiary.

2. A system that depends on a narrow set of design specifications to define a preferred system (e.g. 85 per cent of the doctoring by doctors who spend x per cent of their time serving members of the plan, etc.) is likely to stimulate inappropriate adaptations and narrow the scope of desirable innovation. Better to use performance specifications, i.e. say what a socially acceptable health plan must do, not how it must do it.

3. A system of universal third-party intermediary insurance, with free-choice of doctor, fee-for-service, and cost-reimbursement, as in Canada or in Medicare would kill efficient organized systems. In such a system, there is no reward for economy in the

use of resources and therefore no reasons for consumers or providers to join them. This problem can't be remedied by lip service about special provisions for HMO's; it is fundamental to the design of such systems.[12/] [13/]

4. A system of NHI that builds universal insurance on the link between jobs and health insurance will put the development of cost-effective organized systems at the mercy of employers and unions, both of whom have their own goals which often include higher priorities than optimal cost-effective health care for the employees. In such a system, each new health plan must meet the special requirements of each employer and union before being offered to the employees. That adds greatly to the marketing cost for such plans, something especially critical in the case of new plans starting up. If such a job-related system of NHI allows experience rating of individual employee groups (or preferred-risk selection through enrollment limited to low-risk groups) it will fragment the market. The low-medical-risk groups will get lower premiums through experience rating. This will leave the high risks to be cared for by HMOs which must practice community rating, thus raising their costs and blocking their ability to compete.

5. A system of fair-market competition, in which each consumer or family has a multiple choice of all the qualified plans competing in his market area on an economically fair basis, as in the FEHBP, while not biased in favor of HMOs or any other system of care, would create the kind of economic climate in which efficient organized systems of care that do a good job of controlling cost while satisfying their customers will survive and prosper.

A glossary of which NHI proposals have the aforementioned sins or virtues will be provided to interested persons on written request.

A fair-market test is still as good an idea today as it was when it was recommended by the IOM in 1974. It is still a very long way from being tried.

1/ HMOs: Toward a Fair-Market Test, Institute of Medicine, National Academy of Sciences, May 1974.

2/ Ibid. p. 25.

3/ Steve Goss, A Retrospective Application of the Health Maintenance Organization Risk-Sharing-Savings Formula for Six Group Practice Prepayment Plans for 1969 and 1970, U.S.DHEW, SSA, Actuarial Note 88, DHEW Publication No. (SSA) 76-11500 (11-75).

4/ Daniel Price, "Private Industry Health Insurance Plan: Type of Administration and Insurer in 1974," Social Security Bulletin, March 1977, p. 15.

5/ Alain Enthoven "Competition of Alternative Delivery Systems," Competition in the Health Care Sector: Past, Present, and Future, Federal Trade Commission, Washington D.C., March 1978, pp. 322-351.

6/ Comptroller General of the United States, Factors that Impede Progress In Implementing the Health Maintenance Organization Act of 1973, GAO, September 3, 1976,(HRD-76-128).

7/ Comptroller General of the United States, Can Health Maintenance Organizations Be Successful? -- An Analysis of 14 Federally Qualified "HMOs," GAO, June 30, 1978, (HRD-78-125).

8/ Ibid., p. 58.

9/ Ibid., p. 24.

10/ Ibid., p. 34

11/ Hospitals are classified by the Internal Revenue Service as eligible for treatment under Section 501(c)(3) covering not-for-profit charitable institutions. HMOs are covered under Section 501(c)(4). Two important advantages of being a (c)(3) instead of a (c)(4) are, first, that a (c)(3) can offer favorable tax-deferred employee compensation arrangements not available to (c)(4)'s; and second, a (c)(3) can receive tax-deductible charitable contributions from individual taxpayers while a (c)(4) can't. Also, (c)(4) status can make it harder for a foundation to give money to it, and some foundation by-laws do not permit contributions to other than (c)(3)'s.

12/ Alain C. Enthoven, "National Health Insurance Could Kill HMOs," Stanford MD, Winter/Spring 1978.

13/ Eugene Vayda, M.D., "Prepaid Group Practice Under Universal Health Insurance in Canada," Medical Care, May 1977.

POLICY FORUM

Health Care Costs:

Why Regulation Fails, Why Competition Works, How to Get There From Here

by Alain C. Enthoven, Ph.D.

Alain C. Enthoven is the Marriner S. Eccles Professor of Public and Private Management in the Graduate School of Business at Stanford University and a member of the Institute of Medicine of the National Academy of Science. Previously, he was President of Litton Medical Products and, before that, Assistant Secretary of Defense.

Health care costs continue to soar and strain public finances. From 1965 to 1977, public sector health spending rose from $9.5 to $68.4 billion. Medicare cost $18 billion in 1976. The latest federal budget, using optimistic assumptions, projects it at $36 billion in 1980, and $52 billion in 1982. Thus, medicare will triple in six years. What is new and different now is the sheer size of the outlays. In the face of growing taxpayer resistance and concern over deficits and inflation (30 states called for a constitutional convention to balance the budget). The next tripling won't come so easily. Government will be forced to bring the costs under control.

Many factors contribute to the cost increase: general inflation (though health spending has grown at about twice the general inflation rate), better insurance coverage, new technology, aging population, etc. But there has also been much overutilization of services, overinvestment and waste.

The main cause of unnecessary and unjustified increase in costs in the complex of perverse incentives inherent in our dominant financing system for health care: fee-for-service for the doctor, cost-reimbursement for the hospital, and third-party insurance to protect consumers, with premiums usually paid entirely or largely by employers or government. This system rewards providers of care with more revenue for giving more and more costly care, whether or not more is necessary or beneficial to the patient. It leaves insured consumers with little or no incentive to seek a less costly health care financing or delivery plan. There are many cost-increasing incentives and virtually no reward for economy.

This is not the only way health care can be financed. There are *alternative delivery systems* in successful operation which reward providers of health care services for finding ways to deliver better care at less cost. In these systems, participating physicians accept responsibility for providing comprehensive care to their enrolled members, usually for a per capita payment set in advance. The list of such systems includes prepaid group practices, individual practice associations, primary care networks and health care alliances. There are many variations on each of these concepts, but each includes some reward for economy in the use of resources. Many comparative studies provide convincing evidence that prepaid group practices reduce total per capita costs (premium and out-of-pocket) by 10 per cent to 40 per cent compared to the costs for similar people cared for under traditional insurance programs. In competition, other alternative delivery systems have achieved similar savings.

"Medicare will triple in six years. What is new and different now is the sheer size of the outlays."

The main direction of public policy in the 1970s has been to protect the dominant fee-for-service, cost-reimbursement and third-party insurance system from fair economic competition by alternative delivery systems, and to try to limit the cost-increasing effects by direct controls over prices and capacity.

HOSPITAL COST CONTAINMENT

Since 1977, the Carter Administration has tried to enact an annual percentage limit on the growth of total hospital spending or hospital cost-per-case. The main thing wrong with hospital cost containment is that it does *nothing* to correct the existing perverse cost-increasing incentives. It does not help reform the financing and delivery system, and does nothing to encourage competing alternative delivery systems. It is a pure spending restraint that ignores health care quality, efficiency and equity.

In fact, this approach reinforces and creates new cost-increasing incentives. A hospital that thought it needed less than the proposed annual increase limit would be foolish to take less. To do so would diminish its "entitlement" to future increases.

The 1977 Carter proposal had the undesirable property that it would reward the fat and punish the lean. It accepted present spending patterns as the basis for future allowable increases. This year's proposal

includes an "efficiency bonus and inefficiency penalty" intended to correct that problem. Simple arithmetic makes it clear that the proposed correction fails to accomplish the purpose. Moreover, controlling the cost per admission introduces new perverse incentives. Hospitals that want to beat the system can hold down cost per admission by admitting more low-cost cases than might otherwise have been cared for on a less costly outpatient basis. To DHEW's counter-measures, there would be counter-counter-measures leading to more complex regulations, and so on *ad infinitum*.

"The main cause of unnecessary and unjustified increases in costs is the complex of perverse incentives inherent in our dominant financing system for health care."

Finally, the general history of economic regulation does not support the presumption that regulation reduces costs. The present moves to deregulate transportation are based on the clear evidence that regulation had *raised* costs to consumers. (Admittedly, the feasibility of a competitive alternative is more readily apparent in transportation than in health services. We cannot just "deregulate health care;" we have to reform the basic incentives.) Public utility-type regulation motivates overinvestment. Regulators become "captured by the regulated." The Administration's proposal is riddled with "pass-throughs," exceptions, and exemptions. Inevitably, more will be added as the bill works its way through Congress. The case that mandatory state hospital rate regulation controls costs is far from proved. New York and Massachusetts had the highest per capita hospital costs of all the states when their regulatory systems were enacted. They still do.

At best, according to DHEW's claim, hospital cost containment would reduce hospital spending only 13 per cent by 1954, while locking the hospital industry into its present wasteful patterns. It also will have tied up the key congressional committees and diverted the valuable time of their members from the fundamental issues of delivery system reform. The attention of hospital administrators would be focused on beating the regulations, flying to Washington to plead for exceptions. Over-all efficiency would be reduced.

CERTIFICATE-OF-NEED

The other main regulatory structure is certificate-of-need (CON) regulation by the states, executed through local authorities called health systems agencies (HSAs), as required by the National Health Planning and Resources Development Act. HSAs must issue a permit before increases in hospital capacity can take place. Several broadly-based comparison studies have shown that CON has failed to ameliorate the problem of hospital overinvestment. This is not surprising. The leading experts cannot agree even on standards for the appropriate number of beds, not to mention for more esoteric technologies. Nobody knows how to do "health planning." People accept efficiency-improving changes (e.g. closing unneeded factories or hospitals) produced by impersonal market forces in the private sector. But, when such changes are imposed by government, those who would be harmed resist them, usually successfully, through legal and political action. To anyone who has tried to close unneeded defense installations or post offices, the idea that an HSA will close many unneeded hospitals appears ridiculous.

PRINCIPLES OF A SYSTEM OF FAIR COMPETITION

If government controls on prices and capacity will not solve the problem, what will? It makes sense to go back to the underlying causes and see what can be done to correct the perverse incentives inherent in today's dominant financing system. In a system of fair economic competition among various types of health plans, (including traditional insurance and fee-for-service as one option), consumers who joined health plans that did a good job of controlling costs would pay lower premiums or receive better benefits. Health plans that did a poor job of controlling costs would lose customers and risk being driven out of business. In the long run, the surviving health plans would be the ones that offer a good value to their members. The health care system would be transformed, gradually and voluntarily, from today's system with built-in cost increasing incentives, to a system with built-in incentives for consumer satisfaction and cost control.

"There are *alternative delivery systems* in successful operation which reward providers of health care services for finding ways to deliver better care at less cost."

The essential principles of such a system of competition are:

1. **Multiple Choice:** Once a year, each consumer (individual or family) would be offered the opportunity to enroll for the coming year in any of the qualified health plans operating in his area.

2. **Fixed-Dollar Subsidy:** The amount of financial help each consumer gets toward the purchase of his health plan membership—from medicare, medicaid, employer, or tax laws—would be the same whichever plan he chooses. The subsidy might be more for poor than nonpoor, for old than young, families than individuals, etc., *but no more for people who choose more costly health plans.* The family that chooses a

more costly health plan would pay the extra cost itself. Thus, it would have an incentive to choose wisely.

3. Same Rules for All Competitors: A uniform set of rules would apply to all health plans. Rules would govern premium-setting practices, minimum benefit packages, catastrophic expense protection, etc. The point of such rules would be to assure that all health plans are competing to provide good quality comprehensive care at a reasonable cost, and not profiting by such practices as preferred risk selection or deceptive, inadequate coverage.

4. Doctors in Competing Economic Units: Physicians would be organized in competing economic units, so that the premium each group charged would reflect its ability to control costs.

The main problems in our health care economy rise from the fact that, for the most part, these principles are not applied today.

• **Multiple Choice?** Most people, when they come to work, are presented with a *single* employer-provided health insurance plan. The aged are locked into medicare, the eligible poor get medicaid, both based on fee-for-service and cost reimbursement. (To be sure, the HMO Act requires employers to offer their employees the option of joining one group practice and one individual practice HMO if such federally qualified organizations exist in their area. But HMOs are too few, too small, and too tightly regulated by DHEW to be able to bring the benefits of competition to most Americans in the foreseeable future. And there are other potentially desirable alternative delivery systems that do not meet the HMO Act definition. We need a broader concept of alternative systems.)

• **Fixed Dollar Subsidy?** Today, medicare, medicaid, employers and tax laws systematically pay more on behalf of beneficiaries who choose more costly health care plans or providers. For example, in 1970, medicare paid $202 per capita on behalf of beneficiaries cared for by cost-effective Group Health Cooperative of Puget Sound, but paid $356, or 76 per cent more, on behalf of similar beneficiaries in the same area who chose to get their care from the fee-for-service sector. Among those employers who do give their employees a choice, many pay the whole premium either way, and thus eliminate the employee's financial incentive to choose the less costly plan. Last year, in northern California, General Motors paid $101 per month on behalf of workers who chose Blue Cross, $77 on behalf of those who chose Kaiser-Permanente. What medicare and these employers are doing is to assure the more costly providers who work in the system of fee-for-service and cost reimbursement that there is no need for them to control costs. And they are creating a major barrier to new HMOs because one of the main things some new HMOs have to offer is cost control.

• **Same Rules For All Competitors?** Equal rules are not applied now. HMOs must practice community-rating while insurers are free to experience-rate. HMOs must offer a comprehensive package of prepaid benefits while insurers are free to cover fewer benefits and use more deductibles. In effect, HMOs are required to provide necessary services without limit. Insurers can and do limit the amount they will pay on behalf of someone with catastrophic illness. Some HMOs have received public subsidies not available to insurers. We are far from applying equal rules to all.

• **Doctors in Competing Economic Units?** The market is dominated by "free choice of doctor" insurance plans. The medical profession has traditionally insisted on this principle. The effect is that the consumer's premium payment is the same whether he goes to the most extravagant or the most efficient doctor—again depriving him of a reward for seeking out doctors who use health resources economically. As well as "free choice of doctor," consumers should have the right to agree to get all their care from a limited set of providers in an alternative delivery system in exchange for better benefits or lower premiums.

COMPETITION IS WORKABLE AND EFFECTIVE

There are some groups and some market areas in which these principles have been applied, substantially if not completely.

> "The main thing wrong with hospital cost containment is that it does *nothing* to correct the existing perverse cost-increasing incentives."

The Federal Employees Health Benefits Program (FEHBP), in successful operation since 1960, offers employees a multiple choice of alternative plans and a fixed dollar contribution toward the plan of their choice. The State of California and Stanford University offer their employees a similar choice. (Each has minor exceptions to the equal dollar subsidy principle.) HMOs and similar alternative delivery systems have done very well in such fair competition. For example, about half the federal and state employees in Kaiser's northern California service area belong to Kaiser. More than half the Stanford families choose either Kaiser or the Palo Alto Clinic prepaid plan in preference to the Blue Cross "free-choice-of-doctor" plan.

A comparison of the FEHBP and medicare illustrates another important point. Medicare is based on fee-for-service and cost reimbursement. The medicare law is 102 pages long; the regulations fill 400 pages of fine print. The FEHBP law is eight pages long; the regulations are 16 pages long. A recent study showed that administrative cost per claim processed in the FEHBP was 22 per cent below that in medicare. Thus

we have some large-scale practical examples to show that competitive systems are simple and workable.

Where tried, competition has been an effective contributor to cost control. The best examples are Hawaii, where most people belong either to Hawaii Medical Service Association or Kaiser-Permanente, and Minneapolis where seven HMOs compete. While other factors contribute to cost control in Hawaii, and competition remains attentuated by various government programs, the two plans compete vigorously, and their premiums for comprehensive care are among the lowest in the country. Hawaii's hospital costs per capita are 88 per cent of the national average, despite the fact that consumer prices generally are 20 per cent higher in Hawaii than in the rest of the country.

Health plan competition in Minneapolis is much newer. The decision of major employers to adopt competitive principles is fairly recent. From 1972 through 1977, HMO membership grew at a 28 per cent annual compound growth rate. On average, these HMOs hospitalize their members about 500 days per 1,000 members per year compared to about 850 days for similar people in the community on fee-for-service. The results are showing up in better service and lower costs.

LOW-COST INCREMENTAL PROPOSALS

Competitive principles could form the basis for a comprehensive national health insurance plan. But at a time of rising concern over deficits and inflation, government leaders are understandably wary of new programs that cost money and raise taxes.

Alternatively, we could adopt the same principle in a few low-cost measures that would greatly enhance competition and the performance of our private health care financing system.

Employer contributions to health benefits are excluded from the taxable incomes of employees, and a part of individual premium payments is tax-deductible. This favorable treatment is costing the federal and state governments roughly $13 billion this year in foregone tax revenues. In these laws, the government has an ideal lever to make the market achieve public purposes more effectively. It can set requirements and minimum standards for employee health benefits programs as a condition for the favorable tax treatment.

• **Multiple Choice:** Each employer should be required to include, in any health benefits program he offers to employees, a choice of no fewer than three distinct health insurance or delivery plans that meet minimum standards (see below). Different corporate entities would be required, not merely different options with the same carrier. Competition is the goal. (Small employers could meet the requirement through multi-employer trusts.)

This requirement would give employers a powerful incentive to seek out and offer competing alternatives. (The HMO Act is much less effective because it gives employers no incentive to help HMOs get started, and it puts the burden on the HMOs to enforce dual choice. HMOs are understandably reluctant to antagonize potential customers.)

• **Fixed-Dollar Subsidy:** The employer's premium contribution should have to be the same amount, whichever plan the employee chooses. The employer might contribute more on behalf of employees in different categories (e.g. individuals vs. families, different locations, bargaining units, etc.), but not more on behalf of the employee who chooses a more costly health plan. Employers would not be required to contribute at any particular level.

There are many ways employers and unions who are not now in compliance with this principle could work out alternative arrangements that are in compliance, even without taking away already bargained benefits. One promising route would be through "cafeteria style" benefit plans, whose legality was established by the Revenue Act of 1978.

These two requirements would not be onerous for employers; many have already adopted them.

> "In a system of fair economic competition among various types of health plans, consumers who joined health plans that did a good job of controlling costs would pay lower premiums or receive better benefits."

The same principles should be embodied in a "freedom of choice" provision in medicare. Today, medicare beneficiaries are locked into a fee-for-service cost-reimbursement system. They are vulnerable to large uncovered expenses and the risks of catastrophic expense. Yet they are not allowed to realize for themselves most of the savings generated by joining an efficient alternative delivery system. The law should be changed to permit any beneficiary to direct that the "adjusted average per capita cost" to medicare for people in his actuarial category be paid, as a fixed premium contribution on his behalf, to the alternative delivery system of his choice provided it meets reasonable federal performance standards.

Eventually, the present medicare system, with its extremely complex and rigid regulatory apparatus, should be replaced by a payment system based on fixed prospective per capita premium subsidies (based on actuarial category), and fair economic competition in the private sector. In other words, as of a certain date, new beneficiaries ought to be covered by a new system modelled on the FEHBP. The savings in paperwork alone would be immense. Medicaid should be replaced

by a similar system, with premium subsidies related to income on a graduated scale.

• **Standards for Qualified Health Plans**

Basic Minimum Benefits: All health plans that qualify as non-taxable fringe benefits or for medicare premium contributions should have to cover a minimum uniform set of benefits such as the basic benefits defined in the HMO Act. This would standardize a lot of fine print, make health plans much easier for consumers to understand and compare and protect consumers from tricky and misleading exclusions of important services. It would help focus competition on quality and accessibility of services, and total cost. (This provision need not increase premiums or costs to employers; premiums could be reduced to offset its costs by raising the deductibles and coinsurance rate.)

Catastrophic Expense Protection: All qualified health plans should be required to limit consumer cost-sharing (coinsurance, copayments, deductibles) for basic benefits to a maximum annual amount such as $1,500 per family. That is, every family should have catastrophic expense protection. The infrequency of catastrophic illness expense makes this kind of insurance much less costly than "first dollar coverage." But, as much as possible, this should be done in the *private sector* where people can *voluntarily* choose among alternative systems of cost control. (Catastrophic expense protection on a public entitlement basis would only add to the cost increasing incentives.)

Continuity of Coverage: Qualified health plans should be required to continue coverage for at least 60 days to those who have been members of an insured group. This would apply to people such as the unemployed after termination of employment, dependents after death of an employed family member and divorcees after divorce. There should be automatic coverage of newborn children. The unemployed, survivors, divorced spouses and dependent children and dependent children upon attainment of majority, should be able to convert to individual coverage without proof of insurability. Their premiums should be at group rates plus a reasonable allowance for handling costs. Health plans should not be allowed to cancel coverage because of illness or any reason other than failure to pay premiums.

When people lose their health insurance, there can be serious individual hardships, and for this the private health insurance industry can be justly criticized. This proposal would add little to the cost of insurance, but would greatly enhance people's continuity of coverage, and substantially reduce the number of people without protection.

• **Doctors in Competing Economic Units:** Would competition occur under these rules? There is good reason for confidence. First, there are already active alternative delivery systems in many communities despite the existing disincentives. The HMO idea has achieved enhanced legitimacy in recent years. Kaiser-Permanente is finding great acceptance among employers in its new entry into Dallas, in sharp contrast to its new market entries of a decade ago. Prestigious multispecialty group practices, such as Henry Ford Hospital in Detroit and St. Louis Park Medical Center in Minneapolis, have entered the HMO field. The success of Harvard Community Health Plan in Boston is putting pressure on other groups to form competing HMOs. The Leahy Clinic has stated its intention to do so. The idea is no longer just "California dreaming."

"We have some large-scale practical examples to show that competitive systems are simple and workable. Where tried, competition has been an effective contributor to cost control."

Second, alternative delivery systems have been sponsored by many types of institutions. Potential sponsors are in abundant supply in most communities. The list includes physician groups, industrial companies, insurance companies, Blue Cross and Blue Shield, unions, universities and consumer cooperatives. The proposed requirement of multiple choice would give employers a powerful incentive to help competitors enter their markets.

Third, a market situation in which every consumer is insured by a "free-choice-of-doctor" third-party insurance plan would be unstable under the proposed rules. The potential gains to providers and consumers from joining an alternative delivery system would be too great. The situation would attract innovators.

Finally, health services are gradually being brought under the rules of competition applied to the rest of American business. The Federal Trade Commission has substantially upgraded its expertise and has been achieving significant gains in applying anti-monopoly principles to this field. For example, the FTC staff has recommended that physician organizations be required to divest themselves of control of Blue Shield plans. The Ohio State Medical Society has just been forced to give up ownership of Ohio Blue Shield. Medical society control of individual practice associations, with its obvious monopolistic potential, is coming under similar challenge. An effective anti-monopoly strategy is already evolving to complement these "low-cost, incremental proposals."

The competition of alternative delivery systems with built-in incentives to deliver better care at less cost is rapidly gaining momentum. The most productive thing the federal government could do now would be to eliminate the main barriers to this desirable development. ■

SPECIAL ARTICLE

CONSUMER-CHOICE HEALTH PLAN (First of Two Parts)

Inflation and Inequity in Health Care Today: Alternatives for Cost Control and an Analysis of Proposals for National Health Insurance

ALAIN C. ENTHOVEN, PH.D.

Abstract The financing system for medical costs in this country suffers from severe inflation and inequity. The tax-supported system of fee for service for doctors, third-party intermediaries and cost reimbursement for hospitals produces inflation by rewarding cost-increasing behavior and failing to provide incentives for economy. The system is inequitable because the government pays more on behalf of those who choose more costly systems of care, because tax benefits subsidize the health insurance of the well-to-do, while not helping many low-income people, and because employment health insurance does not guarantee continuity of coverage and is regressive in its financing. Analysis of previous proposals for national health insurance shows none to be capable of solving most of these problems. Direct economic regulation by government will not improve the situation. Cost controls through incentives and regulated competition in the private sector are most likely to be effective. (N Engl J Med 298:650-658, 1978)

HEADLINES will soon appear proclaiming the latest round of health-care cost increases. The nation's health-care spending exceeded $160 billion in 1977 — four times the 1965 amount. Congress will consider cost-control measures with increasing urgency. The Carter Administration is working to develop a national-health-insurance (NHI) proposal that will satisfy key constituencies and still have a chance of passage. The problems are closely interrelated.

INFLATION AND INEQUITY TODAY

Main Problems

Real per capita spending on health care (i.e., net of general inflation) increased 79 per cent from 1965 to 1976; it increased 74 per cent on physicians' services and 110 per cent on hospital care. As a proportion of the Gross National Product, health care went from 5.9 to 8.6 per cent.[1] Costs of medical care are straining public finances at every level of government, and are forcing cutbacks in services to the needy. Public-sector spending rose from $9.5 billion, or 25 per cent of the total, in 1965 to $59 billion, or 42 per cent of the total, in 1976. Most of this outlay is in open-ended, third-party reimbursement programs in which government spending is not controllable. For example, Medicare outlays are increasing from about $17.8 billion in (fiscal) 1976 to about $26 billion in 1978 (i.e., by nearly 50 per cent in two years).[2] In 1975, the increase in medical costs forced Massachusetts to stop paying for the health care of the general-relief population, throwing the burden on local government. From 1968-69 to 1975-76, Medi-Cal costs in Los Angeles County increased from 24 to 42 per cent of property-tax revenue.

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Meanwhile, President Carter has recommended a tax cut of some $25 billion. Such a cut is urgently needed to lower the tax burden on the productive sectors of the economy, to spur saving and capital investment, to create jobs and to enhance productivity. And the pattern of local taxpayer resistance to tax increases is clear. Moreover, society has other pressing needs: helping the poor, rebuilding cities, energy conservation and environmental protection, to mention a few. So there is no ready source of funds to pay for these increases in health-care costs. It may take time, but the government will do what it must to bring health-care spending under control.

There are good reasons for much of the increase in health spending: growth in public and private insurance coverage brought access to many who previously did not have it, especially the aged and the poor; advances in technology increased the power of medicine to prolong life and enhance its quality; the population aged; the health-care system took on new assignments (e.g., in mental health, alcohol and drug abuse); the pay of health-care workers was brought up to the level of other industries; and rising incomes and expectations increased consumer demand for health-care services. Present concern with the growth in spending should not mislead one into thinking it is all bad.

However, the increase has far exceeded what could be justified on these grounds, especially in recent years. Hospital charges and physician fees rose faster than consumer prices in general. Health workers' pay overshot equality with other industries.[3] There is great inefficiency (e.g., duplication of costly underutilized facilities). For example, in California alone in 1975, cardiac operations were performed in 91 hospitals. Millions of dollars could have been saved, and the quality of care improved, if these 15,000 procedures had all been done at 30 or fewer centers. Wide variations in the per capita consumption of various costly health services (e.g., hospitalization and operations) among similar populations, without any

apparent difference in medical need or health outcome, suggest that there is much spending that yields little or no discernible benefit in terms of health.[6,7] People might be just as healthy with half as much hospitalization.

While the nation is spending more, some people are enjoying the benefits less. Gaps in coverage leave some unprotected from heavy financial burdens, and others protected by Medicaid only after medical costs have made them poor. Public funds (including tax subsidies) do more for the well protected well-to-do than for the working poor who need help more. Also, there is uneven geographic distribution, leaving many rural and inner-city residents poorly served, and there are too many doctors in some well-to-do areas.

Causes of Inflation and Inequity

The main cause of the unjustified and unnecessary increase in costs is the complex of perverse incentives inherent in the tax-supported system of fee for service for doctors, cost reimbursement for hospitals, and third-party intermediaries to protect consumers. Fee for service rewards the doctor for providing more and more costly services, whether or not more is necessary or beneficial to the patient. Cost reimbursement rewards the hospital with more revenue for generating more costs. Indeed, a hospital administrator who seriously pursued cost cutting (e.g., by instituting tighter controls on surgical procedures and laboratory use and avoiding buying costly diagnostic equipment by referring patients to other hospitals) would be punished by a loss in revenue (Medicare and Medicaid would cut him dollar for dollar) and a loss in physician staff and, therefore, patients. Third-party reimbursement leaves the consumer with, at most, a weak financial incentive to question the need for or value of services or to seek out a less costly provider or style of care.

The economic factors are important, but the important factors are not all economic. The financial incentives are reinforced by the demands and expectations of anxious patients, the prestige associated with costly technologic care, the malpractice-induced need for "defensive medicine" and the government-inspired proliferation of health manpower — especially physicians. Thus, the financing system rewards cost-increasing behavior and provides no incentive for economy. It is also inequitable. Medicare and Medicaid are among the worst offenders.

Medicare pays more on behalf of people who choose more costly systems of care. For example, in 1970, Medicare paid $202 per capita on behalf of beneficiaries cared for by Group Health Cooperative of Puget Sound, a prepaid group practice, but paid $356, or 76 per cent more, on behalf of similar beneficiaries in the same area who got their care from the fee-for-service sector.[8] Medicare pays more to doctors who charge more and more to hospitals that cost more. At the same time, Medicare pays more on behalf of rich than poor (because they live in better served areas and can more easily afford the coinsurance), white than black and well served than underserved.[9]

Medicaid, which also relies almost entirely on third-party payment, fee for service and cost reimbursement, is particularly vulnerable to fraud and abuse. Its beneficiaries are particularly unlikely to be able to judge the need for or value of services provided to them, and are less motivated to weigh the value against the cost because they are not spending their own money.

Private insurance receives important subsidies through the tax system. Employer contributions to employee health-insurance premiums, no matter how large, are not counted as taxable income to the employee. This exemption means that if an employee takes $100 of additional compensation in the form of health insurance, he gets about $100 worth of benefits, whereas if he takes it in cash, he gets (net after tax) $70 or less. Also, within limits, employee premium payments and out-of-pocket medical expenses are tax deductible. In fiscal 1978, these "tax expenditures" will amount to roughly $10 billion. However meritorious in origin and intent, these features of the tax laws have unfortunate effects in terms of both incentives and equity. They subsidize employee decisions to select more costly health-care systems and encourage employee pressure for rich employer-paid benefits. Also, this tax system provides more subsidy for better paid and covered than for poorly paid and covered people.

The incentives in these systems of payment also help to defeat local efforts to control costs by limiting hospital capacity. Most of the costs of operating unneeded hospital capacity are paid by Medicare, Medicaid and insurance policies whose premiums are rated on the experience of an area larger than a typical county or health-service area. Why should a health-systems agency or a board of county supervisors defy local pressures and force the closing of an unneeded hospital, with loss of jobs, when most of the extra costs of keeping it open are paid for with funds from outside their area?

The Physicians' Role

Physicians receive only about 20 per cent of the health-care dollar, but they control or influence most of the rest. Even though it may not appear so on an organization chart, physicians are the primary decision makers in the health-care system. But the present structure of the system assigns very little responsibility to them for the economic consequences of their health-care decisions. They are not trained in medical economics. Most doctors have no idea what hospital costs, pharmacy costs and other ancillary patient-care costs actually are. The system gives them little or no incentive to find out, or to act on the information if they have it. Their professional values combine with the financial incentives and other factors, such as the

malpractice threat, to minimize concern over cost and to foster cost-increasing behavior. If the decision makers in a system are not concerned with cost effectiveness, the system will not be cost effective.

Lack of Competition and Choice

There are competitive elements in the health-care system. For example, insurance companies compete with each other, and with self-insurance, for group contracts, by offering lower administrative costs. But there is very little competition among providers of care to produce services more efficiently or to offer a less costly style of care, and to pass the savings on to consumers. Most workers are offered a single health-insurance plan by their employer or health and welfare fund, usually a third-party reimbursement plan with no limit on choice of physician. (The Health Maintenance Organization [HMO] Act was intended to open up employee groups to HMO's by mandating dual choice, but the qualification process has been bogged down in the Department of Health, Education, and Welfare, and many employers are holding back on offering HMO's until the HMO's are qualified [10,11])

The Medicare law has a complex provision for paying HMO's, but it is based on retrospective cost finding, includes an implicit tax on HMO's, and has not been put into operation. So Medicare beneficiaries are stuck with a third-party, cost reimbursement system; they cannot choose a more efficient system and realize the savings for themselves.

Although the fee-for-service, third-party-reimbursement system offers the patient a free choice among doctors and hospitals in his community, it does not offer him the alternative of keeping much of the savings that he would generate by choosing effective but less costly care. The premiums and charges that he must pay reflect the cost-generating behavior of the doctors and hospitals caring for his insured group. His choice of doctors and hospitals is generally limited to those who work within the framework of the cost-increasing incentives. If he would prefer, for example, a system that used half as much hospitalization per capita, in exchange for more home care or better access to ambulatory care, at an equal per capita cost, the third-party fee-for-service system would not be able to offer it to him.

For many years, some physicians have been effective in blocking the development of competing alternative systems of care in which consumers could choose a less costly system or style of care and realize the benefit in the form of a reduced premium. They have done so through such devices as boycotts of insurers seeking to develop closed-panel plans, in the name of defending "the patient's right of free choice of physician," and professional ostracism and denial of hospital privileges to physicians participating in closed-panel plans [12] Insistence that every insurance plan give the patient a completely free choice of physician is, in effect, denial of the patient's right to elect to obtain his care from a limited group of physicians who offer less costly care for a lower premium. And these monopolistic practices are not relics of a distant past. As recently as 1977, medical staffs in Massachusetts and California have voted to deny hospital privileges to physicians belonging to highly reputable prepaid group-practice plans. In November, 1977, the Michigan State Medical Society House of Delegates voted to boycott Blue Shield because Blue Shield, acting under pressure from employers and unions, sought to discriminate in favor of participating physicians and to institute reimbursement incentives for utilization control.[13]

Other Failures in the Health-Care Market

In addition to these barriers to competition, consumers today generally have poor information about health-care alternatives. Most do not know what their health premium costs are because the costs are paid by the employer or the government. So they have, at most, a weak incentive to learn about and consider the costs of the care that they receive. In most communities, there is no organized information for consumers on the availability and merits of alternative providers. Moreover, consumers must rely for advice about the benefits of proposed treatments on physicians who often have a financial interest in more costly care. The situation is made worse by the great uncertainty about the benefits in many cases. The system is not built to facilitate thoughtful choices. There are many restrictive laws and practices.

Geographic and specialty maldistribution of physicians is exacerbated by third-party, fee-for-service financing, which creates on open-ended demand for subspecialty care in well-to-do areas, and little incentive to offer primary care in inner-city or rural areas.

Discontinuity of Coverage

Most private health insurance is provided as an employment-related fringe benefit — a system that works reasonably well for a large portion of the economically self-sufficient population with job stability (except that, as noted above, the limit on employer health-plan offerings is a key barrier to competition and consumer choice). However, the employment-health-insurance linkage is not compatible with an effective universal system of insurance coverage because people lose their coverage when they lose their jobs, because job changes commonly require health-coverage changes, with breaks in continuity of coverage and care and nonproductive administrative costs, and because it is very difficult to arrange good coverage for persons in marginal industries or with seasonal, intermittent or otherwise unstable employment. Furthermore, employer-employee financing is regressive. Without mandated employer-provided coverage the low paid, who often need the most protection, get the least; with mandated coverage, in

addition to great administrative problems for workers with unstable employment, the economic burden would fall heaviest on the lowest paid and provide a strong disincentive for employing marginal workers.

In a society that agrees that everyone should have financial access to a decent level of health care, it makes no sense to have a system in which many people lose their coverage when they lose their jobs and many others lose their Medicaid eligibility when they get even a poorly paid job. Cycling in and out of Medicaid eligibility produces hardship and work disincentives for the poor, and heavy nonproductive administrative burdens for states, counties and providers. As incomes fluctuate, contributions, not eligibility, should vary with ability to pay. Everyone's health-care coverage should be continuous.

In sum, the status quo in health-care financing is untenable. If nothing else does, the growth in cost will force a change. The issue is not whether or not to enact national health insurance (NHI). This country already has a sort of NHI system, with separate programs for such groups as the aged, poor, employed middle-class, veterans, military and dependents. The issue today is "what kind of NHI?" I do not accept the view that Americans cannot afford comprehensive NHI now and must wait for it until costs are brought under control. On the contrary, they are already paying for NHI, but are not getting the benefit because of an inefficient, inequitable system that results from historical accident and interest-group pressure. Prompt action is needed to assure universal coverage. But an equally urgent reason for an effective NHI today is the need to find good ways to reorganize the system and build in incentives for equity and cost effectiveness.

Broad Alternatives for Cost Control

The government will do what it must to bring health-care spending under control. The costs are too large for it not to. There are two broad alternative approaches to this end: one is direct economic regulation, the other is cost control through incentives and competition.

Direct Economic Regulation Will Not Make Things Better

In recent years, the main line of government policy has been to attack the problems created by inappropriate incentives with various forms of regulation (e.g., planning controls on hospital capacity, controls on hospital prices and spending, controls on hospital utilization and controls on physician fees). The weight of evidence, based on experience in many other industries, as well as in health care, supports the view that such regulation is likely to raise costs and retard beneficial innovation.[14]

A great deal of regulation of health services is inevitable. And in some fields, regulation is used to maintain competition (e.g., the Securities and Exchange Commission and the antitrust laws). The issue, then, is not regulation in general, but the specific types of regulation and their likely consequences. The point here is that direct controls on costs, in opposition to the basic financial incentives, are not likely to make things better.

To determine a regulated price for a service, a regulator must start with the producer's costs, allowing a reasonable profit margin. So in the long run, price regulation amounts to cost reimbursement, and it gives the producer the same incentives. Because of the incentives that regulators face (e.g., to avoid being over-ridden by appeals to the courts and to avoid a failure in service for which they are blamed), regulation tends to protect regulated firms whenever competition or technologic change threatens established positions within the industry. Regulators often see the purpose of the price structure as providing a mechanism for subsidizing some groups at the expense of others, rather than as a mechanism for offering incentives to buyers and sellers to make economical choices.[14] For example, airline fares subsidize travelers on uneconomic routes at the expense of travelers on dense routes. The main reason some hospitals favor regulation is that it would function as a cartel to protect them from buyers who want to cut costs; they know that the approved rates will be based on their costs.

Medical care has many characteristics that make it a particularly unsuitable candidate for successful economic regulation.[15] Basic to the problem is the subtle, elusive and indeed almost indefinable nature of the product. In the health-care sector to date, the most extensively tested form of economic regulation has been regulation of hospital capacity. And it is clear that certificate-of-need regulation has not helped control the problem of overbedding.[16-18] A fixed legislated limit on total capital spending by hospitals might offer a temporary illusion of effectiveness, but it is vulnerable to a number of countermeasures such as "unbundling" (i.e., breaking proposed investment projects down into small pieces, the value of each of which is below the threshold at which planning approval is required, or placing equipment in physicians' offices or other facilities beyond the reach of the regulators).

Physician fee controls have been advocated and were tried in the Nixon Administration. In judging their likely value as a cost-control device, would-be regulators should be aware that the "doctor visit" is high compressible, and the need for physician services is impossible to test objectively except in extreme cases. So the physician who considers his income to be threatened by fee controls can increase the frequency of recommended follow-up visits, increase the number of services rendered in each visit and bill separately for individual services, thereby making up the loss in increased volume. By triggering higher utilization, such controls might become counterproductive.

Overall controls on hospital spending face similar prospects: circumvention, "unbundling" and exceptions. The Carter Administration emasculated its proposed Hospital Cost Containment Act of 1977 by exempting wage increases from the hospital revenue limit, despite the fact that many hospital workers now earn more than their counterparts doing similar jobs in other sectors.[3] But even if such a law were ultimately successful at controlling total hospital spending at the stated growth rate, there would be no force in the system to assure efficiency or equity in the allocation or production of services. At best, the hospital industry would have been frozen in its present wasteful and inequitable pattern.

The danger in ineffective controls from the physicians' point of view is that they will inevitably bring on demands for more stringent controls that are likely to be increasingly burdensome and unpalatable. The next steps in controlling the costs of physician services are likely to include tighter utilization reviews, justified and accompanied by increasingly strident attacks on "unnecessary surgery" and other abuses. Another step might be, in effect, negotiated budgets for the total of all physician services in each state that are paid for by government or by tax-exempt or tax-deductible insurance policies. One effect of this approach would be to get physicians fighting among themselves over fees. The next step on hospital cost controls might be for the government to extend capital investment and spending limits to all health facilities and to create the detailed regulatory apparatus needed to process requests for exceptions, justified and accompanied by attacks on "obese hospitals." Although exceptions would have to be granted, the regulators could slow the rate of increase in spending by bogging down investment projects in procedural requirements. The failure of Congress to act on the Administration's cost-control proposal is not a rejection of the need for controls; it reflects uncertainty and disagreement over means.

Limitations of Previous Proposals for NHI

In addition to Consumer-Choice Health Plan (CCHP), a new proposal to be explained in the second part of this article, the Carter Administration has been examining four NHI alternatives, all of which have been introduced in previous Congresses. They are the Health Security Act ("Kennedy-Corman"), Universal Federal Third-Party Reimbursement Insurance ("Kennedy-Mills"), the Comprehensive Health Insurance Plan or "CHIP" (Nixon Administration) and the Catastrophic Health Insurance and Medical Assistance Reform Act ("Long-Ribicoff").

Because the first two would essentially give the federal government a monopoly of health-care financing, and because many people assume that NHI must inevitably mean such a monopoly, it is useful to begin evaluation of these alternatives by asking whether health-care financing is more appropriately organized as a government monopoly or through private markets. Much of the case for NHI rests on "private-market failure." And there is no doubt that the private market for health insurance, *as presently constituted and shaped by numerous government policies*, does a poor job of allocating resources, and fails to meet important social objectives. Consideration of private-market failure needs to be balanced by an appreciation of some of the characteristic limitations of government. The following generalizations, although obviously not true in every case, summarize important insights that must be considered in the decision whether NHI should be based mainly on private markets or on a government monopoly. To save time, they are stated here baldly and without applicable qualifications. The point of what follows is not to imply that government is "bad" as compared to private enterprise, or that government people are better or worse than private-enterprise people. Rather, the point is that government has certain limitations that are deeply rooted, if not inherent. Government is good at some things, such as taking money from taxpayers and paying it to social-security beneficiaries, and maintaining competition in many industries; it performs badly at other things. The problem of public-policy design is to define the appropriate role for government to achieve desirable social purposes most effectively.

1. Government responds to well focused producer interests; competitive markets respond to broad consumer interests. People specialize in production, and diversify in consumption. They are therefore much more likely to pressure their representatives on their producer interests than on consumer interests.

2. In Charles Schultze's words,

> we tend to subject political decisions to the rule, "Do no direct harm." We can let harms occur as the second- and third-order consequences of political action or through sheer inaction, but we cannot be seen to cause harm to anyone as the direct consequence of collective actions. The rule of "Do no direct harm" is a powerful force in shaping the nature of social intervention. We put few obstacles in the way of a market-generated shift of industry to the South, but we find it extraordinarily difficult to close a military base or a post office.[4]

Thus, a government-run or regulated system must be very rigid, and government managers are often not allowed to make changes to improve efficiency.

3. When every dollar in the system is a federal dollar, what every dollar is spent on becomes a federal case. The recent Congressional deadlock over Medicaid funding for abortion illustrates the point. Putting permissible medical procedures to majority vote would, to use Schultze's phrase, "stretch thin the delicate fabric of political consensus by unnecessarily widening the scope of activities it must cover."[5]

4. Equality of treatment by government tends to mean uniformity. The uniform product is often a bargained compromise that pleases no one.

5. Government generally does a poor job providing services to individuals.

6 The government performs poorly as a cost-effective purchaser. Think of the Rayburn Building, the Humphrey Building (Department of Health, Education, and Welfare headquarters), Medicaid and the C-5A If a government agency gets tough with suppliers, the suppliers can bring pressure to bear to get the rules changed. Government purchasers are surrounded by many complex procedural rules They have to "go by the book." They are not allowed to exercise much judgment And their incentives to achieve economy are weakened by the fact that they are not using their own money. (An important exception to this situation has been the Federal Employees' Health Benefits Program, in which the Civil Service Commission has acted as a "private" buyer on behalf of federal employees; the statute authorizing the Program establishes a competitive system, exempts the Civil Service Commission from required competitive bidding and allows it to use judgment — which it has done to good effect.) Private purchasers are using their own (or their company's) money. They generally have the authority to use their own best judgment, and they must bear the consequences of poor judgments. The government seems addicted to cost reimbursement despite its notorious record for generating cost overruns. Cost reimbursement protects providers at the expense of taxpayers and consumers.

7. The political system is extremely averse to risk. Private businessmen speak without apology of the gambles they made that did not pay off. To survive in a changing industry, one has to innovate, which means taking chances Business is tolerant of individual mistakes as long as the batting average is good By contrast, the political system gives inordinate attention to individual mistakes. Congressional investigators and the press get large rewards from discovering and exposing error in government. So government has become a sophisticated mechanism for dispersing and avoiding personal responsibility and avoiding risk. Moreover, visible errors of commission are punished far more severely than invisible errors of omission. This fact makes it extremely difficult to innovate in a government environment.

The financing of individual health-care services does not need to be a monopoly. There is no technical or economic factor that makes it a "natural monopoly" like a public utility. Nor is personal health care a "public good" like defense or police protection The benefits of individual health-care services are enjoyed primarily by the individual and his family, and he should be allowed a large measure of choice concerning it The important public purposes of universal access to good-quality care can be pursued most effectively in a decentralized private system guided by an appropriate structure of incentives and regulation to support competition

The Health Security Act,[10] proposed by Senator Kennedy and backed by organized labor, is designed to get away from third-party reimbursement and to shift health-care financing to a per capita and prospective budgeting basis within a publicly determined total. The Act would assign the entire financing and management of NHI to the federal government. It would create a Health Security Board in the Department of Health, Education, and Welfare to administer the program. It would levy payroll taxes and match this amount with an equal sum from general revenue. The Board would establish an annual national budget, not to exceed total receipts, and allocate it to each Health, Education, and Welfare region on a per capita basis in categories for institutional services, physicians' services, dental services, drugs or appliances Within these totals, the Board would then contract for covered services with participating providers (i e., providers who agreed to make no charge to the patient for covered services).

In brief, health security would create a system that is centrally and politically controlled, in which every participating provider received all his money from the federal government. Spending for personal health-care services would be set in the political process on the basis of national priorities rather than in the marketplace on the basis of individual priorities.

Health security has important strengths. It recognizes that the third-party-reimbursement principle provides inappropriate economic incentives in medical care. It seeks to restructure health services into organized systems. Capitation financing, which it emphasizes, gives incentives for economic efficiency in use of total resources. Health security seeks equity in the use of public funds. And it seeks to equalize per capita spending among regions and between HMO's and the fee-for-service sector.

Many of health security's weaknesses were summarized in my earlier discussion of government monopolies and private markets. But the main criticism of health security is that it cannot achieve its goals The government cannot restructure the system by direct controls. Experience with other regulated industries, and with NHI in other countries, suggests that the government would freeze the system in its existing patterns. The "do-no-direct-harm" rule has prevented the government for years from closing unneeded Public Health Service hospitals and military bases Its attempts to close hospitals in obviously overbedded areas drown in a deluge of lawsuits and pressure from employee groups. Imagine the vested interests and the rigidity surrounding the history-based allocations among hospitals, doctors, dentists and others. It would become much more important to provider groups to defend their allocation than to serve patients. The Health Security Act seems designed to freeze existing allocations and to protect existing jobs.

The Health Security Act proposes to bring total spending under control by "top-down budgeting." Top-down budgeting may indeed bring total spending under control, but of itself, without competition, the mechanism has no built-in means for assuring that

much useful output is produced. This deficiency is especially true of a medical-care program whose output cannot be measured in any simple and adequate way. Look at the experience in our largest public health-care systems. At least by civilian standards, the Defense Department operates and fills far too many beds.[21] A recent study of the Veterans Administration (VA) system concluded,

> there are too many acute beds being operated in the system about half the patients in acute medical beds, one-third of the patients in surgical beds, and well over half the patients in psychiatric beds do not require — and are not receiving — the acute care services associated with these types of beds These data provide additional evidence that many more VA hospital beds are being operated than are required to meet the needs of veterans The VA has installed many expensive specialized medical facilities that, in many hospitals, are used at rates far below their capacity.[22]

The point is that in the bureaucratic budgeting system, one strengthens one's case for more by doing a poor job with the budget that one has. If the budgeting system at the insitutional level is based on workload rather than capitation, it gives physicians and administrators incentives for utilization that are similar to fee for service.

The government is simply incapable of managing the Health Security Program. It does not have the organization, and it cannot acquire the mangement capability on a sustained basis To illustrate one of the problems, the Act provides that members of the Health Security Board will be paid at Executive Level IV. This proposal means that the top management of the Program would be paid about 25 per cent less than the average doctor. The Board might attract outstanding management talent to begin with, on the basis of dedication to public service. But when it becomes clear what doing an effective job means — e.g., closing excess acute hospitals in some areas to pay for needed facilities in others — and Board members start feeling the wrath of citizens expressed through their Congressmen, and seeing the implementation of their plans tied up in court, the two-year turnover typical of assistant secretaries in the departments of Defense and Health, Education, and Welfare is sure to emerge. Running a large organization effectively requires long-term commitment by its managers; it cannot be done well on revolving tours of two to four years.

Finally, health security would add over $100 billion to federal outlays in fiscal 1978 costs, which effectively rules it out on fiscal grounds. And there is no way to phase it in; it is an all-or-none proposal.

Universal Federal Third-Party Reimbursement is the most familiar approach to NHI. A bill to create such a system was proposed as a grand compromise by Senator Kennedy and Congressman Mills in 1974.[23] This is the approach that the Canadians took, though theirs is a joint federal-provincial program.

Conceptually, and initially, this is the simplest NHI idea from the point of view of consumers and providers of care: everybody goes right on doing what he was doing, and the government pays the bills. But anybody who has tried seriously to understand and implement the Medicare regulations knows that ultimately this must be the most complex approach. For this system would be "modified Medicare for everybody." The government would have to process over a billion claims a year. If costs were to be controlled, each would have to be reviewed for appropriateness. Arbitrary numerical criteria would have to be used. Rules for retrospective cost finding would become increasingly complex as institutions sought to interpret them to their advantage while the government sought to control the costs.

This approach would set in concrete the third-party reimbursement principle, which experience and economic reasoning indicate is not a rational way to finance medical care. By making scarce resources free, or nearly so, to the user, third-party-reimbursement insurance gives people economic incentives to use them excessively. Third-party-reimbursement insurance relieves the consumer of the additional cost of the services he receives, and therefore the incentive to conserve resources, without putting the incentive on the provider. A rational economic system of health-care financing would tie the physicians to the economic consequences of their decisions and hold them responsible for using total health-care resources wisely It would also allow consumers to realize the full benefits from choosing less costly systems of care.

The worst effect of universal third-party insurance would be to destroy the incentive of consumers and physicians to reorganize the delivery system in more cost-effective ways.[24] It would deny consumers the opportunity to reap the benefit from choosing less costly systems or styles of care. Consumers would be relieved of most of the costs implicit in their choices, and larger reimbursements would be made on their behalf if they chose more costly providers. Similarly, with government-financed, open-ended demand for services where and when they wanted to deliver them, physicians would see little gain from accepting the discipline of an organized system.

"Kennedy-Mills" would not produce a stable equilibrium in health-care financing. The cost growth induced by the third-party-reimbursement incentives would have to be restrained by ever tighter controls. Eventually, the government would be forced to impose a "top-down" limit on health-care spending, with regional caps, negotiated prospective budgets for institutions and negotiated totals on spending for physician services by state or NHI region. Within a decade or less, "Kennedy-Mills" would become indistinguishable from health security. "Kennedy-Mills" would add more than $60 billion to federal outlays in fiscal 1978 costs.

The Comprehensive Health Insurance Plan, or "CHIP,"[25] proposed by the Nixon Administration in 1974, would have established a three-part national program in-

cluding mandated employer-employee health-benefits programs meeting certain standards, a state-operated "assisted health-care program" providing coverage for low-income families and for families and employment groups who are high medical risks, and a federal program for the aged — in effect, expanded Medicare.

The employee plan would require employers to offer full-time employees a health plan including hospital, medical and preventive services and protection against catastrophic illness. Coverage would be implemented through private health insurance, and financed through employer and employee premium contributions. The assisted plan was designed to make health insurance available to all persons not otherwise insured. There would be income-related deductibles, coinsurance and a limit on each family's liability. Premiums would be income related, and tied to the state average for the employee plan.

CHIP is very appealing to federal officials because its costs are largely kept off the federal budget. (Its costs to the federal budget would be roughly $8 billion in fiscal 1978.) And it has the important advantage of keeping much of the management and underwriting in the private sector.

But CHIP has important weaknesses. It reinforces the link between job and health-plan coverage, with all the failings of that system mentioned earlier. Moreover, mandated employer coverage works as a strong disincentive to hiring people with low job skills and productivity. Combined with the recently signed minimum wage, and increases in Social Security payroll taxes, it would mean that by 1981, a person could not get a full-time job unless his services were worth well over $8,000 per year.

CHIP's fatal flaw is that it shares with "Kennedy-Mills" the error of seeing NHI solely as a matter of providing third-party-reimbursement insurance coverage for everybody, not a matter of incentives for cost control or reform of the delivery system. Thus, CHIP would leave to direct economic regulation the overriding problem of cost control. CHIP would not break down a main barrier to competition (i.e., that most employees are offered a single health-benefits plan, usually based on third-party reimbursement). Thus, it would not realize one of the main advantages offered by the private sector. Employers would have to offer membership in one prepaid group practice and one individual practice association, if available, as required by the HMO Act. But that leaves out much potential competition from health-care alliances, variable-cost insurance and other innovative ways that providers and consumers might organize to use resources wisely. The market should not be limited to HMO's meeting the present rigid detailed legal definition. There is no way of knowing whether these are the "best" or the only good means of organizing care. And the legal requirements add greatly to the time, cost and difficulty in starting such an organization. Moreover, CHIP would not correct the inappropriate cost-increasing incentives in Medicare, Medicaid and the tax laws. By continuing to subsidize more costly systems of care, the government would have failed to create the essential fair-market test among competing alternatives.

Ultimately, the need for cost controls would force the government to impose "top-down" limits on spending. And within a decade or less, the system that started with CHIP would also begin to resemble health security.

The fourth alternative is known as "Long-Ribicoff"[16] in honor of its two senatorial sponsors. The federal government would take over the acute-care part of Medicaid, providing essentially full insurance coverage for low-income families — for example, up to an income of $4,800 for a family of four. (Above that income, a family could become eligible if its medical expenses were large enough to cause it to "spend down" to an income net of medical expenses of $4,800.) For nonpoor families, "Long-Ribicoff" would provide insurance against catastrophic medical expense. It would add about $12 billion to the federal budget.

"Long-Ribicoff" has the important strength that it targets the available funds on the areas of greatest urgency — i.e., full coverage for the poor and insurance against catastrophic expense for the nonpoor.

But as it stands, it too has important weaknesses. For one thing, it has a big work disincentive for a low-income family at the cutoff income. There would not be much point for such a family working to earn more than $4,800 if it expected substantial medical bills. This part of the bill could and should be revised to reflect the lessons and decisions that went into the Carter Administration's welfare-reform proposal (that is, the loss of benefits as earned income rises should be gradual, so as to preserve work incentives).

Secondly, it locks in the third-party-reimbursement principle. Not only does this step perpetuate the cost-increasing incentives, but also it denies to institutions that would serve the poor a predictable source of capitation financing. Like everyone else, the poor should have choices among competing alternative health plans, and should be able to buy into good plans that serve the middle class. And the poor should be allowed to benefit from economizing choices. Thus, a voucher system for Medicaid is clearly preferable to an inflexible commitment to third-party reimbursement.

Thirdly, assuring that everyone has full protection against catastrophic medical expense is a good idea. But again, "Long-Ribicoff" locks in the third-party-reimbursement system that rewards providers for cost-increasing behavior and provides no restraint on cost once the catastrophic expense threshold is reached. Instead, people should be allowed to have the actuarial value of their catastrophic expense protection paid to the qualified health plan of their choice in the form of a fixed prospective per capita payment — provided the qualified health plan

provides catastrophic expense protection.

Finally, "Long-Ribicoff" does not correct the cost-increasing incentives in Medicare and the tax laws. And it does not assure every American a choice among competing plans.

If the costs are to be brought under control in a system that seeks consumer and provider satisfaction, and respects individual preferences, millions of Americans must be made interested in and well informed about the cost and quality of their health care, and allowed to benefit from choosing less costly systems and styles of care. The second part of this article will describe a new NHI proposal that meets these requirements.

CONSUMER-CHOICE HEALTH PLAN (Second of Two Parts)

A National-Health-Insurance Proposal Based on Regulated Competition in the Private Sector

ALAIN C. ENTHOVEN, PH.D.

Abstract Medical costs are straining public finances. Direct economic regulation will raise costs, retard beneficial innovation and be increasingly burdensome to physicians. As an alternative, I suggest that the government change financial incentives by creating a system of competing health plans in which physicians and consumers can benefit from using resources wisely.

Main proposals consist of changed tax laws, Medicare and Medicaid to subsidize individual premium payments by an amount based on financial and predicted medical need, as well as subsidies usable only for premiums in qualified health insurance or delivery plans operating under rules that include periodic open enrollment, community rating by actuarial category, premium rating by market area and a limit on each person's out-of-pocket costs. Also, efficient systems should be allowed to pass on the full savings to consumers. Finally, incremental changes should be made in the present system to alter it fundamentally, but gradually and voluntarily. Freedom of choice for consumers and physicians should be preserved. (N Engl J Med 298:709-720, 1978)

IN the first part of this article, which appeared last week, I reviewed the causes of inflation in health-care costs and the inequities in financing today, explained why direct economic regulations will not make things better and reviewed the limitations in the main previous proposals for national health insurance. In this part, I explain the main ideas of, and reasons for, Consumer-Choice Health Plan, a new national-health-insurance proposal.

There is an effective alternative to direct economic regulation. It is to change the financial incentives — i.e., to create a financing framework in which physicians and consumers can benefit from forming and joining organized systems that use health-care resources wisely. In such a system costs can be controlled with freedom of choice that respects each person's preferences. Because the distinctive idea of this proposal is to let consumer preferences guide the reorganization of the health-care delivery system, I have called it "Consumer-Choice Health Plan (CCHP)." Its main ideas are as follows.

ORGANIZED SYSTEMS WITH INCENTIVES TO USE RESOURCES WISELY

To achieve comprehensive care of good quality for all, at a cost we can afford, we must change the fundamental structure of the system of health-care financing and delivery. Instead of today's fragmented system dominated by the cost-increasing incentives of fee for service, we need a health-care economy made up predominantly, though not exclusively, of competing organized systems. In such systems, physicians would accept responsibility for providing comprehensive health-care services to defined populations, largely for a prospective per capita payment, or some other form of payment that rewards economy in the use of health-care resources. Physicians control the lion's share of health-care expenditures. They are by far the best qualified to make the difficult judgments about need and cost effectiveness. Because of the personal, uncertain, often intangible nature of medical care, physicians' judgment is a far more appropriate basis for resource allocation than arbitrary numerical standards are. So it makes sense for physicians to accept the main responsibility for keeping health-care costs within the limits desired by society. I believe that accepting that responsibility is the only way in which the medical profession can maintain its autonomy in the United States.

The government cannot reorganize the health-care economy by direct action. People would resist such changes involuntarily imposed. And nobody can bring about such a change quickly. But the government can change the underlying economic incentives so that consumers and providers of care can benefit from forming and joining organized systems that use resources wisely. The delivery system would then be forced to reorganize itself in response to consumers who are seeking out and choosing what is in their own best interest. CCHP seeks to accomplish this transformation by voluntary changes in a competitive market.

To date, we have not had a great deal of experience with alternative forms of organization and payment of physicians that reward economy in the use of resources. The tax laws, Medicare and lack of competition have discouraged their development. So we

are not in a good position to prescribe how this can best be done. We should seek to learn more about the possibilities by establishing an overall system that rewards desirable innovation — i.e., by a fair market test among competing alternatives in which systems that do a better job for a lower cost survive and grow. Many types of systems might succeed in such a competition. One is prepaid group practice, in which groups of physicians practicing together accept responsibility for providing comprehensive health-care services to defined populations for a fixed prospective per capita payment, and the individual physicians receive a salary, sometimes augmented by a bonus based on the overall success of the program. Another might be the individual practice association, in which the physicians as a group accept responsibility for providing comprehensive services for a fixed prospective per capita payment, but practice individually and are paid fee-for-service. However, the cost-control record of such associations so far has not been impressive. In another model, individual primary-care physicians agree to provide all the necessary office-based primary care to enrolled members who have chosen them, for a fixed prospective per capita payment, and to manage all referral services for a cost-control incentive payment related to the per capita cost experience of their patients. This system makes the family doctor the "general manager" of his patient's health care, a role that should be attractive to many. This plan is comparatively new and exists only on a small scale. Other successful models might include "health-care alliances" as proposed by Ellwood and McClure,[17] and "variable-cost insurance" as proposed by Newhouse and Taylor,[18] in which premiums reflect the cost-control behavior of providers. In such an economy, pure fee-for-service practice would ultimately be reduced to a comparatively small percentage of the total, but it would probably have a secure place, both for specialty services bought by health plans not large enough to have their own full-time specialists and for consumers who preferred to continue to buy their health care and insurance on a fee-for-service third-party reimbursement basis, as most do today, and who would be willing to pay the extra cost above the subsidy level associated with that mode of financing.

Informed Choice among Competing Alternatives

CCHP is designed to assure that all people have a choice among competing alternatives, that they have good information on which to base their choice, and that competition emphasizes quality of benefits and total cost. CCHP would resemble the Federal Employees Health Benefits Program (FEHBP) and similar plans. It would extend to the whole population and to all qualifying health plans FEHBP's proved principles of competition, multiple choice, private underwriting and management of health plans, periodic government-supervised open enrollment and equal premiums for all similar enrollees selecting the same plan and benefits.

Equity and Incentives for Economizing Choices

CCHP seeks to correct inequities and cost-increasing incentives in the tax laws, Medicare and Medicaid. Today, the tax laws exclude employer contributions to health insurance, no matter how large, from the employee's gross income and, within limits, they allow the employee who itemizes to deduct his contributions. This setup has important implications for incentives and income distribution. For example, if a married employee has $25,000 taxable income and his employer pays $1,600 per year for his health insurance, the exclusion saves him $512 in federal income taxes, not to mention savings in Social Security taxes (given the recently enacted rates) and state income taxes. If he sought out and joined a health plan with a $1,500 premium, and asked his employer to pay him the $100 difference in cash, the tax laws would let him keep less than $68 of it. Obviously, this situation weakens his incentive to seek out a less costly plan. At the same time, a self-employed or intermittently employed person earning $6,000 or $7,000 per year is likely to have no employer contribution to his health insurance and no help from the tax laws or other public assistance. This inequity can be corrected by replacement of the present exclusion and deduction with a refundable tax credit that is the same for the high-income and the low-income person. In other words, the employer contribution would be included in taxable income, but the resulting tax would be reduced by a tax credit. ("Refundable" means that the taxpayer gets a cash refund if he has no tax liability.) In CCHP, the tax credit would be based on actuarial cost — i.e., the average total cost of covered benefits for persons in each actuarial category (e.g., men 45 to 64 years of age). Thus, persons in higher-risk groups having higher predicted medical need would get larger tax credits. But people would not get extra subsidies for joining more costly health plans.

In CCHP, Medicaid would be replaced by a system of vouchers for premium payments, integrated with the Carter Administration's proposed cash-assistance welfare reform, and reaching 100 per cent of actuarial cost for basic benefits for families with no income other than welfare. Medicare would be changed to give each beneficiary the right to have the average cost for his actuarial category paid to the qualified plan of his choice as a fixed prospective periodic payment.

Thus, CCHP would take money now used to subsidize people's choice of more costly systems of care, and use it to raise the floor under the least well covered. It would give people an incentive to seek out systems that provide care economically by letting them keep all the savings. While government assures that people have enough money to join a good plan, above the subsidy-level people would be using their own net after-tax money, which should motivate them to seek value for it.

These changes would also permit continuity of coverage regardless of job status.

Incremental Changes

CCHP is not an immediate radical replacement of the present financing system with a whole new one. Rather, it is a set of incremental "mid-course corrections" in the present financing and regulatory system, each one of which is comparatively simple and familiar taken by itself, but whose cumulative effect is intended to alter the system radically, but gradually and voluntarily, in the long run. CCHP corrects the faulty incentives produced by present government programs, and seeks to correct known market imperfections. CCHP preserves flexibility. If these changes do not produce the desired results, after experience has been gained, more corrections can be made. CCHP recognizes that there is no "final solution" to problems of health-care financing, as experience in countries with national health insurance clearly demonstrates. CCHP is not necessarily incompatible with some proposed regulation such as health planning, hospital-cost controls and physician-fee controls. On the contrary, CCHP would increase the effectiveness of the Health Systems Agencies by giving them the incentives to control costs that they now lack. But CCHP would reduce the need for such regulation and, if successful, render it superfluous.

CCHP can be thought of in two related parts: a financing system and rules to create a socially desirable competition.

The Financing System

Actuarial Categories and Costs

The flow of government subsidies to individuals to help them buy health insurance in CCHP would be based on actuarial cost — i.e., the average total costs of covered benefits (insured and out-of-pocket) in the base year, updated each year by a suitable price index, for persons in each actuarial category. For persons not covered by Medicare, the actuarial categories might be the simple and familiar three-part structure of "individual, individual plus one dependent, and individual plus two or more dependents." However, in a competitive situation, this classification might give health plans too strong an incentive to attempt to select preferred risks by design of benefit packages (e.g., good maternity benefits to attract healthy young families), location of facilities, or emphasis in specialty mix (strength in pediatrics, weakness in cardiology). Carried to a logical extreme, such a system could lead to poor care for high-risk persons (though open enrollment — described below — would always assure the right of high-risk persons to join any qualified health plan). So experience might show that a more complex set of actuarial categories is desirable. For example, the three-part structure might be supplemented by special categories for persons 45 to 54 and 55 to 64 years of age. In the limit, one might go to a structure based on individual age (e.g., in 10-year steps) and sex, though I doubt whether this development would be necessary.

Actuarial cost would also reflect location, because there are large regional differentials in health-care costs. The appropriate geographic unit would probably be the state. However, regional differences in real per capita subsidies based on actuarial cost would be phased out over a decade.

The appropriate price index for updating actuarial cost would probably be the "all-services" component of the Consumer Price Index.

The average per capita cost for physician and hospital care in 1978 will be about $200 for people under 19, and about $475 for people 19 to 64 years of age (1976 costs inflated to 1978 at 10.3 per cent per year[19]). So, if these are the covered benefits, actuarial cost for a "typical" family of four would be $1,350. A higher or lower amount, based on a more or less generous benefit package and on broad political judgments about priorities, might be chosen.

In CCHP, premiums would be set by each health plan for each actuarial category and benefit package, on the basis of its own costs and its own judgment of what it can charge in a competitive market. Thus, persons in more costly actuarial categories would pay higher premiums. This step is desirable because we want competing plans to be motivated to serve them and is made socially acceptable by giving such people higher subsidies through tax credits or vouchers.

Tax Credit

The present exclusion of health-insurance premium contributions by employers (and health and welfare funds) from employees' taxable incomes, and the deductibility of individual premium contributions, would be replaced by a refundable tax credit equal to 60 per cent of the family's actuarial cost. (The deductibility of direct medical expenses would be limited to those in excess of 10 per cent of adjusted gross income instead of today's 3 per cent.) Tax withholdings would be adjusted to make the taxpayer's estimated net remaining tax liability at the end of the year approximate zero, so that he would not have to wait until the end of the year to receive the cash. Employers and health and welfare funds would continue contributing to employee health insurance under existing agreements, but they would report such contributions as part of total pay on W-2 forms. The tax credit is allowed only if spent on premiums for a qualified health plan. To the ordinary employee, then, CCHP would appear initially as a quite simple change in the way in which his compensation is taxed.

Consider a typical employee with a family whose employer is contributing, say, $1,600 per year to his health-benefits plan. Under CCHP, his personal income tax would increase roughly $480 because of the inclusion of the $1,600 in taxable income (assuming he is in the 30 per cent bracket), and decline by $810 (60 per cent of the estimated actuarial cost of $1,350) because of the tax credit, for a net saving of $330. The $330 would, of course, have to be financed through some combination of special taxes and federal general revenues. The importance of the change is that the $810 subsidy would be the same for people with higher and lower incomes (above the welfare line), and that the subsidy would not increase if the employee chose a more costly health plan.

The choice of 60 per cent of actuarial cost as the level for the tax credit is based on a judgment that balances a number of factors.

The first is that if the tax credit were too low (e.g., below 25 per cent of actuarial cost), many low-risk employee groups might find it advantageous to form a nonqualified plan and stay out of the system. For the incentive effects of the system to be pervasive, most people must find it to their interest to join qualified plans. Moreover, a tax credit at least as large as the tax benefit in the present law for middle-income taxpayers would help to minimize political opposition to the change from that group. Secondly, if the tax credit were too high (e.g., over 80 per cent of actuarial cost), the incentives of health plans to be truly efficient would be weakened. There would be no point in plans reducing premiums below the tax-credit level. But Medicare experience suggests that prepaid group practices can deliver comprehensive health-care services for an average of 73 per cent of the cost of their fee-for-service counterparts.[8] Similarly, if the tax credit were too high, middle-class consumers would see too little of their own money going into premiums to be motivated to shop for or help form more efficient systems. A tax credit at 60 per cent of actuarial cost would limit the potential for people to manipulate the system to their advantage by taking a minimum-cost "catastrophic insurance" plan when they expected to be healthy, and then switching to a full-benefit plan when they anticipated elective surgical procedures or pregnancy. This level approximates the FEHBP, which has worked well. However, other levels could be chosen, depending on the availability of funds. For example, it could start at 30 per cent, with higher levels phased in as revenues permitted.

Vouchers for the Poor

The poor need more subsidy to assure their access to an acceptable plan. CCHP would provide them with a voucher usable only as a premium contribution to the qualified plan of their choice. It should be administered through the reformed cash-assistance welfare system proposed by the Carter Administration, or whatever program is chosen to assist low-income people. The value of the voucher should be related to family income, and should decline gradually with increasing income on a sliding scale that preserves work incentives. Here is one example. The Carter Administration welfare reform would guarantee a family of four a minimum cash income of $4,200; the cash assistance would be reduced 50 cents for each dollar of earned income until it reached zero at a family income of $8,400 (the "cash assistance breakeven" point). Related to this, one could set the health-insurance premium voucher at $1,350 for a family with a total income, including cash assistance, of $4,200 (i.e., zero earned income), and phase it down to $810 — the tax-credit level for nonpoor families — at a total income of $8,400. The result would be a "benefit-reduction rate" (i.e., the cents worth of cash assistance and voucher lost for each additional dollar earned) of 56 per cent, which would not be inconsistent with the goal of preserving work incentives underlying the Administration's proposed welfare reform. (If the voucher exceeded the family's health-insurance premium, the extra money could be used to buy additional health benefits such as dentistry, or left on deposit to offset cost sharing.) The voucher system can be integrated with the tax system and the unemployment-insurance system.

To illustrate how the voucher system might work, suppose that the rates now in effect for childless couples in the California Public Employees' health-benefits plan were the rates in effect in CCHP. They include $55.88 per month for Kaiser Northern California, $73.17 for the Family Health Program, $92.00 for the United Foundations for Medical Care, $93.15 for Blue Cross-Blue Shield, and others. Suppose a couple were totally dependent on reformed welfare. Using the Administration's proposed amounts for welfare plus CCHP, they would receive a voucher worth $79.17 per month ($950 per year) for health premiums, and cash assistance of $183.33 per month ($2,200 per year). They could elect the Kaiser plan and have $23.29 per month left over for additional health benefits (such as copayments, dentistry and eyeglasses), elect Family Health Program and have $6 per month for such additional benefits, or elect the Foundations plan and have to contribute $12.83 per month out of their cash assistance. If, instead, their income were at or above the "cash assistance breakeven" for childless couples of $4,400, their voucher could be worth $47.50 per month, and they would have to contribute $8.38 per month of their own money to join Kaiser, or $44.50 to join the Foundations plan. (These numbers are illustrative; the actual voucher level might be different, depending on such factors as political judgments and regional cost levels, and I would expect competition to narrow the difference in premiums.)

Medicare would be retained for the aged, disabled and victims of end-stage renal disease. Eligibility would be expanded to all legal residents 65 years of

age and over for Part A (institutional services) and Part B (physicians' services). The benefits should be expanded to conform to the benefits for the rest of the population. The 150-day limit on hospital days should be removed — in effect providing catastrophic coverage. Better still, an annual limit on out-of-pocket expenses on covered benefits by any individual subscriber should be enacted.

The most important change needed in Medicare is a freedom-of-choice provision that would permit any beneficiary to direct that the "Adjusted Average per Capita Cost" (AAPCC) to the Medicare program for people in his actuarial category be paid to the qualified plan of his choice in the form of a fixed prospective periodic payment. If done properly, this change would end the Medicare subsidy to those who choose a more costly system of care, and would permit beneficiaries to reap the benefit of their economizing choices in the form of reduced cost sharing or better benefits.

For example, I pointed out in the first part of this article that in 1970, Medicare paid $202 per capita on behalf of beneficiaries cared for by Group Health Cooperative of Puget Sound, but paid $356 on behalf of similar beneficiaries in the same area who got their care from the fee-for-service sector. Nevertheless, as far as Medicare was concerned, the Group Health members were liable for the same deductibles and coinsurance and limitations on covered hospital days as their fee-for-service counterparts. They received no reward from Medicare for choosing a less costly system. If CCHP had been in effect, they would have been allowed to designate that $356 be paid by Medicare as a premium contribution on their behalf to Group Health or other qualified health plan. In a competitive situation, Group Health would have been able to pass on the extra $154 to the beneficiaries in the form of reduced or eliminated coinsurance and deductibles, removal of the limitation on hospital days covered, increased scope of benefits (e.g., outpatient drugs) or reduction in supplemental premium, as an inducement for those beneficiaries to join Group Health. In CCHP, this option would be available to Medicare beneficiaries not only with respect to HMO's, but with respect to any qualified health plan.

About 7.7 million aged, blind and disabled persons receive Medicaid supplements to assist with costs not covered by Medicare (Medicare pays about 71 per cent of hospital costs and 55 per cent of physician costs for aged beneficiaries.) Under CCHP, these supplements for acute care would be replaced by a voucher similar to that for the nonaged poor. This substitution would assure the ability of the poor Medicare beneficiary to pay the premiums for a policy to supplement Medicare. In 1978 the average per capita hospital and physician costs for the aged not covered by Medicare will be about $385. This would be an appropriate level for the full voucher.

Rules to Create a Socially Desirable Competition: Criteria for Qualified Health Plans

To qualify to receive tax credits, vouchers or Medicare payments, a health plan would have to operate according to a set of rules intended to create a fair and socially desirable competition based on quality and cost effectiveness. (The actual rules that I have proposed in my report to Secretary Califano are somewhat more complex; the essentials are reported here.)

Open Enrollment

Each plan must participate in a periodic government-run open enrollment in which it must accept all enrollees who choose it, without regard to age, sex, race, religion, national origin or, with possible minor exceptions, prior health conditions. Each September, for example, every family would receive an informative booklet published by the administrative agency. The book would give an understandable presentation of the costs, benefits and limitations of each qualified health plan in the area.* During October, each head of household would make an election for the coming year, through his employer, welfare office or local office of the administrative agency. This step would greatly enhance competition by giving each person a choice from among competing plans, and it would assure that every person could enroll in a qualified plan.

The enrollment process should be run by a government agency for several reasons. First of all, an impartial regulatory agency is needed to assure that the information presented is complete, balanced and fair. Secondly, such an agency is needed to assure that every eligible person is truly given an opportunity to enroll in the plan of his choice. Thirdly, this apportionment obviates the need for each health plan to have its own salesmen, reducing cost and possibly preventing the marketing abuses associated with the Southern California prepaid-health-plan scandals.

Community Rating

A qualified plan must charge the same premium to all persons in the same actuarial category enrolled for the same benefits in the same area, to preclude prohibitive rates for poor risks and to spread health-care costs over the whole population. (As noted earlier, each plan can set its own community rates.)

*The best example of such a booklet that I have seen is the one published by the State of California, Public Employees' Retirement System, Health Benefits Division, P.O. Box 1953, Sacramento, CA 95809.

Rating According to Market Area

Qualified plans must set community rates according to market area (such as Health Service Areas or groups of contiguous Health Service Areas). This rule is to prevent anti-competitive cross-subsidies from one area to another, and to "internalize" the costs of health services by Health Service Area so that a decision by a Health Systems Agency to permit construction of a new health facility will be fully reflected in the premiums paid by citizens in that area, thus giving the area a more balanced set of incentives to control costs.

Low Option

Qualified plans must offer a low option limited to the basic benefits defined in the national-health-insurance law. This requirement is to prevent plans from limiting membership to the well-to-do by offering only plans with costly supplemental benefits.

A Limit on Each Person's (or Family's) Out-of-Pocket Costs

Qualified plans must publish a clearly stated annual limit on individual (or family) out-of-pocket outlays for covered benefits (e.g., $1,500 per year). Out-of-pocket outlays include deductibles, copayments and any differences between indemnity payments and the actual cost of covered services. Beyond the limit, the plan must pay all costs for covered benefits. This requirement would help assure that plans do not compete by offering inadequate benefits that would leave the seriously ill uninsured and a burden on the public sector. It would provide full protection against catastrophic medical expenses and prevent medical bankruptcies.

Qualified plans would be permitted to require that their members obtain all their covered benefits from participating providers with whom they have made agreements concerning fees and utilization controls (except for out-of-area emergency treatment). Indeed, the pressure of economic competition would gradually force health plans to make such agreements. But if a plan did not have an agreement with a participating provider in a needed specialty, it would nevertheless have to pay the cost and "hold the consumer harmless" within the agreed cost-sharing limits.

A program to provide meaningful, useful information on the features and merits of alternative health plans would be an essential part of CCHP and a major departure from present practice. To aid consumer choice, each plan would be required to publish total per capita costs, including premiums and out-of-pocket costs. The administrative agency would have authority to review and approve (for accuracy and balance) promotional materials, including presentations to be included in the booklet available to all eligible persons at "open season." The administrative agency would also have authority to review and approve "endorsed options" and contract language so that all options offered would either conform to a standard contract or be able to be described by a standard contract and a manageable number of additions and exclusions. This supervision would force plans to publish their terms in a format that is understandable to consumers and that facilitates direct comparison among plans without forcing the consumer to master and compare a lot of fine print. Uniform financial disclosure would be required — comparable to what the Securities and Exchange Commission requires of public companies. Data on patterns of utilization, availability and accessibility would be required, as is required of HMO's in the HMO Act.

Other

In CCHP, as in any system of national health insurance, there would be requirements for grievance procedures, safeguards for civil rights and against fraud and conflict of interest and quality standards for participating providers.

In the language of economic regulation, these criteria for qualified health plans are "performance standards," not "design standards." They say what a health plan must do to be qualified, not how it must organize to do it. In particular, a health plan would not have to be an HMO or other direct service plan to qualify. Even pure third-party reimbursement-insurance plans could qualify, although their lack of effective cost controls would be likely to put them at a competitive disadvantage.

Benefits and Eligibility

Any plan for national health insurance must include definitions of covered benefits and eligible persons. The choices are largely political judgments. The principles of CCHP can be applied to any of a broad range of benefit packages and eligibility criteria, including coverage of essentially every legal resident of the United States. The philosophy of CCHP suggests that, beyond the essentials that must be specified by law, what is included in health benefits plans should be determined by the consumer desires expressed in the marketplace, rather than by provider interests.

Federal-State Roles in Financing and Administration

CCHP is compatible with many possible ways of splitting federal and state financing responsibilities. The choice must be considered in the context of federal-state burden sharing in general (of which acute-medical-care financing is only one piece), and it must rest largely on political judgments. Because states are potentially important factors in health-facilities planning and cost controls, the federal

government should not pay more on behalf of states that have higher real per capita health-care costs in such a way as to weaken their incentive to control costs.

CCHP could be administered entirely by the federal government or jointly by the federal government and the states under federal standards.

Special Categories: DOD (Champus), Veterans, Indians, Migrants, Underworld, Illegal Aliens, Incompetents, Non-Enrollers

Special measures can be designed for the special problems of each of these categories within the context of CCHP. CCHP will not, by itself, solve the special problems of each of these groups, but it does provide a framework that helps. Special programs are required for special problems. Under any of the proposals for national health insurance being considered, there would need to be a residual system of public providers of last resort.

Transition

The enactment of CCHP would cause no sudden wrenching upheaval in medical-care delivery or financing. There would be a transition period, of perhaps two years, during which health plans intending to qualify would prepare for the first open enrollment. To many plans, this would be a familiar procedure because they already participate in the FEHBP or other multiple-choice systems. Some insurance companies would seek to obtain signed participation agreements with physicians covering fees and assignment similar to those already used by Blue Shield. Some would seek to sign up physicians to participate in capitation-payment arrangements or other cost-controlling incentive systems. Physician groups would doubtless accelerate efforts already under way to form independent practice associations. Various groups would seek to form qualified direct service plans such as HMO's. In all probability, Blue Cross–Blue Shield would offer a qualified plan in each national-health-insurance market area.

Some physicians would sign agreements to participate in several plans. Some would decide to devote their efforts to one plan. Some would decide that the demand for their services was such that they would not need to sign any agreements, although that stance might become economically disadvantageous quite soon. In the first few years of CCHP, most physicians would continue to practice in their same offices and hospitals and care for the same patients as before.

Gradually, however, competitive economic pressures would have their effect. If capitation or other similar incentive-payment systems were effective in reducing cost while maintaining consumer satisfaction, health plans would seek to extend them to more of their participating physicians. Newly trained physicians in specialties in excess supply in a given area would find no health plans interested in signing them up, and they would have to look for work in areas where their services were needed. Primary-care physicians would assume more of the responsibility for the total costs of care of their patients, and specialists whose costs were judged by such primary-care physicians to be excessive would find themselves obliged to negotiate lower fees to retain their referrals. Independent practice associations would tighten utilization controls and more carefully balance the specialty mix of their membership to the needs of their enrolled populations. Prepaid-group-practice HMO's would continue to grow. In short, the competitive market would generate cost controls, but they would be private market controls based on individual and group judgments about cost versus value received and not public controls based on arbitrary numerical standards, insensitive to the quality or value of the services.

Public Policy toward Delivery-System Reform

CCHP would create a competitive economy whose rules were fair to cost-effective organized systems. It would correct the biases against them in the tax laws, Medicare, Medicaid, employer-employee financing arrangements and elsewhere, and it would give them the opportunity to reach their whole potential markets through the government-run open enrollment. It would allow them to pass on to consumers the full benefit of their savings in the form of reduced premiums, which would help them to attract new members. But CCHP would not, in itself, create those systems. If such systems are to come into being, many local efforts to organize them will be required. Such initiatives might be led, as they have been in the past and are being today, by employers, unions, universities, consumer co-operatives, foundations, insurance companies, physician groups, hospitals and local governments. If additional public policies to encourage such efforts prove to be needed, they should be the subject of separate legislation.

I would not place much confidence in proposals for special grants and subsidies for HMO's. Experience with the HMO Act shows that they come at an extremely high price. The HMO Act promised large grants and loans to HMO's on the basis of which many costly restrictions were justified — burdens that were not placed equally on their competitors. The list includes an annual 30-day open enrollment, community rating, data reporting, a requirement that they offer such benefits as mental health, infertility services and preventive dental care for children, as well as complex constraints on staffing. The financial help actually delivered fell far below the amounts originally authorized.[11] This deficiency is typical of

Department of Health, Education, and Welfare programs, and is readily understandable in terms of the political process. Given a truly fair market test as proposed in CCHP, health plans demonstrating the economic superiority of many HMO's will prosper without help. Even the investment capital needed for startup will be far easier to raise if people can be confident that the basic economic ground rules will allow an efficient system to compete successfully.

An antitrust strategy specifically designed for the peculiar economics of the health-care industry is needed. Ordinary antitrust theory, developed for other industries, does not fit very well in health care. It is easy to imagine some noncompetitive outcomes in CCHP. For example, a county medical society might form an independent practice association and use it as a price-fixing arrangement, and keep out would-be competing physicians through control of hospital privileges. Or a market might continue to be dominated by multiple third-party plans, all paying the same providers the same fees and costs. Continuing research, policy analysis and possibly more legislation would be needed. What is clear is that boycotts of qualified health plans, or ostracism or denial of staff privileges to physicians participating in them, would have to be outlawed. The medical profession would have to agree to live by the competitive rules accepted by American business in general.

Costs and the Federal Budget

The costs will depend on the benefits and the amount of the tax credits and vouchers. Here are some illustrative examples using fiscal 1978 dollars.

Assume that actuarial cost is $200 for a person under 19 years of age, $475 for persons 19 to 64 and therefore $1,350 for a "family of four." Actuarial cost for a Medicare beneficiary will be $1,150. On the average, Medicare pays about 67 per cent of this amount. Therefore, a poor Medicare beneficiary needing 100 per cent public support would need a voucher worth $385. (In addition, he would have the right to designate that the $765 of actuarial cost for which Medicare is liable be paid on his behalf to the qualified health plan of his choice.)

Now, assume that the tax credit for families that are not poor is set at 60 per cent of actuarial cost (e.g., $810 for a family of four). Let the voucher for a poor family with no income other than cash assistance (welfare) be 100 per cent of actuarial cost (e.g., $1,350 for a family of four). Let the voucher's value be reduced 12 cents for each dollar of family income, including cash assistance, above the income-guarantee level (e.g., above $4,200 for a family of four), until it reaches the $810 available to the nonpoor at a family income of $8,700. The total cost to the federal budget for these tax credits and vouchers, including the supplemental vouchers for poor Medicare beneficiaries, would be $46.2 billion.* (This figure does not include the costs of the Medicare program, which are assumed to continue unchanged in the short run.) Offset against the tax credits and vouchers would be the extra revenues gained from the proposed changes in the tax laws (eliminating the so-called federal income and Social Security "tax expenditures") worth $10.1 billion, federal Medicaid of $11.8 billion and other programs of $1.9 billion that would be replaced by the tax credits and vouchers, for a total of $23.8 billion. (The states would be relieved of Medicaid acute-care costs but would pay for all costs of long-term care; this revision would maintain approximately the present federal-state division of costs.) Thus, the net additional cost to the federal budget for the full CCHP proposal would be about $22.4 billion. Initially, total national health-care spending would be unchanged, but the federal contribution would be increased.

Alternatively, as the low-cost start of a program to phase in CCHP, let the tax credit for the nonpoor be set at 30 per cent of actuarial cost (i.e., $405 for a family of four). Let the voucher for the poor be 100 per cent of actuarial cost for a family at the income-guarantee level. Let the voucher's value be reduced 20 cents for each dollar of family income (including cash assistance) above that, until it reached the $405 available to the nonpoor at a family income of $8,925. The total cost to the federal budget for these tax credits and vouchers would be $26.9 billion. The net cost to the federal budget, after subtraction of the above-mentioned offsets, would be $3.1 billion.

From a fiscal point of view, CCHP would make the government's contribution to personal health services a "controllable" expenditure that could be set at a level in balance with other priorities, instead of today's open-ended commitments through the third-party intermediary system. Moreover, in CCHP, those who wanted more health services would have the option of using their own net after-tax income to buy them, which would result in less pressure on the Congress than there would be if all the costs were paid by the federal government.

Most important, by establishing strong incentives for cost effectiveness, CCHP promises in the long run to reduce total national health-care costs below what they otherwise would be.

Why CCHP? Some Issues

Will the Desired Reorganization of Health Services Take Place Fast Enough?

Reorganization of health services will take a long time, a decade or more before half the population is served by some kind of organized system with incen-

*The estimates of the costs of the tax credits and vouchers were prepared by Mark Worthington, Office of Income Security Policy, Office of the Assistant Secretary for Planning and Evaluation, Department of Health, Education, and Welfare, whose valuable assistance is gratefully acknowledged.

tives for economy, even under the most favorable conditions. This is a very long time by political standards. Doctors and patients are understandably wary of new organizational schemes. They will want to see how each innovation works before they can be confident that it is a change for the better. The health-services industry is based on many institutions with long traditions and deep roots in their communities. Many people will change their health plans and providers only reluctantly and slowly. There are no easy routes to health-services reorganization. It will take time and a great deal of effort by many people in many localities

Direct regulatory approaches to reorganizing health services promise fast results — but all the evidence shows that the promises are false. Health security and universal third-party insurance would freeze the system in its present patterns. A judgment in favor of the CCHP approach must be based, in part, on a realistic appraisal of the alternatives.

The main reason for optimism about the prospects for a reorganization, given a fair market test among competing alternatives, is that the economic advantage of organized systems can be large. A recent review of the many comparison studies over the past 25 years concluded, "The evidence indicates that the total costs (premium and out-of-pocket) for HMO enrollees are 10-40 per cent lower than for comparable people with health insurance."[30] A Social Security Administration comparison of Medicare reimbursements for beneficiaries served by six group-practice prepayment plans and a matched sample served by fee for service in 1970 found that the former cost 73 per cent as much as the latter.[31] The point is not that all HMO's cost a lot less, in any industry there will be more and less efficient producers The point is that a substantial number of HMO's have shown that the savings can be large Moreover, these HMO's have achieved large savings even in the absence of real competition from similar organizations

The creation of organized systems of care would not have to take the many years of institution and facilities building characteristic of the leading prepaid group-practice plans If there were a market, simpler organizations, based on existing institutions, facilities and practice styles, might be developed fairly quickly on the individual-practice-association model, the health-care alliance, or other broadened definition of HMO. In an individual practice association, the physicians agree to provide comprehensive benefits, largely for a fixed prospective periodic payment, under the following arrangements.[32] First of all, they agree among themselves on a fee schedule. When they render a service to a member of the plan, they bill the plan, not the member. Secondly, they accept peer review of the appropriateness of services. Thirdly, they agree to accept a pro rata reduction in fees if the money runs low. Fourth, the association pays hospital costs or teams up with an insurance company that offers a hospital-insurance policy. The premium for that policy reflects the hospitalization experience of the members of that plan, which is, of course, controlled by the doctors in the individual practice association. So if the total premium for physician and hospital services is determined by the market, the less the hospitalization, the lower the insurance premium, and the more left over for the doctors.

Individual practice associations, like other HMO's, have not grown rapidly in the past for reasons explained below. Moreover, there is evidence that they have been less effective than prepaid group practices at control of hospital utilization. I believe the reason has been a lack of competitive necessity If they had to develop good utilization controls to survive, I believe they would do so.

Individual practice associations like this could be operative within a fairly short time. They could start with physicians already established in fee-for-service solo practice, with existing doctor-patient relations, existing facilities and without the need for large initial investments. I believe that, to survive in the long run, they would have to strengthen internal controls and carefully balance specialty mix. But these changes could come gradually.

Similar arrangements can be created by physicians and insurance companies. Ellwood and McClure call them "health-care alliances," a looser concept than HMO.[33] In one variation on the theme, an insurance company makes capitation payments plus additional cost-control incentive payments to family physicians for providing primary care and for managing total medical-care costs of the enrolled beneficiaries. The range of such interesting possibilities is large; we have hardly begun to see what could be done with cost-control incentives in an appropriately restructured private market.

In CCHP, physicians would be under economic pressure to form or sign up with qualified health plans, where the consumers will be. This pressure will be intensified by the coming doctor surplus. In 1959, there were about 1.49 physicians per 1000 population in the United States. By 1973, the ratio had reached 1.73. And by 1990, it has been projected to reach 2.37.[34] (The specific ratio depends on definitions and assumptions, but by any definition, the relative increase will be large.) The fact that prepaid group-practice plans care for their members with about one physician per 1000 (of course reflecting, in part, a membership that is younger, healthier and busier than the population at large) gives some indication that in a world of efficient organized systems, there will be more doctors than needed. Therefore, given the economic framework created by CCHP, the process of forming organized systems is likely to be accelerated by physicians who are seeking a place to practice. Thus, I do not believe that one should estimate future membership in organized systems with some incentives for economy by applying a plausible

growth rate to today's HMO membership of roughly six million. Rather, there is reason to expect that many new organizations would be formed quickly.

If HMO's Are Superior, Why Haven't They Grown Faster?

The main answers are, first, the monopolistic practices of some physicians described earlier, and second, the strong and pervasive anti-HMO bias in the policies of the federal government, and the consequent lack of incentives for consumers and providers to join HMO's under existing financial arrangements. The tax laws, the Medicare law, the planning laws, and the HMO Act all have important anti-HMO biases.[34,35] And the anti-HMO bias in state laws is notorious. Most people do not have a choice between an HMO and a third-party, fee-for-service plan, or if they do, the tax laws, Medicare and employer financing arrangements do not let them keep the savings. HMO's have done very well in competitive multiple-choice situations. For example, Kaiser-Permanente of Northern California serves 37 per cent of the federal employees, 43 per cent of the state of California employees, and 37 per cent of the University of California employees in its service area. And, despite the obstacles, the growth rate of HMO's in areas where they are established is impressive. From 1960 to 1976, Kaiser's California membership increased from 720,000 to 2,617,000, a compound annual growth rate of 8.4 per cent, despite the fact that in many years, they had to limit new enrollments because of the time and cost required to plan, build and staff new facilities.

The "Consumer-Choice" Issue

Proposals to rely on consumer choice to guide the health-services system are invariably subjected to the attack that consumers are incapable of making intelligent choices in health-care matters. So it seems worthwhile to make clear exactly what is being assumed. Admittedly, the element of ignorance and uncertainty in health care is very large; that is true for physicians and civil servants as well as ordinary consumers. CCHP does not assume that the ordinary consumer is a good judge of what is in his own best interest. Consumers may be ignorant, biased and vulnerable to deception. CCHP merely assumes that, when it comes to choosing a health plan, the ordinary consumer is the best judge of it. The theory of optimum allocation of resources through decentralized markets does not assume that every consumer is perfectly informed and economically rational. Markets can be policed by a minority of well informed rational consumers. And we are seeking merely a good and workable solution, not a theoretical optimum. CCHP provides consumers with substantially better information than they get now and much stronger incentives to use it. If there were a demand for it, much could be done to organize better consumer information. In any case, the key factor is the incentive that CCHP gives to providers — i.e., provider systems will get their money from satisfied consumers rather than from the government. In CCHP, above the tax credit/voucher level, consumers would be working with their own money, not somebody else's.

Critics of the consumer-choice position usually are not very explicit about whom they consider to be better qualified than the average American to choose his health plan for him.

Presumably every national-health-insurance scheme under consideration would allow each consumer choice of physician and free choice of whether or not to accept recommended medical treatment — decisions that could be aided by technical knowledge. *What distinguishes CCHP from the others is that it seeks to give the consumer a choice from among alternative systems for organizing and financing care, and to allow him to benefit from his economizing choices.* The issue, then, is whether consumers can be trusted to choose wisely when it comes to picking health plans — some of which cost less than others.

Part of the "consumer-choice" issue is resistance to the idea of letting the poor, because of their poverty, choose a less costly health plan that might not meet their medical needs. There is appearance of a conflict here with the principle of CCHP that people must be allowed to benefit from their economizing choices. (There is, of course, the issue of how much the poor should be forced to accept their share of society's assistance in the form of costly medical technology of doubtful value, as opposed to leaving them free to spend the resources on other things like food and housing known to be good for health.) The problem can be resolved in CCHP by setting the premium vouchers (usable only for health care) at a high enough level to assure access to a plan with adequate benefits — always letting plans that do a better job attract members by offering less cost sharing or more benefits.

Equity Issues

CCHP uses the most effective way to redistribute purchasing power for medical care — i.e., directly. It takes money from the well-to-do and pays it to lower-income people in the form of tax credits and vouchers. By this method, the amount of redistribution is clearly visible, and one can be sure the money reaches its intended target. CCHP can thus be used to bring about whatever income redistribution for medical purchases the political process will support. By contrast, third-party insurance systems are an exceedingly ineffective way to redistribute income. Medicare pays more on behalf of rich than poor.[9] In a bureaucratic system, individuals and organized groups who are forceful and skillful at getting their way come out ahead.

Will CCHP perpetuate a two-class system of care for rich and poor? The question should be judged realistically in terms of where we are today, in which direction CCHP would move us, and where we are likely to go as a society. CCHP focuses on raising the quality of care available to the poor by assuring that they have the money (through vouchers) and the access (through the government-run open enrollment) to the health plans serving the middle class. Competition is likely to keep the cost of many of these plans in reach for many low-income people. Moreover, unlike the present tax law, under CCHP, the well-to-do would have to pay the extra cost of more expensive health plans out of net after-tax income. Thus CCHP would be a large step toward equalization of health-care purchasing power, without enforcing absolute equality. I believe it would be foolish to reject it on the grounds that it does not reach a hypothetical egalitarian ideal that has never been attained in any society and is surely not supported by the American people today.

Is a Multiple-Choice System Feasible?

The feasibility of a competitive model for national health insurance has been demonstrated by the Federal Employees Health Benefits Program (FEHBP), and numerous other choice-of-plan systems. The FEHBP was authorized in 1959. It now provides health benefits for 10.5 million people. The government pays essentially 60 per cent of the average premium of the six largest participating plans, or, in 1978, $58.72 per month for a family. The employee pays the rest. There are now 79 participating plans, including the government-wide indemnity-benefit plan offered through the Aetna Life and Casualty Company, government-wide Blue Cross-Blue Shield service benefit plan, numerous employee organization plans (e.g., letter carriers), and comprehensive medical plans (e.g., HMO's). The administrative expense is very low. A 1964 report of the FEHBP noted,

> The program finally authorized by Congress permits a wide range of choice of plans by all employees and was, in effect, a negotiated compromise among many divergent and highly organized interests. It was the only approach which at any time during the legislative process gained acceptance by all of the principals: the American Medical Association, Blue Cross-Blue Shield insurance companies, employee unions, group and individual practice prepayment plans, and the Federal Government as the employer. Although there can be no doubt that the "single plan" approach would have been most desirable from the standpoint of administrative simplicity, now that we have learned to live with the administrative problems which stem from multiple choice, it becomes equally clear that the wide choice of plans has produced a program which is more effective in meeting the needs of Federal employees and their dependents. It was anticipated by many that serious administrative problems would develop that would require continual legislation of a perfecting and remedial nature. This has not been the case.[8]

The California State Public Employees' System has been in operation for almost as long as the FEHBP. It provides benefits for about 425,000 people. It has proved so successful that non-state public employee groups are now joining it. And it has helped the growth of HMO's in California.

Underserved Rural Areas

CCHP would not "solve" the problem of underserved areas, but it should help. It would provide assured medical purchasing power to people in rural areas, many of whom have low incomes, and by ending the open-ended tax subsidy in the well served areas, it would put some financial pressure on physician location decisions. The best way to provide good care in rural areas is through organized systems that can provide outreach (e.g., through physician extenders) and that can provide financial and professional support to physicians working in such areas. For example, Kaiser-Permanente operates remote outposts in Hawaii, including a single-physician clinic on the northern shore of Oahu. Though far from the main medical center, this doctor can easily consult with his specialist partners by telephone, and can refer patients if necessary.

The "HMO Underservice" Issue

Some allege that HMO's achieve financial success by underserving their members. The established HMO's like Kaiser-Permanente and Group Health of Puget Sound have for many years served such educated middle-class groups as federal and state employees, university faculties and other teachers. If there were a substantial amount of underservice, one would think that the word would get around and that these people would switch at the next open season. I have been unable to find any documented case of a pattern of underservice among such HMO's. On the contrary, the main selling point of such organizations is usually improved accessibility. A recent study comparing patterns of use of ambulatory-care services in five health-care delivery systems in Washington, D.C., found that "taking patient factors into account... preventive use is lowest in the OPD/ERs (out-patient department/emergency rooms) and highest in the prepaid group (Group Health Association). Rates of initiating care are also highest in the prepaid group. Medication is most likely in the OPD/ERs, while volume of follow-up care is greatest in fee-for-service groups and moderately high in the prepaid group. Services are more equitably delivered within the prepaid group than within the fee-for-service systems, in relation to income, education, and medical need."[9] The allegations of underservice arose for the Medicaid prepaid health plans, mainly in Southern California. There, a state government was trying to cut costs in a hurry, and accepted unrealistically low bids for Medicaid contracts and enrollment practices that interfered with free choice. The underservice

problem arose from the state government's politically motivated purchasing policies, not from the nature of HMO's. If we assure that every family has the purchasing power to buy membership in a good plan, and a free choice among competing plans, organizations that make a practice of underserving members will not last long.

This statement is not to imply that the financial incentives in the existing HMO's are perfect or that their performance is without shortcomings. We simply do not know what are the "right" financial incentives; there is no logical or empirical basis for such a determination. CCHP proposes to find out what are good incentives through experience in a competitive market. And good incentives do not guarantee good performance. Medical care is full of judgment and uncertainty; mistakes are made in any setting, including HMO's. HMO's may have replaced financial barriers with institutional barriers to care. The most effective pressure to perform to satisfy consumers is competition

Conclusions

CCHP's design principles were equity, practicality and rational economics. But it was developed with an appreciation of the broad political realities. Although it may not be a first choice for any group, like the FEHBP, it might well be an acceptable "second best" for many. CCHP offers the *medical profession* the surest basis for maintaining its autonomy. Without an effective system of economic competition to control and legitimize costs, a system of direct government economic controls is inevitable. Such controls would inevitably be based on arbitrary numerical standards applied across the board without respect for individual preferences or quality. They would involve increasing paper work of a frustrating and unproductive kind. The Medicare regulations give a taste of what is in store down that road. The politicizing of the negotiating process over physician fees would inevitably be damaging and unpalatable. By contrast in an effective system of economic competition, such as that proposed in CCHP, medical-care costs could be controlled by the judgment of physicians. Individual preferences would be respected. For this system to work, physicians would have to accept responsibility for managing the total health-care costs of their enrolled population groups. Acceptance of such a role would enhance the social contribution and recognition of the profession.

In addition to offering the best prospect for bringing costs under control, CCHP offers substantial attractions to various important groups in society. This characteristic should give it broad political appeal. For the *poor*, it offers continuity of subsidized health-plan coverage that is independent of job or Medicaid eligibility, access to health plans that serve the middle class and an increased supply of doctors resulting from the "capping" of demand in well served areas. CCHP would be especially helpful to the working poor. For *workers*, it offers an expanded range of choice, improved efficiency and reduced cost through competition and assured continuity of coverage in the face of job changes or unemployment. *Medicare* beneficiaries would be able to obtain protection against catastrophic expense and reduced or eliminated cost sharing by joining an efficient health plan. For the *well-to-do*, CCHP offers a finite "controllable" government commitment to personal health-care services versus today's open-ended commitment, less of a tax increase than for some of the main alternatives, less of a tax burden in the long run than would be entailed by the status quo, and a private-sector solution with a limited government role. For *hospital administrators*, CCHP could mean relief from burdensome, frustrating government regulations and a chance to succeed by offering better services at lower cost rather than today's increasing emphasis on beating the regulations. CCHP offers *private health insurers* continued existence and a meaningful role.

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RECOMMENDED LOW-COST CHANGES TO EXISTING LAWS TO ENHANCE COMPETITION AMONG HEALTH CARE FINANCING AND DELIVERY PLANS

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I. STANDARDS FOR EMPLOYER HEALTH BENEFITS PROGRAMS AND FOR PRIVATE HEALTH CARE FINANCING AND DELIVERY PLANS TO CONTINUE TO QUALIFY FOR FAVORABLE TAX TREATMENT.

The Problem

Private health insurance now covers more than 170 million people.[1/] This industry has thus achieved an important public purpose. This is in substantial part attributable to public policies that encouraged it, in particular the exclusion of employer contributions to health benefits from the taxable incomes of employees, and the deductibility of employee health insurance premium contributions. In 1978, the favorable tax treatment of health benefits cost the federal government roughly $10 billion in foregone income and social security tax revenues. There remain, however, important gaps in coverage, barriers to competition, and other imperfections in the health insurance market. The tax exclusion offers the government the opportunity to set minimum standards for private health plans, as a condition for favorable tax treatment, that will make the market achieve public purposes more effectively.

A. Standards for Employer Health Benefit Programs

1. Multiple Choice of Plans Offered.

Proposal: Each employer subject to the Fair Labor Standards Act, having 25 or more employees, shall include in any health benefits program offered to employees a choice of no less than three health insurance or delivery plans meeting the standards described in Part B below. The choice of plans may include private indemnity or service benefit plans, a self-insured plan, health maintenance organizations, or a labor-management health and welfare trust fund. (Three different "options" from the same carrier would not meet this requirement.)

Reasons: The link between jobs and health insurance, fostered by the favorable tax treatment of employer-provided health benefits, has become one of the most important barriers to competition among health care financing and delivery plans in the United States today--a result Congress surely did not intend when it enacted the Internal Revenue Code of 1954. Most employed people still are offered a single health insurance plan by their employer, and are thus denied some of the important benefits of competition and choice.

The multiple choice of health plan principle has been proved to be practical and desirable in such programs as the 18-year old Federal Employees Health Benefits Program now covering 10.5 million people. It has also found successful though limited application in the private sector.

Congress recognized the desirability of multiple choice in the HMO Act when it required employers to offer their employees one group practice and one individual practice HMO, if available. However, HMOs are too few in number, for the most part too small, and too tightly regulated by DHEW, to be able to bring the benefits of competition and choice to most Americans in the foreseeable future. Moreover, there are other potentially attractive alternative health-care financing and delivery systems that do not meet the detailed specifications of the HMO Act. This proposal would open up competition and multiple choice of health insurance plans to all employed Americans.

The HMO Act would still apply, i.e. if appropriate federally-qualified HMOs are available in an area, the employer would still be required to offer them. They could be included in the required three plans.

2. Equal Dollar Contributions to All Plans Offered

Proposal: The employer's premium contribution must be the same whichever plan the employee chooses The employer must also offer payroll deduction to the employee for the employee's contribution.

The employer may contribute different amounts on behalf of employees in different actuarial categories (e.g. individuals, couples, families). This provision does not require employers to contribute at any particular level. If the employer is not currently making a fixed periodic dollar contribution per employee (because, for example, he is offering a self-insured or retroactively adjusted experience-rated insurance plan), he must ascertain the actuarial value of his current arrangements per employee and contribute an equal dollar amount on behalf of those who join HMOs or other health plans.

Reasons: The intent of this proposal is twofold. First, it would subject health plans to economic competition. The employee who chooses a more costly plan would have to pay the difference in cash or other benefits foregone. Second, it would make the competition fair.

Today, many employers pay 100% of the premium, whichever plan the employee chooses, thus paying more to more costly health plans, and subsidizing plans with weak or no cost controls against those with effective cost controls.

I understand that DHEW is attempting to require equal dollar contributions on behalf of employees who choose HMOs in its new regulations implementing Section 1310 of the HMO Act. It would be more effective to make this a requirement for the excludability of employer contributions from taxable income under the tax laws. This would clarify the legal basis for the regulation, extend it to competing health plans in general, and simplify the enforcement.

Employers or collective bargaining agreements not now in compliance with this principle could work out alternative arrangements that are in compliance. For example, employers could contribute the difference, on behalf of those who chose less costly health plans, to other tax-sheltered fringe benefits. One frequent response would be for the employer to pay no more than 100% of the premium of the least costly plan, leaving it to the employee who selects a more costly plan to pay the difference. An important effect would be to make all employees

aware of the costs of their health benefits.

These two proposals together would put Congress firmly on record as in favor of fair economic competition among health plans.

B. Standards for Health Care Financing and Delivery Plans.
(i.e. any plan that results in nontaxable fringe benefits such as health insurance plans, HMOs, labor-management health and welfare funds, self-insured health benefits plans, etc.)

1. Standard Basic Minimum Benefits.

Proposal: All health benefits plans must cover, as a minimum uniform set of benefits, the Basic Benefits defined in the HMO Act. Coverage may be subject to substantial copayments and deductibles. Additional benefits may be offered.

Reasons: The covered benefits of health plans are often hard to understand and compare. There are tricky exclusions and limits on coverage. Consumers can understand copayments and deductibles and make reasonable judgments about quality and accessibility of services. But the effort required to become well informed about the significance of many "fine print" exclusions is very great. This proposal would standardize a lot of the fine print. All health benefits could then be described in terms of Basic Benefits plus a manageable number of additional benefits. This would focus competition on quality and accessibility of services, and price. Price comparisons would be easier and more meaningful. And consumers would be protected from tricky or misleading exclusions of important services.

This provision would also hold HMOs and other health benefits plans to a more comparable standard of benefits.

This provision need not increase premium costs; premium can be reduced even to quite low levels by raising the deductible. (For example, a 1973 Rand Report found that raising the annual deductible for a 25-percent coinsurance policy from $100 to $1000 for an employee in Los Angeles would reduce the monthly premium from about $13.50 to $3.40[2/].)

2. Limits on Cost-Sharing-"Catastrophic Expense Protection."

Proposal: All health plans must limit consumer cost-sharing (co-insurance, copayments, deductibles) for Basic Benefits to a maximum annual amount, e.g. $1500 per family.

Reasons: Tens of millions of Americans lack "catastrophic expense protection" even though they have some health insurance. This is particularly unfortunate in view of the fact that the infrequency of catastrophic illness expense makes this kind of insurance much less costly than "first dollar coverage." Many millions of Americans now must plan to fall back on the public sector in the event of catastrophic illness. Thus, it seems reasonable to require that every plan provide such protection.

Cost-sharing by the patient has been considered to be a valuable economic incentive to motivate the patient to consider the cost of care. Whatever its merits in the case of ambulatory visits might be, when the patient is seriously ill, it is the providers, not the patient, who make the main cost-generating decisions. Thus, cost-sharing by the patient should be limited to the comparatively low cost "patient-initiated" and "elective" care.

If some believe that a $1500 limit would make premiums too high, then the limit could be raised for example to $2000. But the extremely costly expenses should be insured before "first dollar" coverage is provided.

3. Continuity of Coverage

Proposal: All health plans must provide to covered beneficiaries:

(a) at least 30 days coverage to the unemployed after termination of employment, to dependents after death of an employed family member, and to divorcees after divorce;

(b) automatic coverage of newborn children;

(c) the right for the unemployed, widows or widowers, divorced spouses and dependent children, and dependent children upon attainment of majority, who have been members of an insured group to convert, without proof of insurability or reference to prior medical conditions, to individual coverage at group rates (plus reasonable allowance for handling costs) within 90 days.

Health plans may not cancel coverage because of illness or any reason other than failure to pay premiums.

Reasons: Many people lose their health insurance when they lose their jobs, are divorced, their spouse dies, etc. Dependent children lose coverage upon relinquishing dependent status. This causes individual hardships, and subjects the private health insurance industry to justifiable criticism. This proposal would add little to the cost of insurance, but would greatly enhance people's continuity of coverage.

4. Dependent Coverage Based on a Uniform Definition

Proposal: All health plan must offer coverage of dependent spouses and children; employers must offer payroll deduction for employee premium contributions. The definition of these dependents must include at least those defined as dependents by the IRS.

Reasons: Different health insurance policies now use different definitions of a covered dependent--thus adding an unproductive element of complexity to the consumer's decisions, and unexpected gaps in coverage.

5. Anti-Monopoly Provisions

Proposal: If a health plan offers care through a limited number of participating physicians, it may not have participation agreements

with more than 50% of the physicians actively engaged in the care of patients in a county or metropolitan area (SMSA), unless the Secretary of HEW waives the provision because the area is sparsely populated and not able to support competing health plans, or because he finds that significant health plan competition exists in the area.

Reasons: Blue Shield plans or Individual Practice Associations (IPAs) could become important barriers to competition if they were to sign up all or most of the doctors in an area. The FTC has been taking action against physician control of Blue Shield plans. A more effective approach would be to make sure the Blue Shield plans, IPAs and others, are subjected to competition from other health care plans. Genuine competition requires that each physician community be broken up into competing economic groups.

II. AN EFFECTIVE AND FAIR HMO OPTION FOR MEDICARE BENEFICIARIES

Proposal: Change Section 1876 of the Social Security Act to permit any Medicare beneficiary to direct that the "Adjusted Average Per Capita Cost" (AAPCC) to the Medicare program for people in his actuarial category who are not members of HMO, be paid, as a premium contribution on his behalf, to the federal or state qualified HMO of his choice in the form of a fixed prospective periodic payment.

Each HMO agreeing to this form of payment would construct an "Adjusted Community Rate" which would be its basic community rate actuarially adjusted for Medicare benefits and the utilization of the Medicare beneficiaries. If the "Adjusted Community Rate" is less than the prospectively determined AAPCC, the HMO must pass on the difference to its Medicare beneficiary members in the form of better benefits, or reduced premiums or cost-sharing. If the Adjusted Community Rate exceeds the AAPCC, the HMO entering such a "risk basis contract" must provide the Medicare benefits for the AAPCC amount.

Reasons: Today, Medicare does not pay HMOs in a way that conforms to their usual way of doing business, i.e. on the basis of a fixed prospective periodic payment for comprehensive services. Instead, Medicare imposes on them the fee-for-service cost-reimbursement mode of payment with its cost-increasing incentives. (There is a provision--Section 1876--for paying HMOs on a quasi-per capita basis, but it is very complex, is discriminatory against HMOs and their members since the government keeps half the "savings", retains elements of cost reimbursement, and has not been put into operation to any appreciable extent.)

Thus, Medicare often pays substantially less on behalf of beneficiaries who join HMOs than on behalf of similar beneficiaries in the same area who choose to get their care from the fee-for-service sector. For example, in 1970 Medicare paid $202 per capita (on a cost-reimbursement basis) on behalf of beneficiaries cared for by cost-effective Group Health Cooperative of Puget Sound, but paid $356, or 76 per cent more, on behalf of similar beneficiaries (i.e. an age-sex-area matched sample) who chose fee-for-service. On average, for six group practice prepayment plans around the country included in the study from which these date come, Medicare paid 36 per cent more on behalf of similar beneficiaries who chose fee-for-service.[3/4/] And it is in the nature of Medicare cost reimbursement that this subsidy to fee-for-service will increase as the cost differential widens. This Medicare system deprives beneficiaries of an important financial incentive to join a cost-effective organized system of care. In 1977, less than 300,000 Medicare beneficiaries were HMO members, about one per cent of all beneficiaries.[5/]

This proposal would enhance fair competition and incentives for cost control. Thus, it would make Medicare more of a force for delivery system reform. Under it, Medicare would pay equally for HMO and non-HMO beneficiaries, which would be fair.

Eventually, the present Medicare system, with its extremely complex and rigid regulatory apparatus, ought to be replaced by a payment

system based on fixed prospective per capita payments by actuarial category, and fair economic competition in the private sector, based on a broadened definition of health plans eligible to participate.

Eventually, also, a similar HMO option should be required in all Medicaid programs.

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June 7, 1979

The following is the text of a speech prepared by Representative Al Ullman, Chairman of the Ways and Means Committee, for delivery to the National Journal Conference on Health Policy in Washington:

National Health Insurance is a monument still waiting to be built in this country. But certainly not for lack of architects. Teddy Roosevelt ran on a national health ticket in 1912. Sixteen presidential campaigns later, Jimmy Carter called for (and I quote) "A comprehensive national health insurance system with universal and mandatory coverage".

Campaign politics demand a major debate on health. The President will soon add his own national health plan to a list of others that have been announced this year. I am confident that his plan will give us some long-range direction.

But it is my judgement that Congress is in no mood to vote for a multi-billion dollar health package this year or next. We've just spent months struggling over a budget for the coming fiscal year. We held a tough line. And I think we can maintain that discipline and balance the budget in fiscal 1981.

Congress is not opposed to the idea of national health insurance, but Congress is opposed to any major plan that breaks the budget.

It is within that apparent contradiction that I want to propose a modest health plan for this Congress. My plan does not broaden health coverage; nor will it increase the layer of benefits. It costs the government nothing. And it can be achieved this year.

But while the debate over the grand design of national health insurance goes on, we can start by turning around some of the incentives that have been driving up the cost of health for years. That means making this country take a collective look at exactly what the "last dollar" really buys -- and whether we should spend it on something else. That means forcing the consumer, the doctor, the provider and the insurance company to open their eyes to the wide range of health benefits and their price tags -- and then asking the consumer to decide exactly how much coverage he wants for his health dollar.

The proposal I will lay out today restructures the financing of our health care industry. It encourages competition within the health industry to offer more economic policies to the consumer. And it would check and stabilize today's rising proportion of the gross national product spent on health care:

My proposal has six essential cost controls:

1. Changing tax laws to encourage greater enrollment in pre-paid health plans.
2. Placing a cap on the Federal tax subsidy for medical insurance.
3. Requiring a choice of health plans where only one expensive fee-for-service health plan is currently offered by an employer.
4. Requiring employers to pay equally to each plan.

5. Changing medicare law to encourage elderly patients to join health maintenance organizations (HMO's), and
6. Mandating a statewide demonstration project similar to Oregon's project health for our low income population.

I want to capsule a few of the most visible incentives now driving up health costs - and then explain how my plan limits them.

Our Federal tax system invites almost limitless health care spending. The way our laws are written now, medical and insurance payments by the employer for the employees are not taxed. If the same dollar were paid directly to the employee to buy his own health plan, that dollar would be taxed as ordinary income. Consequently, employees would rather have a dollar of health insurance than a dollar of wages. That tax break has encouraged tough bargaining for "first dollar", very expensive and comprehensive medical plans in contract settlements.

In short, this incentive distorts consumer choice. Instead of spending a taxable dollar on housing or food, the consumer is almost forced to take that dollar in health care to beat the tax. This must end.

Today's health system has built-in incentives for doctors to increase costs. Doctors and hospitals enjoy the finest billing system one could theoretically design. It reimburses all costs. The higher the fees, the more revenue that automatically flows. The patient and the doctor have no incentive to hold down costs.

There is also the costly tendency among doctors to practice what's known as "defensive medicine" to avoid rising malpractice suits and awards More tests, more hospital days -- more money.

Million dollar equipment and technology have become the symbols of blue-ribbon hospital care -- both for the doctor and the patient. There are few incentives and few excuses in our cost-reimbursement world that encourage a hospital administrator to say no to a doctor who wants the latest novelty in high technology.

In many instances, exotic equipment has not improved health care significantly. In fact, sometimes the opposite is true.

The risk imposed by radiation may, for example, offset the benefits derived from marginal X-rays. The open-heart surgery unit is a major medical advance and has saved many lives. But it must be used at full capacity both from the standpoint of cost efficiency and decreased risk. Units operating at less than full capacity typically show greater mortality rates and higher per capita costs.

Like the billing system for doctors, hospital costs are fully reimbursed. It is the marginal decision -- like an extra day in the hospital for routine lab tests -- that often generates the most revenue relative to costs. With an invisible "third party" insurer paying more than 90 percent of the cost, the consumer and the doctor rarely spare the expense.

The consumer has absolutely no incentive to keep costs down. He is completely insulated from the actual cost of his care once he walks through the

hospital door. In most cases, he has bargained for the Cadillac of health plans -- unaware that he is paying the cost.

Thus, the effect of most present insurance plans is to distort the choice of what the doctors and the patient - at a distance - would regard as appropriate medical care. Instead, the hospitals are encouraged to add to the expense.

Although the consumer eventually pays for full cost of his care through higher prices, the choice of care -- once that patient is in the hospital -- clearly reflects his net out-of-pocket cost. And since that cost appears so modest, or even zero, the patient and doctor normally choose more expensive care than they would if insurance coverage weren't so handsome.

In this way, our current method of financing hospital care denies patients and their doctors the opportunity to choose effectively between higher-cost and lower-cost hospital care -- and maintains the consumer's illusions that hospital care is virtually free.

Some simple but striking numbers will illustrate this point. In 1950, per capita cost for hospital care was slightly over $24 per year, and private insurance and government programs paid 49% of hospital bills. This meant that, on the average, the net cost to a patient was $12. By 1977, per capita cost had jumped to about $297, but private and public insurance was paying 94% of the hospital bill, leaving a net cost to the patient of only $17. In real terms, taking into account inflation, the net annual cost to the patient for hospital care at the time of illness has decreased significantly during the past 27 years.

Medicaid and medicare are major social landmarks -- but have turned out to be financial monsters. Both of these systems reimburse medical costs retrospectively, with disastrous results. Once again, doctors and hospitals have no incentives to control costs because federal payments are automatic no matter how high.

All tied together, these incentives are rapidly adding billions to the nation's health bill. The facts have been cited many times before but bear repeating. From 1950 to 1977, the percent of GNP spent on health increased from 5.2% to 8.8% or an increase in the share of 69 percent. Per capita health expenditures have increased from $141.63 a year to $763.92 a year over this same period. The largest source of this increase has been hospital care. In 1969, hospital care represented 32.9 percent of total health care expenditures. In 1977, that share had increased to 40.4 percent.

Various ways of changing the health care market have been discussed this morning. Some of these ideas involve more government regulation of the health care industry, other attempt to reduce "third party" payments and make the consumer more aware of the true cost of care, while other proposals build competition into the health care industry.

Government simply cannot regulate the entire industry effectively. Once the accelerator is stuck, putting on the brakes may slow the car -- but the damage is extensive.

We can, however, identify the cost to the consumer and foster keener competition.

We've got to begin by removing the tax incentives for employers to provide very expensive coverage -- when the employer might well be satisfied with a more limited plan. To turn that incentive around, I propose that all employer-paid premiums be taxed as ordinary income to the employee unless the employer's health plan meets three conditions:

First, that employer's contributuions to all employee health plans be limited to the least expensive Federally qualified Health Maintenance Organization (HMO).

The emergence of HMO's has demonstrated that high-quality, comprehensive health care can be provided at less expense than a traditional indemnity plan which relies on fee-for-service reimbursements. This new and efficient delivery concept eliminates the excuse for an open-ended tax subsidy for less efficient health plans.

For employers not offering a qualified HMO, their contribution would be limited to the median cost-of HMO's across the country. Employers would continue to offer more expensive plans, but employees would have to pay the additional costs. If, for example, the median cost of HMO's were $100 a month and the company's present high-payment plan cost $140, the employee must make up the $40 difference out of pocket.

Thus, workers could continue to choose a more expensive plan if they believed the benefits from such a plan were worth the extra money.

Second, I would require employers not offering Federally certified HMO plans to provide a qualified prepaid health plan if one is available and can handle the business.

If no such plan is available, employers would have to offer their employees a "low option" plan costing no more than 50 percent of the median cost of Federally-certified HMO's. A "low option" plan can reduce costs by making copayments and some benefit expenses deductible which gives the consumer a direct financial stake in the cost of health care.

Employers simply must give their employees a clear choice of health plans. Right now, that choice is typically limited to one plan which often provides much more care than the employee needs. I want the employee to sit down and choose exactly what he wants for the money -- the cadillac or the chevette.

Third, employer contributions for all plans -- low-cost or high-cost -- would be the same. This makes the employee's choice of plans even more critical. If he chooses a plan that costs more than the employer's fixed contributuion, he would pay the difference himself. If the employee chooses a plan that costs less than the employer's contribution he would receive the difference in cash. If, for instance, the employer's contribution were fixed at $100 and his employee wanted the low option plan costing $60, he would receive the $40 difference in his pay.

The implications of this proposal can be drawn from the Federal employees health benefit package, which already offers employees a large choice of plans. Among the plans offered is a "high option" Blue Cross-Blue Shield plan, whose cost is $110a month per month per family, and a "low option" Blue Cross-Blue Shield plan, whose cost is $40 a month per family. The Federal government now pays $27 per month more toward the high benefit plan -- thus subsidizing the additional, perhaps largely unneeded, coverage. My proposal would prevent the employer (in this case the Federal government) from distorting the employee's judgement whether the extra is worth the extra cost.

My proposal would also change the law to encourage prepaid plans to participate in medicare. Under today's medicare laws, HMO's may be reimbursed on a cost, or "risk", basis. The level of payment, however, is determined retrospectively -- an approach that is fundamentally inconsistent with the prepaid approach.

Under my proposal, an HMO would receive 95 percent of the amount medicare pays for the same benefits in a private plan. That's a five percent saving to the government without any loss of benefits to older Americans. In addition, the elderly would be offered broader benefits to encourage them to join an HMO. These benefits would be paid for by the savings generated by the HMO's more cost effective medical service.

Finally, we need to experiment with alternate health care systems for the poor. For several years, Oregon has funded an interesting demonstration experiment called Project Health. In essence, Project Health is an agency for the county which acts as a broker for low-income families. It offers six health plans ranging from per capita to fee-for-service.

Once enrolled, families are counseled on what health plans would best suit their needs and provides a sliding scale of payments based on income and the type of plan chosen. The scale is highest for the most expensive plan and lowest for the least expensive plan. Yet, there is some contribution required to all plans.

This project has shown that such a system can be administered and holds the potential for reducing health care costs. I recommend that a state-wide system similar to Project Health be implemented to determine whether other forms of health care delivery can economically serve the poor. Again, I believe that competition between HMOs and fee-for-service plans will yield the finest care to the most people for the government dollar.

The proposal I am outlining today strikes at several areas.

It will reverse the incentives created by our tax system to select the most expensive health care coverage. It will create incentives for employees and employers to choose plans that contain cost incentive features. It will encourage, and ultimately force, employers to offer their employees a choice between plans that are prepaid and plans with substantial cost reducing capability.

It changes the incentives in medicare to encourage elderly patients to select prepaid plans rather than the fee-for-service system. And finally, it sets up, on a demonstratic basis, a plan to change the way health care is offered to the low-income sector of our society.

This proposal encourages the formation of alternative health care delivery systems. It does not force anyone to join prepaid plans. It does not end the tax subsidy for medical care. It simply encourages competition. Ultimately, it would encourage doctors to form health care delivery systems and actively compete for the patronage of employee groups.

This proposal will be formally discussed as part of the Committee's study of broader national health programs.

There's no question that this country needs a long-term commitment to economical and quality health care. But hammering out a national insurance program is going to take a great effort. Like building a sky-scraper, we've got to progress one story at a time. I don't have the blueprint for the entire building. I just want to add the first floor.

Consumer-centered vs. job-centered health insurance

Today's dominant health care financing system blocks economic competition and rewards doctors and hospitals for cost-increasing behavior

Alain C. Enthoven

Most employees and their dependents in the United States have health insurance provided by the employer or labor-management health and welfare fund. In this system, employees and their families lose their health insurance when the breadwinner loses his or her job while, at the same time, a Medicaid beneficiary can lose Medicaid eligibility by getting a job, even a poorly paid one. Most health insurance pays the doctor on the basis of fee-for-service and the hospital on the basis of cost-reimbursement, rewarding both with more revenue for providing more and more costly services. The insured employee has little or no incentive to seek out a less costly provider. There are no rewards for economy in this system. It should be little wonder, then, that health care costs are out of control. There are alternative financing and delivery systems with built-in incentives to use resources economically, but, the author of this article asserts, their ability to compete and attract patients with their superior economic efficiency is blocked by many laws and government programs. The author believes that the most effective and acceptable way to get costs under control, and at the same time achieve universal coverage, would be through a system of fair economic competition. He discusses his Consumer Choice Health Plan proposal and describes how one of the main barriers to competition is today's system of job-linked health insurance.

Mr. Enthoven, a former assistant secretary of defense and president of Litton Medical Products, has been studying health care financing since he joined the Graduate School of Business at Stanford University, where he is Marriner S. Eccles Professor of Public and Private Management.

In 1977, the nation's health care spending exceeded $160 billion—four times the 1965 amount. From 1965 to 1977, real per capita spending (i.e., net of general inflation) increased 94%; health care spending went up from 5.9% to 8.8% of the GNP. Business bears much of this cost, as employer and taxpayer. For example, from 1965 to 1977, General Motors' health insurance premiums increased 6.8 times over, from $170 million to $1.16 billion.

Public sector spending rose more than seven-fold, from $9.5 billion (25% of the total) in 1965 to $68.4 billion (42% of the total) in 1977. Federal Medicare outlays alone will double from 1976 to 1980, up from $18 billion to $35 billion. Most of this government spending is open-ended and not controllable. Not only does this spending contribute much to the tax burden, but also to the federal deficit and inflation, and therefore to the "inflation tax" on business (i.e., taxable income based on historical cost rather than replacement cost).

Reduced to simplest terms, the main cause of runaway health spending is that our health care financing system is dominated by cost-increasing incentives and is almost devoid of economic competition in the production of health care services.

Today's familiar system of job-centered health insurance is one of the main barriers to economic competition in health services. It is thus a major contributor to health care cost inflation. It is incompatible with universal continuous coverage. And it is the cause of many nonproductive administrative burdens.

To achieve real economic competition in health care services, universal continuous coverage, and

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Editor's note. All references are listed at the end of this article on page 152.

administrative simplification, we need a fundamental change to a consumer-centered system. We need a system in which each consumer (i.e., individual or family) can choose annual membership in any of the health care financing and delivery plans ("health plans") meeting appropriate standards in his or her area; and in which employer and government premium contributions on behalf of each consumer are directed to the plan of his or her choice.

The need for this change is one of the most fundamental, and poorly understood, issues in the national health insurance policy deliberations in Washington today.

Today's financing system causes inflation

There are good reasons for much of the increase in health care spending: growth in public and private insurance coverage brought access to many who previously did not have it, especially the aged and the poor; advances in technology increased the power of medicine to prolong life and enhance its quality. But the increase in spending has far exceeded what could be justified on these grounds, especially in recent years.

The main cause of the unjustified and unnecessary increase in costs is the complex of perverse incentives inherent in today's dominant system of health care financing. Consider:

- Most doctors are paid on a fee-for-service basis that rewards them for providing more and more costly services whether or not more is necessary or beneficial to the patient.
- Hospitals are reimbursed for their costs, and so are rewarded with more revenue for generating more costs. Indeed, a hospital administrator who seriously pursued cost cutting (e.g., by instituting tighter controls on surgical procedures and laboratory use and avoiding purchase of costly diagnostic equipment by referring patients to other hospitals) would be punished both by an immediate loss in revenue (Medicare and Medicaid would cut dollar for dollar) and eventually by a loss in physician staff, and therefore, patients.
- Most consumers have health insurance and thus are left with, at most, a weak financial incentive to question the need for or value of services. Today's system gives most patients the right of "free choice of doctor," but little or no incentive to seek out a less costly doctor or system of care because their health insurance premium will be the same whichever they choose. Furthermore, benefits for more than two-thirds of the employees in private industry health plans are paid for entirely by employers, so many employees have little or no knowledge of or concern over how much their health insurance costs.[1]

Within this financing system, the question of how best to spend a limited amount of money for the health care of a population is never even posed. Providers of health care services (mainly doctors and hospitals) are not required to set priorities, look at alternatives, and make hard choices. Such a system must produce inflation in prices and waste in the use of resources.

What we have today can be described as tax-subsidized membership in an "Expensive Lunch Club." Imagine that you and 19 friends belong to a lunch club. You agree that you will each pay 5% of the total lunch bill for the group. Consider the incentives. Suppose you go to lunch one day feeling that a $2 salad would satisfy your needs and be just fine for your health. You sit down and watch your friends order. One orders filet mignon; another orders lobster. Now it is your turn. You calculate that if you order the $12 filet instead of the $2 salad, it will cost you only 50 cents more.

Not only does membership in this club give you little incentive to choose the less costly meal, but also, if everybody in town is a member of this or a similar club, there is not much incentive for anybody to open an economical restaurant that specializes in healthy $2 salads.

Alternative financing & delivery systems

This system so dominates our health care financing that most people take it for granted. But there are alternatives in successful operation in the United States today, economically rational health care financing and delivery systems that reward people for finding ways to deliver better care at less cost.

Physicians control or influence most health care spending: the key issue in cost control is how to motivate them to use hospital and other resources economically. In the alternative systems, the source of funds is not open-ended. Rather, physicians accept responsibility for providing comprehensive health-care services to defined populations, largely for a periodic per capita payment.

The list of such alternative systems includes prepaid group practices, individual practice associations, health maintenance plans, health care alli-

ances, and variable cost insurance.[3] There are many variations on these concepts, but each includes some reward for economy in the use of resources. (Their essentials are summarized in the ruled insert opposite, *Alternative health care financing and delivery systems.)*

Many comparison studies provide convincing evidence that prepaid group practices reduce total per capita costs (premium and out-of-pocket) to levels some 10% to 40% below those for comparable people cared for under traditional fee-for-service insurance programs.[3] The main way they do this is by cutting the use of hospitalization by some 30% to 50%. Such cost reductions can be achieved without reducing the quality of care.[4] Other systems might be able to achieve similar savings.

I believe that if they were given an opportunity to compete on equal terms, alternative financing and delivery systems that use resources wisely would largely replace the system of uncontrolled fee-for-service, cost-reimbursement, and third-party intermediaries.

Decentralized market to control costs

The main direction of public policy in the 1970s has been to protect the dominant system, and then to try to limit its cost-increasing effects by government regulation in the form of direct controls over prices and capacity. I believe public policy should be directed to creating and maintaining a system of competition among health plans that relies on a decentralized market to control costs.

Competition works better than regulation

There are many reasons for believing that the competitive approach would be far more satisfactory than reliance on direct controls on prices and capacity as a means of limiting cost. For example:

1. Experience in health care and other industries shows that government controls on prices and capacity are likely to raise cost and retard beneficial innovation.[5] In the long run, price regulation amounts to cost reimbursement, and it gives producers the same incentives. An across-the-board percentage limit on hospital revenue increases, as proposed by the Carter administration, rewards the fat and punishes the lean.

Alternative health care financing and delivery systems

Prepaid group practice
An organized group of physicians, working together in shared facilities, in collaboration with professional managers, provides voluntarily enrolled members with comprehensive health care services, for a periodic per capita payment set in advance. Most of the physicians are committed full-time to the care of enrolled members. They may be salaried, or be paid on a per capita basis, and may receive bonuses related to the program's overall financial success, or some combination of these. Examples of these plans are Kaiser-Permanente Medical Care Program, in six states, mainly in California and Oregon; Group Health Cooperative of Puget Sound, Washington; Harvard Community Health Plan, Massachusetts.

Individual practice association
Physicians practice in their own offices on a fee-for-service basis. As a group, they agree to provide comprehensive health care services to their enrolled population largely for a per capita payment set in advance. To reconcile fee-for-service with the per capita payments, the physicians agree to a maximum fee schedule (they bill the association, not the patient) and to a peer review of appropriateness of services and other internal management controls, and accept varying degrees of financial risk (e.g., a pro rata reduction in fees if the money runs low). Typically, the association accounts for only a fraction of the doctor's practice. Examples of these plans are Physicians' Association of Clackamas County, Oregon and Choicecare Health Services in Fort Collins, Colorado.

Health maintenance plan
The beneficiary agrees to get all his or her care from or on referral through the participating primary care physician (i.e., a generalist such as family doctor) of his or her choice. This physician agrees to provide directly all office-based primary care services for a monthly retainer fee. (In some variations on the idea, the physician is paid fee-for-service.) He arranges referrals and supervises all other care, including specialist services and hospitalization, for each of his enrolled beneficiaries. An account is set up, with receipts based on premium revenue, from which he pays the bills for all the other care. At the end of each year, he shares in the surplus or deficit in this account. Examples of this plan are Northwest Healthcare (SAFECO Life Insurance Company) in Washington and the Wisconsin Physicians' Service.

Health care alliance and variable cost insurance:
These names refer more to a financial concept than to a particular type of organization. Beneficiaries agree to get their care from a limited set of providers, or on referrals under their control in exchange for a lower premium or better benefits. (The plan may pay for the services of a nonparticipating provider, but on a basis less advantageous to the beneficiary – e.g., 20% coinsurance instead of 100% covered.) The insurance premium reflects the cost-generating behavior of these providers. In a competitive situation, the providers must control costs, or else the premium increase will cause them to lose patients to other health plans. Stanford University employees group insurance plan with the Palo Alto Medical Clinic, California and the Hawaii Medical Service Association are examples of this concept.

2. Certificate-of-need regulation by states in which a regulatory authority must issue a permit before an increase in hospital capacity can take place has failed to control overbedding. The leading experts cannot agree on standards for the appropriate number of beds.[6]

3. Where tried, competition *has* been effective in controlling cost. The best example is Hawaii where most people belong either to the Hawaii Medical Service Association or to the Kaiser-Permanente Medical Care Program. While other factors contribute to cost control there, and competition remains attenuated by various government programs, the two plans do compete vigorously. Their premiums for comprehensive care are among the lowest in the country. In 1976, hospital expense per Hawaii resident was 68% of the national average despite the fact that consumer prices generally are higher in Hawaii than in most areas.[7]

4. Medical care has many characteristics that make it particularly unsuitable for successful economic regulation. Because of the nature of the service, the government cannot measure output or evaluate its quality (except in cases of extreme abuse). The "doctor office visit" and the "patient bed day" are not standard units whose prices can be regulated like passenger miles or kilowatt-hours.

5. Government often responds to well-focused producer interests; competitive markets respond systematically, if imperfectly, to consumer interests. People specialize in production, diversify in consumption. They are therefore much more likely to pressure their representatives in government on their producer interests. Health care resource allocation ought to be guided primarily by consumer preferences.

6. People accept efficiency-improving changes (e.g., closing unneeded plants or hospitals) produced by impersonal market forces in the private sector. But, when such changes are imposed by government, those who would be harmed resist them, usually successfully, through legal and political action. (Consider the extreme difficulty of closing post offices and defense installations.) This makes for great rigidity in regulated industries. It would be virtually impossible to close many unneeded hospitals by regulatory action.[8]

7. Even if government were successful at controlling total health care spending at the desired growth rate, there would be no force in the regulatory system to motivate efficiency or equity in the production or allocation of services. At best, the controls would freeze the health services industry in its present wasteful and inequitable patterns.

8. The decentralized competitive market leaves maximum freedom to individual providers and consumers. It encourages the pluralism and diversity that is valued by the American people. The regulatory approach works on the basis of uniform numerical standards. It does not tolerate diversity.

9. The Carter administration's recent failure even to get its proposed Hospital Cost Containment Act through the House Health and Environment Subcommittee illustrates that there is little political support for more direct federal controls. The administration is simply incapable of enacting, let alone implementing, an effective system of controls.

10. As FTC Chairman Michael Pertschuk recently observed, "Although regulation might appear to be capable of achieving faster results, it would be unlikely to have much impact before it is fully in place and any unforeseen imperfections worked out .... All our national experience with such programs, in fact, teaches that implementation of a regulatory program takes a long time and never fully achieves the promise which is so eloquently laid out on paper."[9]

Fair economic competition today?

The usual response to recommendations that we follow a strategy of fair market competition is: "We already have competition in health insurance and health services and it is not working." This response is based on a lack of understanding of today's system. To be sure, we do see hospitals competing for doctors and for prestige and doctors competing for patients and for professional recognition. And we do have vigorous economic competition in health *insurance* (i.e., insurance carriers compete with each other and with employer self-insurance for contracts to insure employee groups).

But because of the way that health *insurance* connects to health *services*, with few exceptions, there is not *economic* competition in health *services*. The competition we see is not of a kind that rewards economy in the use of resources either in the production or purchase of health care services. Just as a town full of Expensive Lunch Clubs would have competition only among expensive restaurants, so today's dominant system of health care financing, for the most part, limits competition to costly health care delivery systems.

When economists talk about the competitive economy as the most efficient way to allocate resources, they are referring to a system in which:

1. Each producer pays the full cost of production of the goods or services he sells. His profit margin

Consumer Choice Health Plan (CCHP) compared to today's situation

Personal income tax law

Today Exclusion of employer contribution from taxable income: Subsidizes choice of more costly health plans;
Ties employee to health plans offered by employer or union;
Treats health insurance of employees more favorably than that of self-employed.

CCHP Replaces exclusion with a refundable tax credit based on actuarial category (i.e., predicted medical need) usable only as a premium contribution to a qualified health plan. This means that:
Those who choose more costly health plans pay the extra cost with their own net-after-tax incomes;
The employee is freed to use his tax credit in any qualified health plan operating in his area;
The tax subsidy is made equal with respect to income;
The tax subsidy is made equal with respect to the employed and self-employed.

The eventual incentive effect of this would be to redirect employee demands from health benefits to other benefits and to take-home pay. (Corporate tax deductibility of contributions to employee health benefits would be unchanged.)

Medicare

Today Beneficiaries are locked into fee-for-service cost-reimbursement system. Medicare pays more on behalf of people who choose more costly systems of care. People who choose less costly systems do not get to keep much or any of the savings.

CCHP Each beneficiary could have the average per capita cost to Medicare for people of his or her age, sex, and location paid as a premium contribution to the qualified plan of his choice. If a person chooses a more cost-effective system, he or she can pay lower premiums or get better benefits.

Medicaid

Today Eligible people get all covered benefits paid, with no reward for choosing a more efficient provider of care. If their earnings take them from below to above the eligibility threshold, they lose all benefits.

CCHP Low-income people would get a voucher, based on average cost of comprehensive benefits in their area. To preserve work incentives, the value would be reduced gradually with increasing income to the tax credit level for the nonpoor. The poor could get more benefits by choosing a more cost-effective health plan.

Insurance regulation

Today Different types of health plans are regulated according to different rules by different agencies at the state and federal levels. There is a bewildering array of insurance plans with complex exclusions and limitations. Many plans offer inadequate coverage. Many are free to reject poor medical risks, thus leaving uninsured those who need insurance most.

CCHP All qualified plans would be brought under a uniform system of regulation. All would be required to participate in the annual open enrollment (in which all citizens can enroll in the plan of their choice), follow nondiscriminatory pricing (i.e., community rating by actuarial category), offer comprehensive benefits (as defined by the national health insurance law), and provide full protection against the cost of catastrophic illness. (Nonqualified plans would not be eligible for tax credits, vouchers, or Medicare contributions.)

Employer role

Today Great variation among employers. They usually offer employees a single health insurance plan, specially negotiated with the insurer, suited to the particular needs of the employer and collective bargaining agreement. This is sometimes augmented by a "dual choice" option of a HMO. Employers pay some or all of the premium.

CCHP Employers would manage the enrollment process for their employees in which employees select one of the health plans offered in their community. Employers would aggregate premium payments made up of payroll deduction and employer contributions. (If the government wants to require employers to provide health insurance, it should require them to make hourly contributions to the plan of the employee's choice, and not provide a whole-family policy for one of the family's members.)

(i.e., the difference between the competitive market price and unit cost) is reduced if he lets his production cost increase.

2. The consumer has limited resources. If he spends more on one thing, he has less money for other things, so he is motivated to consider the value received for each dollar he spends. The consumer is assumed to be well informed about the price and quality of his purchases before he buys, and his purchases are voluntary.

Under competitive conditions, trade produces a kind of social optimum in which all opportunities for mutual gain have been exhausted. For the most part, these conditions are not satisfied in our health care economy today.

The system does not hold doctors and hospital administrators responsible for the costs they generate. Doctors face no economic penalty for giving care in an unnecessarily costly way. And, within weak restraints, hospital administrators can pass on increased costs to the third-party intermediaries who pay more than 90% of the bills.

Even the consumer is not cost-conscious because his medical purchases are largely paid for by insurance. And the consumer is at a large disadvantage when it comes to information about the costs and benefits of various health services. If his need is urgent, his purchase is not well characterized as voluntary.

Instead of requiring that the alternative financing and delivery systems be allowed to compete on a

fair basis, the government blocks competition by the unintended effects of many laws and programs. Virtually all Medicare beneficiaries are stuck with the system of fee-for-service and cost reimbursement. So Medicare pays more on behalf of people who choose more costly systems of care.

For example, in 1970, Medicare paid $202 per capita on behalf of beneficiaries cared for by cost-effective Group Health Cooperative of Puget Sound, but paid $356, or 76% more, on behalf of similar beneficiaries who chose to get their care from the fee-for-service sector. So while the Medicare program strains the federal budget, its beneficiaries are locked into an Expensive Lunch Club. And the tax laws block competition in ways that are described below.

Consumer Choice Health Plan

A system of universal health insurance and fair market competition among health plans would work as follows:

1. Once a year each consumer would be offered the opportunity to enroll for the coming year in any one of the qualified health plans operating in his area. While traditional insurance plans offering "free choice of doctor" on a fee-for-service basis would be allowed, I believe that competition would encourage, and in fact compel, the development of "limited provider plans" with built-in cost controls.

In these plans the consumer would agree to get his care from, or on referral by, physicians participating in that plan, and each health plan would have agreements with participating providers covering costs and delivery of services. (Plans might allow "out of plan" use on financial terms less favorable to the beneficiary, and would have to cover emergency services for members temporarily outside the plan's service area.)

2. Whatever financial assistance each person or family got toward the purchase of its health insurance—from Medicare, Medicaid, employer, or tax laws—would have to be the same whichever qualified health plan the family chooses. Today, these financing sources usually pay more on behalf of people who choose more costly health plans. Thus, if a family chose a more costly health plan, it would pay the extra cost itself out of its own net aftertax income.

3. A uniform set of rules would apply to all health plans. For example, each plan would have to accept all comers, up to its capacity, without regard to age, job status, prior medical conditions, and so forth. (The system would include means for compensating health plans for serving a less favorable than average mix of medical risks.) Every health plan would have to follow rules with respect to nondiscriminatory pricing (called community rating), comprehensive benefits (as defined by the national health insurance law), and full protection against the cost of catastrophic illness (i.e., a limit such as $1,000 on each family's annual out-of-pocket cost for covered benefits).

The point of such rules would be to assure that the health plans compete to provide good quality comprehensive care at a reasonable cost—the social goals of the program—and not to profit by such practices as selection of preferred risks or catering to the willingness of some people to take chances with inadequate coverage.

4. For simplicity, each health plan would offer one or two standard plans for the whole community rather than a different, specially negotiated plan for each employee group.

Consumers who join health plans that do a good job of controlling costs would pay lower premiums or receive better benefits. Health plans that do a poor job of controlling costs would lose customers and risk being driven out of business. Thus, in the long run, the surviving health plans would be the ones that offer a good value to their customers.

These are among the fundamental design principles of the Consumer Choice Health Plan, a new national health insurance proposal intended to assure universal health insurance coverage and to control costs through fair economic competition in the private sector.[10] Its main elements are summarized in the ruled insert on page 145, *Consumer Choice Health Plan (CCHP) compared to today's situation*. The proposal has been receiving serious consideration by the Carter administration. Its adoption will require substantial business understanding and support.

(Carter and Kennedy's views on national health insurance are summarized in the ruled insert on page 148, *Carter, Kennedy, and the AMA: where they stand*.)

The feasibility of such a competitive system is demonstrated in the ruled insert on page 150. *The Federal Employees Health Benefits Program*. The plan has been in successful operation since 1960.

Consider a couple of simplified models of health insurance, chosen to illuminate the essence of today's problem and the character of the competitive solution:

□ Today all the doctors in town practice on a fee-for-service basis, each charging what he or she considers "usual, customary, and reasonable." The hos-

pitals charge amounts that cover their costs. There are many insurers, each paying these fees and charges. Each person is covered through an insurance plan linked to his or her job (or parent's or spouse's) and 100% paid by the employer, with complete freedom of choice of doctor. (This simplified model of traditional insurance abstracts from the fact that some of the insurance carriers are active in creating alternative delivery systems and some other reforms; this is part of "competition" described below.)

Today the insurers cannot control the cost of health services. (The administrative cost they do control is a small percentage of the total.) They can only pay the bill after the fact. They cannot negotiate effectively with doctors and hospitals over fees and charges, because they do not have the authority not to buy if the price is not right. Only the patient, with his free choice of doctor, has that. Similarly, the employers (or unions) cannot control the cost unless they are willing to tell their employees which providers they can and cannot use—a willingness not much in evidence in most industries.

The providers can control the cost of care, but today there is no reward for doing so. Lower cost does not attract more patients because the insured patients have no reason to consider the cost. On the contrary, a patient may perceive a reduction in cost as a reduction in quality.

The insured patient realizes little or no savings from going to a less costly provider or accepting a less costly style of care (e.g., substituting outpatient for inpatient care for the same condition). Even if he does choose a less costly provider, his insurance premium reflects the costs of all the more costly providers in town used by his insured group.

□ Contrast the foregoing model with economic competition in which those who have the power to make economizing choices are rewarded for doing so. Most of the doctors in town are full-time participants in one or another of several competing alternative health plans. Each employee gets the full multiple choice of health plans. Each employer pays, say, $60 per family per month toward the premium of whichever health plan is chosen by the employee. The employee pays the rest, as well as any copayments charged by the health plan.

The patient still has "free choice of doctor" in the sense that he can join the health plan in which his favorite doctor participates. But now he also has the right to agree to get his care from a limited set of providers who offer him a lower premium and/or better benefits. In this system, the patient is cost-conscious because he can benefit by joining a more cost-effective health plan.

The competing health plan must control costs and pass the savings on to the consumers. And it can control costs because it has the authority not to buy from providers that it considers too costly. Providers must sell their services to consumers who have incentives to consider cost as well as quality.

Among other things, these simplified models illustrate why the individual consumer, and not the employer or union, should be the customer. It is the consumer-patient who chooses the doctor. Together, they decide the costs. If we want the costs to be controlled, they must both benefit from economizing choices.

The right product for economic choice

The conditions under which the competitive market produces an efficient allocation of resources cannot be well satisfied by a market in which the "product" the consumer buys is the individual medical care service. (The following are also reasons why consumer cost-sharing in individual medical purchases is not likely to produce satisfactory cost control.)

First, our society has accepted the principle that everybody should have health insurance. This confronts us with the incentive effect of insurance on the purchase of individual units of care. If the insurance pays 80%, the consumer has an incentive to treat a unit of care that costs $10 as if it really cost $2. Moreover, in order to protect families from the risk of serious financial loss, an increasing number of insurance policies include an upper limit on the family's out-of-pocket costs above which all costs will be paid by insurance. At that point, the weak economic incentive introduced by coinsurance is removed altogether.

Second, for most illnesses, the physician cannot quote a fixed price for treatment in advance. You go to the doctor with a pain in your chest and you want to buy a cure. He cannot quote you a price for a cure. Until he has done some work, he does not know whether you have indigestion or a heart attack. Thus in buying a cure, a patient buys a sequence of services whose composition is uncertain at the outset. And the doctor's fee for an office visit, for example, may be a poor indicator of what the total cost for treatment by him will be.

Third, the individual episode of medical care is not good material for rational economic calculation. If the patient is in pain or urgent need of care, the transaction is not entirely voluntary. The sick patient is in a poor position to make an economic

Carter, Kennedy, and the AMA: where they stand

President Carter sent a statement of principles of national health insurance to HEW Secretary Califano in July 1978.

He noted: "The health care system is highly inflationary... These expenditures cannot be successfully contained under current health delivery and financing methods, which produce unnecessary hospitalization, overreliance on expensive technology, and inadequate preventive care." He directed the secretary to "analyze the issues of cost control and health system reform in greater depth."

His principles included comprehensive health care coverage for all Americans with freedom of choice in the selection of physicians, hospitals, and health delivery systems.

"The plan must support our efforts to control inflation in the economy by reducing unnecessary health care spending...and should also strengthen competitive forces in the health care sector."

He went on to speak of "greater efficiency in the health care system,... the ability of many consumers to share a moderate portion of the cost of their care," and "... such major reforms in delivering health care services as substantially increasing the availability of ambulatory and preventive services...and encouraging the use of prepaid health plans."

President Carter's principles are compatible with Consumer Choice Health Plan. The emphasis on health system reform, with no mention of increased regulation for cost control, points in the direction of a strategy that emphasizes incentives and fair market competition. However, the president has not yet proposed a specific plan.

The president's emphasis on fiscal restraint gave some the impression that little action was intended until fiscal year 1983. Doing nothing in the face of the current inflation would not be a tenable position. Public sector spending on health is now increasing at a rate of 12% per year, and the strategy of direct price and capacity controls is failing.

Senator Kennedy first introduced the Health Security Act in 1970. Health Security was designed to get away from third-party reimbursement and to shift health care financing to a per capita budgeting basis within a publicly determined total. There would be a firm lid on total health care spending based on earmarked tax revenues. Within this total, the Health Security Board would contract for covered services with participating providers. Health Security would have created a centrally and politically controlled system in which every participating provider would get all his money from the federal government.

In April 1978, in search of compromise, Senator Kennedy sent President Carter an outline for a new proposal called "The Private Guaranteed Plan." In his words:

"This plan would guarantee universal coverage of comprehensive insurance benefits within a system designed to constrain costs at all levels and provide for reform of the delivery system. This is accomplished through the *private sector*, under government regulation, and does not create a two-class system of medical care that inevitably results from a mixed public and private plan ...Under this plan, certified private insurers and HMOs would insure the entire population. Financing would rely, to the maximum extent possible, on employer/employee-paid premiums to private insurers and HMOs, thus minimizing on-budget costs. Cost containment would be attained by a mixture of incentives for competition and federal and state regulatory controls on insurers and providers."

Thus Senator Kennedy, and the labor leaders associated with him, appeared to take a large step in the direction of universal health insurance in the private sector. But having failed to reach a compromise with President Carter, they developed their own proposal which Senator Kennedy released in October. It includes:

> Mandated employer-provided health insurance, thus reinforcing one of the main barriers to health plan competition.
> Upgraded Medicare for the elderly; government-paid premiums for the poor and unemployed.
> Immediate federal limits on hospital and physician revenues.
> A potpourri of overlapping regulatory programs including state rate review, hospital budgets and physician fees negotiated between providers, a "public authority," insurers, and HMOs, within national, area-wide, and state budgets.

The proposal appears to be a negotiated compromise between those who would keep health insurance in the private sector and those who want a complete government takeover. And they seem to have gotten the worst of both worlds: a tightly regulated industry with no room for cost-reducing innovation. It does not have the advantage of clear public accountability offered by Health Security, and it does not offer any of the advantages of competition in the private sector offered by CCHP.

The American Medical Association-sponsored National Commission on the Cost of Medical Care published its summary report in December 1977. It acknowledged the inevitability of a choice between "strengthening cost consciousness or increasing public utility-type regulation." They chose the former and recommended a strategy of fair market health plan competition, alternative financing arrangements, and economic incentives in purchasing insurance and health plans and consumer cost-sharing as the most promising approach to cost containment. This would represent a fundamental departure from today's situation and from the past position of the medical profession. Yet these recommendations won at least a "cautious approval" from the AMA's House of Delegates this past June.

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analysis of treatment alternatives or negotiate with the doctor over fees.

Fourth, it is very costly for the patient to become well-informed about the costs and benefits of alternative treatments. He needs an appropriately motivated doctor to act as his adviser and agent. The comprehensive health plan can satisfy this need. Part of what it offers is the confidence that services will be provided only if they are necessary and efficacious.

I believe the appropriate "product" for rational economic choice by the consumer is the annual membership in one or another health care plan that provides comprehensive services (i.e., whatever medical care you need) largely for a fixed prospective monthly payment. (This does not rule out limited use of copayments.) And the annual enrollment is the time when one can reasonably expect people to make a considered choice.

Thus a fair economic competition that allocates resources efficiently can be organized around the annual choice among comprehensive health plans.

Negative effects of job-linked health insurance

Today's job-centered system of health insurance is largely the product of a series of actions by the federal government, in the 1940s and 1950s whose primary focus was on wage controls, labor relations, and taxes, and not on the structure of the health insurance industry. Employer health plan contributions were excluded from World War II wage ceilings. In 1948, the National Labor Relations Board ruled health benefits an appropriate subject for collective bargaining. The Internal Revenue Code of 1954 confirmed the exclusion of employer health plan contributions from gross income.

The consequence of these actions was to make the employee group the predominant basis for health insurance and to tie most people's health insurance to the job of the head of the family. Two important economic effects of these tax laws are to subsidize employee decisions to select more costly health care systems and to encourage employee pressure for more employer-paid health benefits. If the employees take an additional dollar of gross compensation in cash, they get to keep roughly 60 to 70 cents after tax; if they take it in health benefits, they get the full dollar. Employers and unions are motivated to exhaust this opportunity for tax-sheltered pay.

The end point of this process is 100% employer-paid comprehensive benefits. One serious consequence is that employees then no longer have any financial incentive to choose a less costly health plan. For example, the autoworker who chooses membership in a prepaid group practice plan that provides comprehensive benefits for $77 per month, rather than the Blue Cross plan that costs $101, does not get the savings because General Motors must pay the whole cost either way. Thus some collective bargaining agreements force the employer to subsidize the employee's choice of a more costly health plan.

It should not be surprising that the alternative systems have grown slowly when one considers that such powers as the U.S. government and the auto industry pay large subsidies to the fee-for-service sector on behalf of people who choose not to join them.

An equally important unintended effect of the tax laws excluding employer contributions from taxable income is to limit the employee's health insurance options to the plan or plans offered by the employer or labor-management health and welfare fund.

Employers have seen health benefits as a way of attracting qualified employees to their company, or as a way of discouraging unionization. Union leaders have seen health benefits as a prize to be won at the bargaining table, and as a way of making the union the worker's benefactor. Both emphasize benefits specific to the employer or union, and not the use of this medical purchasing power to create a market of competing provider groups in the community.

As we approach 100% employer-paid comprehensive benefits, health benefits cease to be an effective tool for management to use in competing for employees. Other companies offer similar benefits, and opportunities for bargaining prices for unions become exhausted. At this point, management, unions, and workers are locked into the Expensive Lunch Club.

While management may try to roll back the benefits, experience in 1978 with the mineworkers and in 1976 with the autoworkers illustrates that union leaders must forcefully resist any "take away" of previous bargaining gains.

As we approach the end point, health benefits become an albatross around the necks of employer and union, eating up an increasing percentage of total compensation, and yielding no additional benefit to either.

Labor and management might be able to control health care costs by bargaining with providers over

The Federal Employees Health Benefits Program

The FEHBP covers about 10 5 million federal employees, retirees, and dependents More than 80 different health plans participate, including Blue Cross-Blue Shield, Aetna Life and Casualty, and many health maintenance organizations. Whichever plan the employee chooses, the government as employer contributes 60% of the average of the premiums of six of the largest plans, about $58 per family per month in 1978. The employee pays the rest The cost and consumer satisfaction of the plans are "policed" by the beneficiaries and the competition

One indicator of the remarkable simplicity of the FEHBP is that the law that creates it is 8 pages long, while the regulations to implement it fill about 16 pages. By comparison, the Medicare law (Title XVIII of the Social Security Act), which is based on fee-for-service and cost-reimbursement, and which covers about 27 million aged and disabled people, is 102 pages long, and the regulations fill about 400 pages

charges and controls on hospital use. To be effective they would have to be able to limit the employees' care to providers with whom they have reached cost control agreements (or at least reward employees for choosing participating providers). While this has been tried, it has not become widespread because it would take away the employee's free choice of doctor—a valued right. Also, there is the threat of physician boycott to enforce the free choice principle.[11]

Since the employee—not the employer or union—chooses the provider, it seems reasonable to let him bear the costs or realize the savings associated with his choice. Labor and management could accomplish this by agreeing that the employer's contribution would be the same whichever health plan the employee chose.

The Health Maintenance Organization Act of 1973 requires employers to offer their employees the option of joining one group practice HMO and one individual practice HMO if such federally qualified organizations are operating in their area. But this small step in the right direction still leaves the health plan market segmented.

For example, some employers might offer one HMO in addition to their conventional insurance plan while others offer a different one, so that the HMOs rarely or never meet each other in direct competition. Each can become, say, 25% to 30% more efficient than its fee-for-service competitor and then settle into an equilibrium in which its costs rise at the same relative rate as in the fee-for-service sector.[12]

To create real competition, we need multiple choice for each consumer. Also, to make the competition fair, the law should require the employer contributions to be equal among health plans. And we need a tax law that does not subsidize the choice of more versus less costly health plans, and that gives the same tax benefit to premium payments for any qualified health plan as it gives to employer-provided plans. The way to do this is to replace today's exclusion of employer contributions from taxable income with a refundable tax credit usable only as a premium contribution to a qualified health plan.

In 1974, the Nixon administration proposed its "Comprehensive Health Insurance Plan" (CHIP), intended to achieve universal coverage by a three-part national program including mandated employer-employee health benefit programs meeting federal standards, a state-operated "assisted health care program" for low income families and high medical risks, and a federal program for the aged.

The Department of Health, Education and Welfare staff has recently developed a version called "Publicly Guaranteed Health Protection" (PGHP), which would require everyone in the country to purchase health insurance from a federal insurance plan, unless employment groups chose to "opt out" and purchase equivalent insurance—approved by the government—from a private company.[13] The first groups to opt out would be the low medical risk employment groups who could get lower premiums through experience rating. This would leave the high risks to be cared for by HMOs, which must practice community rating (i.e., same premium for same benefits for all groups), or by the federal plan. Thus PGHP would leave the market fragmented and strengthen today's barriers to competition.

Officials at HEW defend their reliance on the job-link on the basis that it is familiar and, therefore, easier to sell politically. The federal plan would have to be a "free choice of doctor" plan based on fee-for-service and cost reimbursement (the Expensive Lunch Club again). Lacking competition, PGHP would have to rely on direct price and capacity controls to limit spending. Thus it is an example of the way government intervention tends to freeze existing patterns and block desirable change.

Administrative complexity

Systems that try to build universal coverage on the employer-provided plan assume implicitly that everybody is a member of a "typical family" headed by one earner continuously employed at one full-

time job. But millions of people do not fit that model; for example, of roughly 20 million manufacturing workers, about 800,000 leave their jobs each month.[14] Their failure to fit raises a host of administrative complexities.

People who change jobs are often forced to change health insurance plans, with gaps in coverage, new starts on annual deductibles, and possible exclusions or waiting periods for preexisting medical conditions. If they belong to a closed panel plan such as a prepaid group practice, they are likely to be forced to change doctors when they change jobs, which means new starts on medical records and doctor-patient relationships.

In March 1977, of 47.5 million husband-wife families, about 27.2 million had two or more earners.[15] How would CHIP or PGHP deal with such families? Are they to be covered twice, through each spouse? In fact, in 1976, about 30 million people under 65 had duplicate hospital insurance.[16] That is wasteful, can produce excess insurance (collecting twice for the same bill), and creates a need for complex "coordination of benefit" rules. If one employer must provide the family's health plan, what are the rules for deciding which it will be? Rules can be devised, but they are likely to become extremely complex and have perverse and unforeseen effects.

The job-health insurance link adds greatly to administrative complexity in other ways. Each employer negotiates his own package with his insurance company, with a special mix of benefits, coinsurance schedules, and provisions concerning cash flow and experience rating. Many of the variations are idiosyncratic and add little or nothing to consumer choice or better health care at less cost. It would make more sense if each insurer offered one or two standard policies, a "high option" and a "low option" in each market area.

While marketing to employee groups instead of individuals certainly aided the spread of health insurance, the job-link adds greatly to the time and cost required to market a new health plan. A health plan must first sell the employer and/or union and meet their special requirements, and then sell the plan to the employees. New alternative delivery systems such as individual practice associations would have a far easier time getting started if they were merely required to satisfy the criteria of one regulatory agency and if they were then allowed to participate in a government-run open enrollment in which membership was made available to all persons in a market area.

A new role for labor & management

There is little to lose and much to gain by cutting today's link between jobs and health insurance. Instead of labor and management bargaining with each other over the details of comprehensive health benefits, they should join forces and use their considerable resources to create competition in the health services industry—as industrial companies have often done in other industries that supply them.

They could sponsor the creation of prepaid group practices, supply managerial talent and know-how, help them raise money for start-up investment, and sit on their boards. They could encourage the offering of prepaid groups, individual practice associations, health maintenance plans, and other cost-effective organized systems to their workers. They could organize good consumer information on the alternatives (not an easy task), and act as advocates for their employees in dealing with the health plans.

By creating an effective competitive system, labor and management could cut the albatross of increasingly costly health benefits from their necks and simplify employer-union relationships. They could agree, for example, on an employer health insurance contribution level that would pay for membership in a good comprehensive plan. The worker who wanted a more costly plan could then pay the extra cost with his own money. Employer contributions would no longer be tied to the costs generated by the most costly providers. Union leaders would then feel less management pressure for roll backs in health benefits, and they could concentrate on more meaningful benefit improvements. And it would let those employers who want to get out of the health insurance business do so.

Workers would benefit from breaking the job-link. They would have the assurance that their families could remain covered by the health plan of their choice, even if the breadwinner were to become disabled or die, be laid off, or change jobs. And health plan competition would give the employees the benefits of better service and quality of care at lower cost.

A company that can help reduce health care costs in its area can thereby lower its total employment costs and improve its competitive position relative to employers in other areas. A company that leads in creation of a cost-effective organized system of care can earn recognition as a benefactor to its workers and its community.

Creating a competitive system and making it work would reduce the need for government regulation and government spending on health care. Public spending on health care is now increasing about 12% per year. Heading off a fourfold increase in public spending on health care over the next 12 years surely deserves the high priority attention of business leaders.

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ALAIN C. ENTHOVEN
MARRINER S. ECCLES PROFESSOR
OF PUBLIC AND PRIVATE MANAGEMENT

May 15, 1979

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health and
the Environment
Interstate and Foreign Commerce Committee
United States House of Representatives
Washington D.C. 20515

Dear Henry:

At our dinner meeting on May 2, we discussed the Administration's proposal for Hospital Cost Containment. Because the circumstances were somewhat less than conducive to sustained discussion of such a complex issue, I thought it might be useful for you if I set down in writing my analysis of the proposal.

In criticizing the proposal, however, I do want to make clear that I agree that there is a serious problem of excessive cost growth. The status quo is unsatisfactory and untenable. The question is, do we try to improve things by what Charlie Schultze calls "the command and control techniques of government bureaucracy," or do we try to find a solution in rational economic incentives and fair competition in the private sector? I think the people in your disctrict would be best served by a situation in which they all had a fair multiple choice of Kaiser, Ross-Loos, Family Health Program, California Medical Group (to mention a few that are in operation in or near your district), plus a number of new entries such as the new HMO being started by the Lutheran Hospital Association.

1. The main reason hospital costs are increasing beyond the rate they should, why there is so much overinvestment, overutilization and waste, is the complex of perverse incentives inherent in our dominant financing system of fee-for-service for the doctor, cost-reimbursement for the hospital, and third-party intermediary insurance with premiums 100% paid by employers or government to protect the consumer from medical costs. The system rewards providers of care with more revenue for giving more and more costly care, whether or not more is beneficial to the patient. It leaves insured consumers with little or no incentive to choose a less costly health care financing or delivery plan. (Most aren't even given a choice.) There are many cost increasing incentives; there is virtually no reward for economy.

2. The main thing wrong with the proposed Hospital Cost Containment Act is that it does nothing to correct the perverse incentives. It does nothing to help basic reform of the financing and delivery system. It is a pure spending restraint that reflects no concern for health care quality, efficiency or equity. There is no good reason for supposing that its effects will be focused on reduction in waste as opposed to reduction on spending in general.

   On the contrary, it reinforces the cost-increasing incentives. In the face of such a control system, a hospital that thought it needed less than a 9.7% increase in revenues would be foolish to take less than 9.7%. To do so would diminish its "entitlement" to future increases. (Hospitals that think they need more than 9.7% will apply for exceptions.)

   The original Carter Administration proposal clearly would have rewarded the fat and punished the lean. (Imagine two hospitals doing exactly the same job, one for $1 million a year, the other for $2 million. An equal percentage increase allows the latter an increase of twice the dollar amount.) In recognition of this problem, this year's proposal includes an "efficiency/inefficiency bonus/penalty." Hospitals would be grouped by size and location into "peer groups." A hospital whose routine costs per day are between 90% and 100% of the group mean would be allowed an additional .5% annual growth. Hospitals between 100% and 115% of the group mean would be allowed no such bonus/penalty, etc.

   What is wrong with this? First, routine costs per day are a very poor proxy for "efficiency." Indeed, most of the factors responsible for the unjustified increase in costs such as overutilization and overinvestment in costly specialized facilities are excluded from it. The "Hospital Cost Containment Legislative Proposal" dated March 5, 1979 admits this in a footnote on page 26, but it also admits that "data do not yet exist for classifying hospitals by type of patients cared for," a necessary ingredient (in DHEW's view) for a more precise measure. The lack of a suitable efficiency measure is not the result of a lack of trying to find one. This problem will not be solved soon. Developing a reliable method for classifying case severity is one of the toughest, unsolved problems in health services research.

   A low hospital cost per case does not necessarily mean efficiency. It may reflect a system that hospitalizes too many people who are not really sick. The efficient HMOs in your district tend to have high hospital costs per case (but low costs per capita) because they only hospitalize people who really need it. Some areas may produce similar results without federally qualified HMOs (such as Minneapolis).

   Second, this system is sure to lead to endless complex arguments as to which hospitals are suitable peers. When Medicare tried a similar concept, a bunch of our local people had to fly to Washington to explain why they should be included in the adjacent county's market area, why they should be given credit for the severity of the cases they treated, etc., etc. There is nothing as unique as a hospital!

Third, the system would not work very fast to narrow the disparities. Consider two peer hospitals, one with a routine cost of $90 per day, the other with a routine cost of $115. If the former takes its allowed 10.2% for 5 years while the latter takes its allowed 9.7%, at the end of 5 years the costs will be, respectively, $146.27 and $182.70. The former will have gone from 78% of the latter to 80%, hardly an overwhelming "bonus."

Thus, the new Carter proposal still "rewards the fat and punishes the lean."

Moreover, controlling cost per admission introduces perverse incentives. Hospitals that wanted to beat the system could increase total spending faster while holding down cost per admission by e.g. admitting more low-cost cases that might otherwise have been cared for on an outpatient basis, or "cycling" patients in and out of the hospital, etc. Would-be regulators will reply that they will develop counter-measures to detect and punish such behavior. Inevitably, this will elicit counter-counter-measures, and so on.

At best, the system would, according to DHEW's claim, reduce hospital spending about 13% by 1984 (i.e. from $145.8 billion per year to $126.50) while locking the hospital industry into its present wasteful patterns.

3. Worse yet, this proposal and the need to extend the National Health Planning and Resources Development Act have tied up the key Congressional committees and diverted your valuable time and energy away from the issue of basic financing and delivery system reform.

4. DHEW's case for the effectiveness of Hospital Cost Containment in achieving even its modest stated objective is far from proved.

First, what is apparently the only systematic analysis of the experience under the Economic Stabilization Program from 1971 to 1974, by Dr. Paul Ginsberg, found the controls were not effective.

Second, the general history of economic regulation does not support the presumption that regulation reduces costs. Indeed, the present moves to deregulate transportation are based on the powerful evidence that regulation has raised costs. (Admittedly, the competitive alternative is readily apparent in the case of transportation. The feasibility of a competitive solution in health care is much less apparent--though I believe the evidence for it is strong.) The consensus among economists is that public utility-type regulation motivates overinvestment, just one of the phenomena DHEW decries. In all likelihood, state or federal rate regulation will evolve into total budget review, which is likely to mean

pretty much that each hospital next year gets X per cent more than this year, regardless of how good a job it does in serving patients or improving efficiency. How would these regulators avoid "capture" by the regulated--a fate all too common in other regulated industries? Why should regulators hold down the costs and take the political heat from outraged local interest groups? There would be no reward in it for them. If they do an effective job, the hospitals will bring pressure to bear on their legislators and the legislators will put the heat on the regulators. (I speak from eight years' experience reviewing and trying to hold down the Defense budget.)

Third, the Administration proposal is riddled with pass-throughs, exemptions and exceptions. Perhaps the worst is the pass-through of each hospital's non-supervisory wage increases, a large element of cost. This was purely a political concession to Labor, despite the fact that hospital workers are now paid more than people with equal education and experience doing similar jobs elsewhere. The Ways and Means Committee added more exceptions, and it seems inevitable that more will be added as the bill works its way through Congress.

Fourth, DHEW's table on page 18, intended to support the efficacy of mandatory state rate regulation, is manipulated data carefully selected out of context to prove a pre-determined point.

A more revealing table would compare each state's hospital spending per capita, in the year the mandatory controls program began, as a per cent of the national average, with the same number computed for 1977. This might tell us something about how the controls influenced each state's position relative to the national average. (Incidentally, I doubt DHEW's classifications of states with mandatory controls and dates the programs started. For example, AHA reports Colorado's law was enacted in 1978, not 1977, and my conversation with the Commissioner in February 1979 certainly did not leave me with the impression they were exercising mandatory controls. However, I will accept their states and dates for this table.)

Per Capita Hospital Spending As a Per Cent of National Average

State	Year Controls Started	Per Cent That Year	Per Cent in 1977
Conn.	1974	105	102
MD	1973	93	91
MA	1976	145	146
NJ	1971	88	92
NY	1969	148	135
RI	1971	114	109
WASH	1973	79	77
WISC	1975	93	95

This is hardly a picture of overwhelming success. Only 3 of the states "improved" by more than 2 percentage points, while 3 actually lost ground. The only large reduction was that of NY which was the second worst state in 1969 and remained in that position in 1977. (The most costly per capita state is Massachusetts.) The New York case involves some quite special circumstances that are unlikely to be reproduced in a national control program. The state was in a financial crisis to which Medicaid was a major contributor. New York's hospital costs per capita were practically the highest of any state. The political will to act was there. And New York's "drastic action" still left it second most costly in the nation. Even this drastic action apparently yielded a gain of 13 percentage points relative to the national average over an 8-year period. This hardly supports DHEW's claim of a 13% national reduction over a 5-year period. (To satisfy a Californian's curiosity, our state was 11 per cent above the national average in both 1969 and 1977.) From a statistical point of view, the New York experience might be explained as "regression toward the mean."

Fifth, some would-be regulators officials like to dismiss proposals aimed at fundamental delivery system reform on the basis that "it would take too long and we can't wait." Then they turn around and defend hospital rate regulation by states from charges of apparent ineffectiveness with the argument that "we have to give it time to get going."

5. What the proposal will do is to focus the attention of hospital administrators on beating the regulations. More and more of their time will have to be spent flying to Washington to plead for exceptions and reinterpretations. There will be growing complexity. The system will follow the path of the Medicare Law and Regulations and Internal Revenue Code and Regulations. More resources will be spent in lawsuits, intensified lobbying, etc. Overall efficiency will be reduced.

Finally, the Administration's case for regulation ignores the key issue, and therefore is a non sequitur. The issue is not whether or not costs are going up, and if they are we should regulate. The real issue is how best to correct the perverse incentives inherent in the present system: through more regulation, or through rational economic incentives and fair-market competition in the private sector. I hear you are interested in doing some hearings on competition. I think that is an excellent idea, and I would be pleased to cooperate in such a venture. The lead-off witness ought to be the Charles Schultze who wrote Public Use of Private Interest. That should be followed by presentations by people who have studied the results where there is competition. There is a lot going on around the country with respect to

competition of alternative delivery systems. A lot of it is going on around that beautiful Twenty-Fourth District in California. What needs to be done is to recognize it and to help it along.

With best wishes.

Sincerely,

Alain

Alain Enthoven

cc. The Honorable William Philip Gramm
The Honorable Gary A. Lee
The Honorable Barbara A. Mikulski
The Honorable David Stockman

bcc. John Iglehart
Paul Ellwood
Jim Vohs
Scott Fleming
Rose Wooden
Martin Feldstein
5/23 James Walker

STATEMENT BY ALAIN C. ENTHOVEN, Ph.D.
BEFORE THE SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES
IN SUPPORT OF HR4444

June 18, 1979

Mr Chairman:

Thank you very much for the privilege of appearing before this Committee. I am speaking as a private citizen, presenting my own views, not necessarily those of my employer, Stanford University, or Kaiser Foundation Health Plan, Inc., for whom I serve as an economic and financial advisor.

There is no need to elaborate on the fact that the costs of health care are increasing at a rate that cannot and should not be sustained. Medicare outlays alone are almost doubling every four years. The next doubling will be very painful for the federal budget.

Many factors contribute to the cost increase: general inflation (though health spending has grown at about twice

the general inflation rate), better insurance coverage, new technology, aging population, etc. But there has also been much overutilization of services, overinvestment and waste.

The main cause of unnecessary and unjustified increase in costs in the complex of perverse incentives inherent in our dominant financing system for health care: fee-for-service for the doctor, cost-reimbursement for the hospital, and third-party insurance to protect consumers, with premiums usually paid entirely or largely by employers or government. This system rewards providers of care with more revenue for giving more and more costly care, whether or not more is necessary or beneficial to the patient. It leaves insured consumers with little or no incentive to seek less costly health care financing or delivery plan. There are many cost-increasing incentives and virtually no reward for economy.

Medicare is based on fee-for-service and cost-reimbursement. It is the single most powerful engine of inflation in our health care economy.

The structure of the Medicare program is a major barrier to the growth of Health Maintenance Organizations and other organized systems of care that use resources economically. The reason for this is that Medicare systematically pays more on behalf of people who choose more costly systems of care. For example, in 1970 Medicare paid

$202 per capita (on a cost-reimbursement basis) on behalf of beneficiaries cared for by cost-effective Group Health Cooperative of Puget Sound, but paid $356, or 76 per cent more, on behalf of similar beneficiaries (i.e. an age-sex matched sample) in the same area who chose to get their care from the fee-for-service sector. On average, for six group practice prepayment plans around the country included in the study from which these data come, Medicare paid 36 per cent more on behalf of similar beneficiaries who chose fee-for-service. And it is in the nature of Medicare cost-reimbursement that this subsidy to fee-for-service will increase as the cost differential widens. Medicare beneficiaries could get their care from the less costly provider, but they were not allowed to keep for themselves the savings generated by that choice either in lower premiums or better benefits. Thus, the persons making the choice are deprived of the reward for choosing economically.

Mr. Chairman, we will never solve the problem of health care costs until we allow consumers and providers to realize for themselves the benefits generated by forming and joining systems of care that use resources economically.

There is a provision now, Section 1876 of the Social Security Act, for paying HMOs on a quasi per capita basis. The provision is based on retrospective cost-finding -- a method that is fundamentally inconsistent with the HMO's way of doing business. It is an attempt to force the HMO into

the mold of an insurance company. It is unbelievably complex. It is unfair to HMO beneficiaries. I have attached to my statement, for the record, a more detailed critique of Section 1876 (Attachment A). The main point is that in over six years of existence, it has failed to be put into operation to any appreciable extent.

Mr. Chairman, your new proposal would change all this It would allow the Medicare beneficiary to direct that 95 per cent of his or her Adjusted Average Per Capita Cost to Medicare (AAPCC), prospectively determined, be paid to the HMO of his or her choice as a fixed prospective premium contribution. The beneficiary, in turn, would pay the difference between that amount and the HMO's community rate, adjusted for the greater utilization of the Medicare beneficiary group. This would mean that virtually all the beneficiary's medical care costs would be predictable in advance. By joining an HMO under this plan, the beneficiary would be relieved of the uncertainty about expenses he faces today and the complexity of claims forms. It would mean that the beneficiary who chooses a HMO that does a good job of controlling cost would get the benefit of that economizing choice in the form of better benefits and lower cost. Your bill would relieve the HMO of uncertainties regarding its revenue. It would allow the HMO to plan on a sure projection of per capita revenue, one of the keys to HMO success today. And it would free the HMOs of the

totally useless wasteful burden of retrospective cost finding now inflicted on them by the Medicare Program.

Your bill is an important first step toward the ultimate reform of the entire Medicare program. Eventually, today's Medicare Program, based on fee-for-service and cost-reimbursement, with all its incredible complexities, should be replaced by a payment system based on fixed prospective per capita premium subsidies (based on actuarial category, like the AAPCC), and fair economic competition in the private sector, among private health plans meeting reasonable Federal performance standards. In other words, as of a certain date, new beneficiaries ought to be covered by a new system modelled on the Federal Employees Health Benefits Program (FEHBP) The savings in paper work alone would be immense.

The FEHBP now covers some 10.5 million people. It has been in successful operation since 1960. It offers employees a multiple choice of competing alternative private plans, and a fixed dollar contribution toward the plan of their choice.

A comparison of the FEHBP and medicare illustrates an important point. The medicare law is 102 pages long; the regulations fill 400 pages of fine print. The FEHBP law is eight pages long; the regulations are 16 pages long A recent study showed that administrative cost per claim

processed in the FEHBP was 22 per cent below that in medicare. Thus we have a large-scale practical example to show that competitive systems of the type I am recommending are simple and workable.

If this reform is such a good idea, why hasn't it happened before? What are the arguments against it?

In general, the answer is that most people have been misled by certain false premises which have dominated thinking on this subject. The false ideas and my answer to them are as follows.

1. Many people believe that fee-for-service and cost-reimbursement are the only right and proper way to pay the doctor and the hospital.

These payment methods are, of course, very advantageous to providers, from an economic point of view. But they are not the only valid or successful payment methods. Health Maintenance Organizations serve millions of people and have been in successful operation for decades. Today about half the federal and state employees in Kaiser's Northern California service area belong to Kaiser. My own employer, Stanford University, offers its employees a multiple choice and, in the case of families, a fixed dollar contribution toward the plan of their choice. Well over half the

Stanford families choose either Kaiser or the Palo Alto Clinic prepaid plan in preference to the ordinary third party insured plan.

There is nothing experimental, risky, or second-class, about paying for care on a fixed prospective per capita basis.

2. Many people believe that more medical care is necessarily better than less. And many believe that you cannot cut cost without cutting the quality of care. Therefore, a system that hospitalizes people much less or does less surgery must be suspect.

Both these notions are false. Much medical care is useless; that is, it has no effect on health outcome. Some care is harmful.

About a year ago, I gave the annual Shattuck Lecture to the Massachusetts Medical Society on the subject "Cutting Cost Without Cutting the Quality of Care." It was published in the New England Journal of Medicine. I have attached a copy for the record (Attachment B) There is no question but that, compared to today's wasteful patterns, costs could be cut substantially while improving the quality of care

3. A third argument one hears is that your bill would be a "windfall for Kaiser and other large HMOs."

That claim is not true. Under your proposal, the Medicare beneficiary, not the HMO, would get the benefit of the savings. The HMO would be required to pass the savings on to the beneficiary.

Provided they are efficient enough to generate a surplus, the HMOs would be allowed to retain some of that surplus to finance growth. If you want efficient HMOs to grow, you have to allow them to generate capital to help finance facilities and working capital. It is as simple as that. Without adequate capital generation, they cannot grow.

Is it a windfall for the beneficiaries already members of HMOs? No. It is simply a case of treating them equally (or 95 per cent of equally) and allowing them to realize the benefit from making an economical choice.

4. The next argument advanced against this proposal is a suggestion that somehow this would lead to a reenactment of the prepaid health plan (PHP) scandal of Southern California in the early 1970's.

Nothing could be further from the truth. The cause of the PHP scandal was a state government that was trying to cut costs in a hurry, that accepted unrealistically low bids for Medicaid contracts from companies or health plans created for the purpose, health plans without established reputations, and enrollment practices that interfered with the free choice of the beneficiaries The scandal arose from the state government's politically motivated purchasing policies, not from the nature of HMOs.

What we are talking about under your bill, Mr Chairman, is the opposite of these conditions. We are talking about giving individuals the freedom to choose for themselves. Using some of their own money, they would be able to choose to join established health care organizations that have proved themselves in the private, employed market And they could join at dues rates that are realistically based on the experience of those organizations in that market. We are not talking about cutting costs in a hurry We are talking about setting in motion a long term process of fundamental reform of the structure of the health care delivery system. And I trust that we are talking about enrollment procedures that respect the individual's freedom of choice and help him to choose wisely

5. Finally, one hears that under proposals like yours, the government won't be auditing the costs of the HMOs, so you won't be able to know whether the government is getting its money's worth.

First, the existing auditing approach is obviously not doing a very good job of protecting the taxpayer's dollar in Medicare. The Inspector General of HEW estimated that in Fiscal 1977 there were $2.2 billion of fraud, waste and abuse in Medicare alone. So the case for inflicting these audit procedures on HMOs cannot be very compelling.

Second, under your proposal, the HMOs would charge an Adjusted Community Rate, a price tested in their competitive private markets. Thus, the question of "getting their money's worth" would be tested in the best possible way, that is by the judgment of satisfied customers who were given a choice.

In a sense, your proposal would move us toward a system like the FEHBP, a fair competitive market in which the buyers are putting in some of their own money and are therefore motivated to get value for it.

Finally, the government's contribution is capped at [illegible] per cent of AAPCC. It is a bargain for the taxpayer.

Mr. Chairman, this completes my statement

ATTACHMENT #1

Excerpts from

"Prepaid Group Practice and National Health Policy"

Alain C. Enthoven, Ph.D.

Keynote Address, 1976 Group Health Institute
Denver, Colorado

June, 13-16, 1979

On the negative side, Medicare seems fully committed to the fee-for-service and cost-reimbursement approach, even where Prepaid Group Practices would serve Medicare beneficiaries for fixed prospective capitation payments.[10] I believe

[10] More recently, Medicare has moved to reimbursement below full cost in some cases, while adhering to cost-related as opposed to fixed prospective capitation payments of the type used in the FEHBP.

there is widespread agreement that Medicare is one of the main contributors to medical care cost inflation.

Because of its insistence on reimbursement related to cost, Medicare is systematically biased in favor of more costly systems of care. This grows out of a dilemma. People spend more on health services (per capita) in part because of greater need, and in part because they choose more costly ways of meeting the same need. A perfectly reasonable principle of social insurance is to pay more on behalf of people who need more. But in health care services, needs have been equated to costs, because we have no other usable standard of medical need. This unfortunately means paying more on behalf of people who choose more costly forms of care. The Corbin and Krute study I mentioned earlier provides powerful evidence in support of this. Medicare pays 20 percent more on behalf of beneficiaries who elect fee-for-service than on behalf of their neighbors who select the five hospital-based Prepaid Group Practice plans studied. The Government does not help your business to grow and prosper by paying a 20 percent subsidy to your competitors. A public policy that pays more on behalf of people who choose more costly systems of care is a contributor to health care cost inflation.[11]

Ironically, there seemed to be a very clear understanding of the effects and importance of financial incentives for health care costs in the Congress when it was developing the Social Security Amendments of 1972. For example, the House Ways and Means Committee Report of May 1971 included these words:

> "*Payments to health maintenance organizations.* Under present law, organizations providing comprehensive health services on a per capita prepayment basis cannot be reimbursed by Medicare through a single capitation payment encompassing all covered services provided to Medicare enrollees. Instead, Medicare reimbursement to group practice prepayment plans, whether it is made on a cost or charge basis, must be related to the costs to the organization of providing specific services to beneficiaries, so that the financial incentives that such organizations have in their regular business to keep costs low and to control utilization of services do not carry over to their relationship with Medicare.
>
> "Your committee believes that a serious problem in the present approach to payment for services in the health field, either by private patients, private insurance, or the Government, is that, in effect, payment is made to the provider for each individual service performed, so that other things being equal, there is an economic incentive on the part of those who make the decisions on what services are needed to provide more services, services that may not be essential, and even unnecessary services. A second major problem is that, ordinarily, the individual must largely find his own way among various types and levels of services with only partial help from a single hospital, a nursing home, a home health agency, various specialists, and so on. No one takes responsibility, in a large proportion of the cases, for determining the appropriate level of care in total and for seeing that such care, but no more, is supplied. The pattern of operation of health maintenance organizations that provide services on a per capita prepayment basis lends itself to a solution of both these problems with respect to the care of individuals enrolled with them. Because the organization receives a fixed annual payment from enrollees regardless of the volume of services rendered, there is a financial incentive to control costs and to provide only the least expensive service that is appropriate and adequate for the enrollee's needs. Moreover, such organizations take responsibility for deciding which services the patient should receive and then seeing that those are the services he gets.
>
> "Your committee believes it would be desirable for Medicare to relate itself to health maintenance organizations in a way that conforms more nearly to their usual way of doing business. The objective is to provide, in the case of Medicare beneficiaries, the same kind of financial incentives that health maintenance organizations have with respect to their other enrollees."[12]

The Senate Committee on Finance used similar language.[13]

[11] The data in Actuarial Note 88, referred to in footnote 4, above, imply that the difference is not 20 percent, but 37 percent (i.e. 1/.73=1.37).

[12] *Social Security Amendments of 1971*, Report of the Committee on Ways and Means on H.R. 1, May 26, 1971, pp. 89-90.

[13] *Senate Report 92-1230*, Report of the Committee on Finance to Accompany H.R. 1, the Social Security Amendments of 1972.

But Section 226 of the Social Security Amendments of 1972 creating Section 1876 governing payments to health maintenance organizations failed to achieve these commendable purposes. The Section authorizes the Secretary of HEW to contract with HMOs for a per capita rate of payment based on the adjusted average per capita cost of all Medicare beneficiaries in the community, other than the HMO's own members, and the HMO's own per capita incurred cost. But this complex provision does not really get away from the cost reimbursement principle, and it does not offer the incentives that would be provided by a fixed prospective per capita payment. First, if the HMO's incurred costs are between 80 and 100 percent of the average per capita cost, it gets more revenue, though less net income, by incurring more cost. This provides a weaker incentive for cost reduction than would be provided by a fixed prospective per capita payment with the HMO being allowed to keep all the savings. If the HMO's incurred costs are below 80 percent of the adjusted average per capita cost, the Government recaptures all of the saving in excess of 20 percent, thus depriving the HMO of any incentive to reduce costs further as far as Medicare beneficiaries are concerned. This is important because a recent analysis of the Prepaid Group Practices studied by Corbin and Krute found that the incurred costs of all five hospital-based Prepaid Group Practice plans were less than 80 percent of the adjusted average per capita cost in both 1969 and 1970. In fact, their 1970 incurred costs averaged 73 percent of the adjusted average. (The non-hospital-based PGP considered in the analysis had incurred costs of 85 and 91.8 percent of the adjusted average in 1969 and 1970 respectively.) HMOs ought to be allowed to retain further savings so that they can reduce premiums or provide additional benefits not covered by Medicare for their Medicare beneficiary members. Moreover, HMOs can have significant capital costs not considered reimbursable under Medicare to which they need to apply their "savings."

Furthermore, the formula is not symmetrical with respect to risks. If the "risk-basis" HMO's costs are below the adjusted average, the Government shares in the savings, but if the HMO's costs exceed the average, the HMO must absorb the entire difference (though there is a provision whereby losses can be carried forward and offset against future savings). And the Section, in effect, imposes risks on HMOs. For example, the proposed regulations published in the summer of 1975 say: "Upon request by the HMO, the Secretary makes a preliminary estimate of the adjusted average per capita cost for the current year and/or the following year, . . . Such a preliminary estimate . . . is furnished to the HMO with the understanding that the adjusted average per capita cost computed at the time of final settlement may be significantly different from the estimate." This means that if the Secretary makes a mistake, the HMO has to suffer the consequences. The HMO has no assurance that the factors on which it based its plan will not be changed in the retrospective adjustment. The law should be changed (or interpreted) so that the Secretary can commit himself in advance to costs and actuarial factors based on past experience, so that the retrospective adjustment would reflect only changes in the HMO's age-sex composition and the general price level, factors which the HMO can keep track of and on the basis of which it can adjust its costs.

Furthermore, the law as it stands still requires the HMO to do a great deal of otherwise useless cost finding and bookkeeping. And it requires the Government to do a great deal of auditing and other costly administrative procedures.

The incentives could be greatly improved, the risks reduced, and the administrative costs to both the Government and the HMO greatly reduced by changing the law so that the Secretary of HEW could contract with HMOs to pay them, on behalf of Medicare beneficiaries who join them, the adjusted average per capita cost to Medicare, prospectively determined, and without any retrospective adjustment or recapture of "savings."

The CHAIRMAN. As our next witness we are pleased to have the senior Senator from Massachusetts, the Honorable Edward M. Kennedy. He will testify on his proposal and in addition he will be accompanied by some distinguished witnesses in the health area.

Senator, this is a small hearing room. Our committee selected this room at the time when I was a junior member. If I had been chairman at the time we would have a more commodious room. If you have some of your associates out in the hall, I will be happy to make room for them, Senator.

As I understand, we are piping the sound out into room 1202 for those who are not able to be inside. I am sorry we do not have closed circuit television.

I wanted your charts placed somewhere so the audience can see them as well as those in the media. I would hope the staff would try to arrange it so if you want to speak from your charts, you could have a mike available to you.

STATEMENT OF HON. EDWARD M. KENNEDY, A SENATOR IN CONGRESS FROM MASSACHUSETTS

Senator KENNEDY. Thank you very much, Mr. Chairman and the members of the committee.

If it is permissible by the committee, I would like to make a rather brief opening comment then move to a chart presentation which I think will take 25 or 30 minutes. Then perhaps we can have brief comments from some of the members of the Coalition for National Health Insurance and then I'll be pleased to respond to questions.

I will first introduce the members that are with us here today. I think their faces are familiar and their organizations well known. They have appeared before your committee at different times. Bill Hutton, executive director of the National Council of Senior Citizens; Althea Simmons representing the NAACP; Ken Young the director of the department of legislation for AFL–CIO; Howard Paster who is the director of legislation for the United Auto Workers; Bob Barrie of the health task force of the Interreligious Staff Council; Rashi Fein from the Center for Community Health and Medical Care at Harvard; Max Fine the executive director of the Committee for National Health Insurance; and Mildred Jeffrey the national chair, National Women's Political Caucus.

Mr. Chairman, I appreciate the invitation to appear before the Senate Finance Committee today along with members of the Coalition for National Health Insurance. I think we all agree that the time has come for the Congress to act—to remedy the increasingly serious deficiencies and inequities in our health care system. We all share the common goal of providing high-quality health care to the American people within a structure that controls runaway medical costs. We may disagree on the steps to be taken; we may disagree on the dimensions of the problem; but we all agree that what we have today is flawed, and something needs to be done, and done soon.

Whatever action is taken—whether it be the enactment of catastrophic health insurance or comprehensive health insurance, whether it has a first-year cost of 5 billion or a first-year cost of $20 billion,

will be doomed to failure if it doesn't include firm cost controls and needed system reforms. The time is long past when we can add benefits now, no matter how needed they are, and worry about costs later. Business as usual is a prescription for national bankruptcy. Even catastrophic health insurance would be too inflationary if enacted without cost controls. This committee knows the problems of runaway costs, and the fallibilities of cost projections, better than most. You have written some of the most important, most humanitarian programs ever enacted into law. They have made an enormous difference in the lives of millions of Americans. But those very programs are now becoming victims of runaway costs. Medicare costs the Federal Government today more than double the costs projected by this committee for 1990! Medicaid costs have similarly outstripped estimates. These charts tell the story.

I would hope that any legislation reported by this committee is responsive to the following questions:

(1) Does it have adequate provisions to control runaway costs? Does it budget hospital costs and require negotiated fee schedules for physicians?

(2) Does it treat all Americans fairly—is it a single-class system of care, blind to age, sex, or income?

(3) Does it foster competition in the health care sector? Does it provide incentives for alternative delivery systems, such as HMO's? Does it allow insurers to compete on the basis of administrative efficiency, and focus the competition on innovative ways to control costs?

(4) Does it promote needed system reforms? Does it provide incentives, through reimbursement reforms, for the practice of primary care? Does it pay for needed preventive services?

Mr. Chairman, any proposal responsive to these questions would be a step in the right direction, whether it provides $1 billion worth of benefits or $20 billion. Any proposal failing to address these questions would be a step backwards, a step not worth taking, a step that would do more harm than good in the long run.

The Health Care for All Americans Act, which I will describe in a few minutes, is responsive to these questions. It provides universal, comprehensive health insurance to all Americans under a structure that controls costs, promotes system reforms, and fosters competition. It is not an all-at-once proposal. It would be phased in over many years. The progression from one phase to the next could, if the committee desired, be linked to the success of each prior phase in meeting its objectives. But it would guarantee to all Americans that, at some point in the future, they and their children would be fully covered for comprehensive benefits. It is not identical to the plan in effect in any other nation. It is unique. It does have similarities to the Canadian system. We have tried to learn from the experience of our Canadian neighbors. Their program, which is universal and comprehensive, has dispelled some myths about this approach. The frank analysis of the strengths and weaknesses of that system by Professors Eugene Vayda, Robert G. Evans, and William R. Mindell show:

(1) Costs have been controlled as a percent of GNP, while giving everyone comprehensive benefits;

(2) The enactment of the plan did not place significant new demands on the system;

(3) Quality of care has remained high; and
(4) Consumer satisfaction is extraordinary.

I commend this paper to you.

Mr. Chairman, the Health Care for All Americans Act is a new proposal, with some new ideas. It has not yet been the subject of public hearings. The President's proposal is new. It has new ideas. It has never been the subject of public hearings. I know this committee will want the opportunity to review these and other new proposals in depth in order to evaluate their relative merits. I would be delighted to make myself and my staff available to the committee during that process.

Mr. Chairman, if I may, I would like to review for the committee some data which demonstrates the pattern of increasing health care costs over the last two decades.

Health spending has increased dramatically since 1963 when we spent 5.6 percent of GNP on health, in 1973 we spent 7.7 percent, and now in 1979 we will spend 9.1 percent of the gross national product—$206 billion. This is the national increase in the total care. By 1984 we will be spending $368 billion or 10.2 percent of GNP on health. If no changes are made in the current system of health care we are going to bankrupt the American people.

I will mention briefly the difficulties that we have seen and the lessons we should have learned from medicare and medicaid including the problems of estimating what the costs would be. These programs did not have cost controls or system change. The Finance Committee in 1965 made annual projection on the costs of the program through 1976, and then every 5 years for 1980, 1985, and 1990.

The Finance Committee estimate for medicare part A in 1990 was to be $9 billion. Already in 1979 costs are double that. There has been some modification in terms of the benefits but I think your staff would generally agree that does not account for the increases.

This chart illustrates the increased costs over the estimate of this program.

[The material referred to follows:]

[In billions of dollars]

Year	Estimate	Actual
1966	1.065	
1967	2.358	2.5
1968	2.574	3.7
1969	2.807	4.7
1970	3.060	4.8
1971	3.293	5.5
1972	3.535	6.2
1973	3.688	6.6
1974	4.053	7.8
1975	4.330	10.4
1976		12.3
1977		15.1
1978		17.8
1979		
1980	5.680	
1985	7.341	
1990	9.414	

Senator KENNEDY. The point being if we add more benefits under a catastrophic program or any other program, without effectiv cost

controls and system changes, I think we will see the same kind of escalations and inflation as we have seen with medicare.

The situation is similar under medicaid. The actual costs have doubled over the estimates. This chart again illustrates the increases of that program.

[The material referred to follows:]

[In billions of dollars]

Year	Estimate	Actual
1968	1.391	1.837
1969	1.584	2.275
1970	1.611	2.617
1971	1.653	3.374
1972	1.713	4.360
1977		9.713

Senator KENNEDY. What I have in this particular chart is the Federal and non-Federal expenditures with and without NHI. This does not include noncovered benefits.

Today we are spending $196 billion. In 1983 Federal and non-Federal costs with national health insurance and cost containment our total program would be $301 billion. Without any kind of additional benefit—just current paring the cost would be $339 billion.

The point that I am making—and our coalition, particularly the elderly feel strongly on this is that if we add benefits without cost controls or system change, we, because of cost increases soon find out they may be added today but effectively they disappear tomorrow.

Under our Health Care for All Americans Act, every American is automatically eligible for benefits. When you move from a total public system into a private system there are certain individuals who could fall through the gaps. We apply our program to every American for the whole range of broad health services which I will illustrate later. Premiums are related to income. This is a very key point.

The premiums themselves are related to the income of the individuals. They have the complete discretion whether to enroll in the HMO or an insurer of their choice.

The range of benefits are those which would be generally understood as necessary. There is a broad package but I believe it is an essential package. This kind of program is only available to 13 percent of the American people at this time. It includes the hospital, physician services, laboratory, unlimited hospital care, X-rays, and ambulance services.

It includes a mechanism to insure preventive services. Under a total program phased in, there would not be the cost sharing.

I would like to leave for the benefit of the committee and the staff the two different studies that have been done on cost sharing. For example, in the various provinces of Canada which have had cost sharing and noncost sharing, you will find that the utilization of benefits is virtually the same.

In the Harvard Community Health Plan there is a $1 a visit cost for some benefit. We do not find an overutilization of the program. I would like to submit some additional information on that point.

[The material referred to follows:]

Universal Health Insurance in Canada: History, Problems, Trends

(By Eugene Vayda, M.D.,[1] Robert G. Evans, Ph. D.,[2] and William R. Mindell, M.P.H.[3])

ABSTRACT

This paper describes the universal health insurance program in Canada and identifies the historical events and social values leading to its adoption. Universal hospital insurace was adopted in 1958, 10 years before medical insurance; as a result hospital based patterns of practice were solidified. For both hospital and medical care insurance cost sharing was the mechanism employed by the Federal Government to influence the provinces to adopt relatively uniform universal plans.

From 1951 to 1971 there were rapid rises in health are expenditures to 7.3 percent of the gross national product (GNP). Since 1971 the percent of GNP spent on health care decreased and stabilized at about 6.9 percent. In the United States the GNP share for health care is 8.6 percent. Hospital use also increased rapidly in Canada to 1970 but appears to have stabilized and decreased slightly in the 1970's. Physician incomes rose rapidly before 1971, but since then the increases have slowed and relative incomes of physicians have fallen.

Although the percent of GNP spent for health care has levelled, there are still substantial annual increases in expenditures which are paid for by Government. As a result, cost containment has become a major Federal and Provincial goal. Most recently, greater taxing authority has been shifted from the Federal Government to the provinces where the authority for cost containment resides. The Lalonde report, despite its focus on individual responsibility for health, grew largely from concerns regarding escalating health care costs. In the long term, the Provinces, to contain costs, are moving in the direction of regionalization, decentralization and greater coordination. In the short term, the provinces have limited hospital budgetary increases to percentages less than the rate of inflation, effectively reducing hospital budgets.

On balance cost constraints may be long overdue. Planning cannot proceed without finite fiscal limits. It does not appear that the health of Canadians will be adversely affected, nor essential benefits curtailed by present budgetary restrictions or reorganization.

The National Health Insurance controversy in the United States has waxed and waned during this century. Since U.S. medicare was adopted in 1965 pressures for universal coverage have mounted, spurred largely by increases in health care costs. The universal health insurance controversy has stuggled with if, what, when and how. Discussions have frequently included analyses of other countries and their health insurance plans. Generally, when the eastern European countries and England and Sweden are dismissed for political reasons, attention turns and returns to Canada.

To understand the "national" health insurance program in Canada some knowledge of geography, history, and political structure is required. Canada is a federation of 10 Provinces and two northern Territories covering an area of over 3.5 million square miles. Its 1971 population was almost 22 million, and over 75 percent lived in urban areas. Population density was 6 persons per square mile, about 10 in the Provinces but only about 0.05 in the Territories. Over 80 percent of the population live within 100 miles of the northern U.S. border. Canada contains two peoples with distinct cultures and populations, French and English, as well as native minority groups of Eskimo and Indians and immigrant groups from China, Japan, Europe, Asia, and the Caribbean Islands. Cultural differences are supported and preserved resulting in what Porter has called "The Vertical Mosaic." Canada has a cultural system based

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on humanitarianism and investment in human capital, although in recent years these values have been stressed by the economic problems common to western civilization: Inflation, unemployment, and restricted economic growth.

1. THE HISTORY OF THE DEVELOPMENT OF CANADIAN UNIVERSAL HEALTH INSURANCE

Government in Canada is by means of a parliamentary system based on the British model. Although Canada and the United States both have Federal Governments, Canada's is a relatively loose confederation of its 10 Provinces and 2 Territories, while the U.S. has a strong central government. The 50 states, generally, have less authority than the Canadian Provinces. In many domains the provincial governments have greater power and authority than the Government of Canada. Once such area is health. The British North American Act of 1867, which is the Canadian constitution, fixed responsibility for health care at the provincial level; the Provinces were given exclusive powers to legislate in matters dealing with:

"The establishment, maintenance and management of hospitals, asylums, charities and other eleemosynary institutions in and for the province, other than marine hospitals."

The Federal authority was limited to residual areas and included quarantine, and health services for Indians, Inuit, and aliens. Despite these limitations, the Federal Government, 111 years after Confederation, now spends 10 percent of its total budget for health care; mainly as payments to the Provinces to finance their provincial health care schemes. These payments give the Federal Government considerable leverage in determining how health care dollars are spent but no control over the amounts spent. The Federal Government also influences the direction of medical research because it finances most medical and health care research in Canada.

Universal health insurance in Canada was first proposed in 1919. Over the next two and one half decades industry sponsored health care plans and voluntary medical and hospital service prepayment plans were developed, but by 1945, there were still numerous gaps in coverage—both in numbers of people covered and in benefits for the insured.

Following the depression and the second world war, a Federal-Provincial Conference was convened in 1945 to develop programs of social reform which had been delayed by the economic deprivations of the depression and the war. The Federal-Provincial Conference on Post War Reconstruction proposed universal health insurance with federal-provincial cost sharing. The Conference also produced a model draft health care bill for the provinces which provided for health regions, pre-selection of family physicians who would be responsible for patient "lists" and paid by capitation. They would also be paid additional sums to serve as medical health officers providing preventive services. Provincial administration was to be under the direction of a commission representing both consumers and the profession. Regional medical officers would be appointed to supervise the distribution and quality of services which would be based, wherever possible, on health centres.

Despite favourable public opinion and the approval of key professional groups, the 1945 health insurance proposals were not enacted. Health, as defined in Sections 91 and 92 of the British North America Act, is a provincial responsibility and the new proposals were regarded as threats to provincial autonomy. However, planning and hospital construction grants were made available and the concept of federal-provincial cost sharing for health services was accepted in principle. By 1955, five of the ten provinces had universal hospital insurance plans which rescued their hospitals financially and proved popular politically. The five provinces pressed the federal government to honour its 1945 hospital insurance cost sharing offer. In 1958 the Hospital and Diagnostic Services Act was enacted; by 1961 it had been adopted by all the provinces.

This major social benefit led to some of the present financial problems. Services were insured and eligible for 50 percent federal cost sharing only when carried out in the hospital. There were no incentives to provide services in less expensive sites. As a result, many procedures that could have been done on an out patient basis were provided in the hospital and hospital based patterns of practice were solidified.

Hospital construction which began before universal insurance continued after its enactment. Bed availability is associated with bed use. Whether provinces have

four or seven acute care hospital beds per 1000, their occupancy rates remain about 80 percent. Between 1961 and 1971 hospital beds in Canada increased twice as rapidly as population growth (33 percent versus 18 percent), but bed occupancy remained at about 80 percent. By 1971, Canada had 23 percent more beds than the U.S. and used 30 percent more hospital bed days.

Universal hospital insurance in Canada provided payment to hospitals, but did not mandate an organizational framework to deal with problems of efficiency or dupliction of services. The historical relationships between physicians and hospitals were also not disturbed.

Universal medical care insurance was adopted 10 years after hospital insurance. By then a hospital intensive system was well established. The Medical Care Act of 1968, like the Hospital and Diagnostic Services Act which preceded it, was an instrument of social benefit, because it removed financial barriers to medical services. However, the Act allowed federal provincial cost sharing only for services provided by physicians. As well, the Medical Care Act, like the Hospital Act, authorized payment for services but failed to mandate reorganization, although reorganization had been recommended by the 1964 Royal Commission on Health Services which proposed universal medical insurance.

That same Royal Commission, in addition to recommending universal medical care insurance, also predicted a shortage of physicians and other health professionals and recommended increases in the output of existing medical and health professional schools and the development of new schools. These recommendations were adopted and medical school output increased 70 percent over the next ten years. However, the projections on which the Royal Commission based its recommendations were not realized. Population grew less than expected, emmigration of Canadian physicians decreased and immigration of non-Canadian physicians increased sharply. The Royal Commission projections were based on 1961 utilization patterns and failed to anticipate changes in technology and productivity. The physician to population ratio fell to 1:600 from 1:850 as the stock of physicians rose; other health professional groups also increased. However, by 1973 nursing personnel and physicians still made up about 78 percent of all health care workers.

The number of physicians is one of the factors associated with the volume of health care services. More surgeons are correlated with higher discretionary surgical rates and more physicians with an increased volume of medical services, just as more hospital beds are associated with greater bed use. In the short term, insurance may also be associated with increased utilization. In Nova Scotia, universal medical insurance increased coverage from 63 percent to more than 95 percent of the population; that province's elective surgery rate rose 25 percent in the first post insurance year although beds and surgeons increased only 4 percent.

To qualify for federal-provincial cost sharing for hospital and medical services the provinces had to meet certain terms of reference:

(1) Universal coverage on uniform terms and conditions (95 percent of the population, without exclusions, had to be covered within two years of provincial adoption of the plan).

(2) Portability of benefits from province to province.

(3) Insurance of all medically necessary services.

(4) A publically administered non-profit program.

Federal provincial cost sharing was developed as a stimulus to the provinces to adopt universal health insurance programs. As well, it served as a means of income redistribution between the wealthier and poorer provinces. For hospital services each province is paid 25 percent of its actual per capita costs plus 25 percent of the national average per capita cost multiplied by the province's population. For medical insurance each province receives 50 percent of the average national per capita medical care expenditure multiplied by its population. As a result, the wealthier provinces which spend more receive less than 50 percent of their costs and the poorer provinces which spend less receive more than 50 percent of their costs. The differentials are especially apparent for medical care cost sharing. In 1973–74 Ontario received 49.4 percent of its hospital costs and 44.8 percent of its medical care costs. At the other end of the spectrum, Newfoundland received 57.6 percent of its hospital and 81.5 percent of its medical care costs. The federal contributions are drawn from general tax revenues; the provinces use premiums, special taxes and general tax revenues.

For the hospital act, public administration was mandated from the start, but medical insurance allowed a brief transition period during which private health

insurance companies continued to operate. At present private health insurance plays no part in the universal plan; it covers only supplemental benefits.

Initially, most provinces had separate medical care and hospital commissions which were quasi public agencies, separate from government. In recent years, many provincial hospital and medical care commissions have merged and come under direct control of their provincial ministries of health.

As a result of the universal program virtually every Canadian has comprehensive medical and hospital insurance. There are no deductibles or co-insurance fees. Hosptials are paid on the basis of negotiated budgets. Physicians are paid on a fee for service basis with negotiated fee schedules, not usual and customary charges. In 1974 over 90 percent of Canadian physicians were "opted into" the provincial Plans. Although there are provincial differences and exceptions, generally "opted into" means that the physician accepts some percentage of the negotiated fee as full payment, does not extra bill and is paid directly by the provincial government and not by the patient. The universal insurance program has enjoyed considerable consumer popularity. It is, however, an insurance program which pays bills, not a National Health Care Program.

2. CANADIAN HEALTH CARE EXPENDITURE AND SOME U.S. COMPARISONS

Increased expenditures, additional health manpower and facilities and universal insurance have reduced regional and socio-economic disparities in the use of health care services. However, the health benefits are not as readily apparent. A newborn male in 1931 had a life expectancy of 60 years; by 1971 this had risen to almost 70 years. On the other hand, a 40 year old male had a life expectancy of 72 years in 1931 and 73 years in 1971. Thus, contrary to common belief, people are not living longer; rather, more are surviving the first year of life. Infant mortality rates have decreased substantially in the last 40 years, but much of the improvement in infant mortality can be attributed to better living conditions (food, housing sanitation) as well as to more health care. Canada has a world ranking of eighth in composite mortality rates. However, England and Wales which spends a third as much as Canada ranks sixth. On the other hand, the United States which spends about 20 percent more than Canada ranks twentieth.

In the analysis of health care expenditures in Canada, and their comparison with U.S. experiences, the year 1971 marked a significant watershed. For the previous two decades health expenditures in both countries were rising rapidly, both in absolute terms and as a percentage of G.N.P. U.S. spending rose from $78.35 per capita and 4.6 percent of G.N.P. in 1950, to $141.63 and 5.2 percent in 1960, and $368.25 and 7.6 percent in 1971. Canadian data in the 1950's are less complete, but showed a growth in the less inclusive Personal Health Care component from 3.5 percent of personal income in 1953 to 4.9 percent in 1960. In 1960 a broader based health expenditure measure made up 5.5 percent of G.N.P. ($118.01 per capita) and by 1971 this had risen to 7.3 percent of G.N.P. ($318.90 per capita). U.S. and Canadian cost increases were thus roughly parallel, with Canada's costs advancing somewhat more rapidly during the 1950's and the U.S. speeding up in the 1960's. Comparisons of per capita health care expenditures across countries are not very meaningful unles carefully adjusted for different price levels and monetary exchange rates, but the share of G.N.P. ratios suggest that by 1971 both countries were devoting approximately equal shares of their national resources to health care.

Since 1971 breaks in trend have occurred on both sides of the border, with the sharpest break in Canada. There, the increases in nominal G.N.P. resulting from the inflation of the early 1970s were not fully reflected in health spending, which drifted off to 7.1 percent of G.N.P. in 1972, dropped sharply to 6.7 percent, 6.6 percent, and increased to 6.9 percent in 1975. Estimates for 1976 are not yet available but are not expected to be very different. In the U.S. expenditure levels as a share of G.N.P. stabilized in the 7.7–7.8 percent range, but did not actually drop, then took off in fiscal 1975 (July 1, 1974–June 30, 1975) and in 1976 to 8.6 percent. At present, then, health care is taking up a much larger share of G.N.P. in the U.S. than in Canada. The present discrepancy of over 20 percent, in share of G.N.P. was reflected in per capita spending of $499 in Canada in 1975 compared with approximately $599 in the U.S., although per capita spending is harder to compare because of fluctuations in the rate of exchange and the rate of inflation. The difference in percent of G.N.P. is the largest in the historical record, at least for the past quarter century, and suggests that Canadian policies

of cost control in the health care sector are showing more success than those in the U.S.

Corresponding to these broad aggregate movements over the past quarter-century were major changes in health care financing. The Canadian universal hospital insurance program was put in place province by province in the late fifties, and was associated with a sharp jump in hospital spending between 1958 and 1961. In the late 1960's the universal Medicare program provided similar comprehensive coverage for physician services, and a corresponding increase in relative expenditure occurred between 1969 and 1971.

In the U.S. hospital and medical coverage (non-comprehensive) for the aged and/or impecunious in the mid-sixties is often perceived as having been associated with significant expenditure increases. Relatively tight price controls between August 1971 and April 1974 under the Economic Stabilization Program appear to have contributed to the U.S. flattening and subsequent 1975 rebound, while in Canada direct public responsibility for (almost) all hospital and medical expenditures since 1971 has encouraged much more rigorous budgetary control. These two categories of health expenditure dominate the totals in Canada (hospitals 49.6 percent and physicians 16.6 percent in 1975), and are almost as significant in the U.S. (39.2 percent for hospitals, 18.2 percent for physicians). Thus the forces driving total health spending can be traced primarily to these two sectors.

Hospitals

Perhaps the most interesting aspect of hospitalization experience in Canada is what did not happen. During the period of introduction of universal hospital insurance, little or no significant utilization response is demonstrated. Admissions and patient-days (adult and child) per capita in general and allied special hospitals increased slowly and steadily throughout the 1950s and 1960s, but no trend-break is observable in the late 1950s. Patient days (per thousand population) rose between one and two percent per year to 1971, from about 1529 in 1955, to 1639 in 1960, 1778 in 1965, and 1898 in 1971. Since then, utilization has actually begun to drop slightly for the first time. Admissions per 1000 show a similar pattern, 132.8 in 1955, to 144.4, 152.2 and 164.9 in 1971. Admission rates rose somewhat more rapidly after universal medical insurance was introduced, and have been static since, rather than falling. Thus, the decrease in hospital days used has been due to small reductions in length of stay.

These statistics suggest that the principal impact of universal public insurance in Canada was on the unit cost of hospital care, not on levels of utilization. Further analysis shows that this was principally due to wage costs, primarily increases in manpower in the early 1960s and in relative wage levels of hospital workers in the late 1960s and the 1970s. Since 1971 hospital costs have been controlled by direct administrative limits on budgets and on availability of facilities, combined with powerful "moral suasion" to discourage excessive use of hospitals. In the U.S., by contrast, utilization of non-federal short-term general and other special hospitals has continued to climb since 1971. From 1973 to 1977 admissions increased 10.1 percent, while average length of stay fell 2.7 percent. Average daily census remained unchanged. Utilization rates for short-term general hospitals in Canada (admissions or patient days per capita) are still above the U.S. but the rates are now converging with recent Canadian decreases. These data do not include psychiatric or federal hospitals; the latter in particular play a much larger role in the U.S. system than in Canada. Increases in short-term general hospital utilization in the U.S. appear to be led by bed construction, up 10.8 percent from 1971 to 1976, despite a drop in occupancy rates from 76.7 percent to 74.4 percent. However, recent small increases in bed availability in Canada do not appear to have been associated with additional utilization.

Physicians' services

The rapid increases in expenditures for physicians' services in the 1960s, averaging 12.0 percent per year from 1960 to 1971, combined both price and utilization effects. In the pre-Medicare period actual prices charged and collected were only loosely related to official fee schedules, such schedules often representing the hopes and objectives of physicians rather than their fulfillment. A combination of increasing affluence, changing attitudes toward medical care and expanding insurance coverage in this period enabled physicians to increase their gross and net billings per capita very rapidly, despite steady increases in physi-

cian supply per capita, so that from 1957 to 1971 the income status of physicians relative to the average worker rose about 8 percent per year for a total gain of 50.8 percent. Over the same period the physician stock per capital rose 28.7 percent. It is of some interest to note, as well, that the relative income status of physicians rose somewhat faster (25.1 percent) in the earlier period 1957–64 than the later period 1964–71 (20.5 percent) when the universal public medicare programs were established in all provinces but Saskatchewan (which had begun its plan in 1962). Thus the forces leading to expenditure increase predate medicare, and the net impact of the public programs is not wholly clear. In those provinces where the introduction of Medicare was associated with sharp increases in expenditures, we have no baseline evidence to determine how much was utilization and how much price increase. Since there is no evidence of a sudden shift upwards in physician workload, the principal impact was probably an increase in unit prices received by physicians (as well as some improvement in reporting of physician incomes for tax purposes). Certainly "free" care did not lead to physicians being overwhelmed by new demand.

Since 1971, fee increases have been tightly restricted by provincial governments. From 1971–72 to 1976–77, average increases in fee schedules, Canada-wide, are computed by the Department of National Health and Welfare as 3.91 percent per year compared with 8.3 percent annual changes in the consumer price index. Physician incomes have not been wholly restricted by these low fee increases. From 1971–72 to 1975–77 the average billings per physician in Canada have been rising 1.5 percent per year faster than the fee schedule. Utilization per physician has increased most rapidly in provinces with low fee increases—4 percent per year in Quebec where no fee increase was achieved in this period—and has not occurred in provinces with relatively large fee gains. Such an observation is consistent with target income behaviour by physicians; if income targets are not met through fee increases, more billings are generated in other ways. Nor has the income generation process been prevented by rapid increases in physician stock per capital, 3.9 percent per year from 1971–72 to 1975–76 (6.0 percent in Quebec). But despite these efforts the relative incomes of Canadian physicians after rising in the 1960s have clearly fallen since 1971.

As of 1975 the rate of immigration of foreign physicians has been sharply curtailed, so that continuing stability of physician expenditures in Canada will have to depend on stability of both physicians per capita and relative income levels of physicians. The former will in fact continue to creep up on the basis of current forecasts of graduating classes, and the latter would be very vulnerable to any "catch-up" efforts by physicians to regain the huge gains of the 1960s by negotiating large fee increases.

U.S. data does not, of course, permit detailed income or utilization analysis. Costs of physicians' services certainly rose more slowly over the period 1960–71, an average of only 9.5 percent per year, and from 1971 to 1974 these costs have moved more or less in line. In the U.S., however, the total cost increases since 1971 have been primarily price changes, while in Canada increases in numbers of physicians per capita seem to be more important. The U.S. medical care component of the consumer price index rose an average of 7.2 percent per year from 1971 to 1976, compared with the Canadian figure of 3.9 percent, and even if all of the 1.5 percent annual increase in "utilization" per physician was really price change (as some of it was, due to, for example, shifts in billing behaviour), U.S. price increases would still be about 1.7 percent per year faster over the whole five year period. One would therefore expect U.S. physician incomes to have risen more rapidly in the 1970s, if data of equivalent reliability were available for comparison.

The variation in price behaviour thus seems considerably greater in Canada, with sharp increases in fees received producing large income gains for physicians in the 1960s and corresponding administrative cut-backs restraining incomes in the 1970s. U.S. physicians seem to have made slower gains in the 1960s but are continuing their upward march in the 1970s. In neither country are population increases a significant factor in health care costs, at least in the short run, though the large aged population in the future is of concern in both countries. Utilization increases in Canada prior to Universal Insurance and in the U.S.

since Medicare for those 65 and older are hard to identify because available data does not permit one to observe the pattern or even total volume of services supplied. Utilization, however, is not demand, it can be initiated by the patient or by the provider, and post Medicare experience in Canada suggests that the latter is the more important component. Certainly there is no evidence that universal insurance triggered a massive response of patient-initiated demand, and in the hospital system it clearly did not.

In Canada taxes and premiums collected by federal and provincial governments finance the entire system. Although percent of gross national product for health care services and percentage increases in per capita health care expenditures are important, politicians are concerned with total dollar costs and dollar increases. Health care costs make up 10 percent of federal expenditures and 33 percent of Ontario spending, sums which must be raised by taxes or premiums. In 1965 the total cost of health care services was $3.3 billion—in 1970, $6 billion and in 1975 over $11 billion. The magnitude of these expenditures and the rate of their increase has captured the attention and concern of the politicians. Health care in Canada has now moved into the political arena, and is there to stay.

3. TRENDS AND DIRECTIONS

The trends and directions are most easily discussed around three interrelated concepts: cost containment, Bill C–37 and the Lalonde Report, and they must be viewed from both the Federal and provincial levels.

Cost containment is the major issue. Regardless of whether the increases and the present levels of health care spending are justified, the entire bill is now being paid by government—roughly 50 percent by federal and 50 percent by provincial governments. In the United States only about 40 percent of the total health care bill is now paid for by government. Of the two levels of government in Canada, the federal has been able to determine only the terms of reference but has had no control over the total amounts expended.

Because of this lack of federal control, and after earlier attempts to limit federal contributions without transfering additional taxing authority to the provinces, the federal government enacted Bill C–37[4] in 1977. This Bill will reduce direct federal contributions for health care to 25 percent and tie further direct federal increases to growth of the gross national product. At the same time, federal taxes will be decreased and the provinces will have the opportunity to increase their tax rates to balance the federal reductions. (This has been called Tax Room—the tax points vacated by the Federal Government can be levied by the provinces.) In subsequent years, the revenues to meet cost increases in excess of growth of the gross national product will have to be raised entirely by the provinces, not, as in previous years, jointly by the federal and provincial governments. In this way, cost control is being shifted to the provinces where the constitutional authority rests.

The 50/50 federal-provincial cost sharing arrangements made provision for adjusting provincial payments from the federal government so that the poorer provinces received more than 50 percent of their health care costs and the wealthier provinces received less. This feature has been retained to some degree in Bill C–37, as have the original terms of reference. On the other hand, the federal contribution is now largely independent of provincial health care costs and completely independent of cost increases. Provinces can no longer spend "50 cent health care dollars" since they will receive federal contributions and tax room credits which are far less dependent on their health care expenditures. As well, federal contributions for health care will no longer be earmarked for health; they will be lumped with federal funds for education, further increasing the competition for dollars at the provincial level. For 1977–78, the provinces may also receive additional per capita grants to develop potentially less costly services such as home and extended care. In 1977–78 the federal contributions plus the transfer of tax points will produce more money for the provinces than cost sharing would have. However, the long term trends seem clear. Health care costs will be met mainly by provincial rather than federal taxes. As a result, the major responsibility for raising the money for increased health care costs will shift to the provinces. Increases in federal contributions from year to year will be limited to increases in the gross national product and reductions in federal taxes (greater Tax Room). Lowered federal taxes can be reassessed by the

[4] Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977.

provinces at the same, higher or lower levels. As a result of Bill C-37, the provinces will have greater flexibility and less book-keeping, but far greater responsibility and accountability.

Increased health care costs in one year can be dealt with in subsequent years in a number of ways:

(1) Decreased benefits.

(2) Utilization or deterrent fees. Such fees when used in the past in Canada have deterred only price sensitive consumers and have not reduced costs. Although the former Minister of National Health and Welfare, Marc Lalonde, has repeatedly spoke out against deterrent fees the possibility of use fees is still regularly considered.

(3) Higher taxes or increased health care premiums.

(4) Increased spending for health care at the expense of other publicly funded programs such as education, housing or environmental control.

(5) Combinations of any of the above.

Increased taxes seem unlikely in the short term. The system will attempt to reduce costs by providing increases that are less than the rate of inflation, thus effectively reducing expenditures. New programs which have implications for higher costs (and most do initially) will be rejected unless they can be justified by reducing or terminating existing programs. With 90 cents of every health care dollar going to pay service costs, trade offs will be difficult if not impossible. Virtually no new hospital beds will be built and whenever possible politically, existing beds will be closed.

Pressure will be exerted to reduce the numbers of health professional graduates. Immigration of physicians has been stopped—except in those provinces which depend on foreign graduates to maintain present ratios. More and more government involvement in the control and management of health programs can be expected, if only be budgetary reductions. To date the budgetary limitations have been applied mainly to the institutional sector, but tighter negotiation of fee schedules has also slowed the rate of growth of physicians' incomes in recent years. There is now support in some provinces to replace fee for service payment to physicians by salary or capitation on an experimental basis.

The Lalonde Report, "A New Perspective on the Health of Canadians" adds yet another dimension to cost containment. Part of the genesis of that Report was what was perceived as an unacceptable increase in health care costs. The Report identified the major causes of early and premature mortality as accidents, ischemic heart diseases, lung cancer and suicide. It then described "The Health Field Concept", whereby health problems were separated into four components: Human Biology, Environment, Lifestyle and Health Care Organization. The principal underlying factors in the causes of early death were identified as self imposed risks or lifestyle and the environment. factors which could not be attacked by the medical model.

By questioning the "medical solution" for many health care problems, the Lalonde Report demonstrated an understanding that expenditures for personal health services contribute only small and decreasing marginal benefits to health. The Report is particularly important because in it the Federal government has gone on record to say that it understands that more doctors, more nurses, more hospitals and more dollars will, by themselves, have little or no effect on health status or health outcomes. Thus, there appears to be little justification for increased health care expenditures if they will not improve the health status of the Canadian population.

The concept of greater individual responsibility has great appeal but as yet, unproven benefit. It also runs the risk of penalizing the victim. As well, many of the major problems (environmental and occupational) can only be solved on a collective basis despite the Report's exhortation that they be confronted by individuals.

Bill C-37 and the Lalonde Report are Federal initiatives. At the provincial level cost containment has been achieved with budgetary constraints, reduced hospital construction and tightly negotiated fee schedules. The open-ended nature of fee for service payment has been balanced by physicians service profiles. monitoring, limitations on numbers of services which a physician can bill for and greater legal and investigative authority for regulatory bodies (the provincial Colleges of Physicians and Surgeons).

As well, the provinces have begun to employ organizational alternatives such as: (1) Decentralization, primarily through regionalization, and (2) coordination and integration of related health and social services.

Decentralization

Virtually all the provinces and territories are divided into administrative regions by their respective health ministries. Services such as public health, mental health and many other community health and social services are delivered on a regional basis by provincial government branch offices. Control of public health has often been turned over to large municipalities, while the province retains responsibility for the administration of services in regions outside these municipalities. Several provinces are now actively attempting the decentralization of health planning and the control of delivery of personal health care services on a regional basis. The concept of a regionalized health system in the Canadian provinces is not new, but regionalization is being increasingly viewed as the vehicle to rationalize health care delivery. Health policy makers who support regionalization approaches argue that crucial decisions regarding the delivery of care should be made at the regional or community level, with emphasis on meeting the needs of geographic areas containing 100,000 or more people. With cost containment redirecting services away from high cost institutions, "hard" decisions like the closing of a hospital or reduced resource allocation are more credibly attributed to a local community based board than to a more distant bureaucratic agency.

As a result, a number of provinces are currently attempting or considering regionalization schemes. Quebec, Ontario, Manitoba and Saskatchewan have established regional planning bodies, generally local boards consisting of consumer and provider representatives. Only Quebec has boards established for the entire province. Despite all the legislation, reports and administrative decisions, no province has yet relinquished to these local boards any significant fiscal control or executive authority over a region. However, proposals have been made in Manitoba and Saskatchewan to allow boards to control regional global budgets or major delivery programs in the funture.

In 1971, Quebec established twelve regional councils for its ten health-social service regions (Montreal is one region with three councils). The councils have planning responsibilities for health and social services and are charged with eliminating duplication, promoting the amalgamation of common support services such as hospital laundries and recommending to the Minister of Social Affairs the preferred allocation of dollars among health and social services within their region.

Ontario has opted for a more evolutionary approach to regional planning. This province has established District Health Councils (DHC), each serving populations of 100,000 or more. A district is encouraged by the Ministry of Health to form a steering committee of local citizens. The steering committee, using general terms of reference and after consultation with providers and the public, recommends to the Ministry of Health whether or not a DHC should be formed and who the members should be. (No more than 50 percent can be health professionals.) The districts have boundaries which coincide with regional or county governments or combinations of local government units. Of the 31 potential regions in Ontario, 21 now have DHCs. Ontario DHCs are advisory to the Ministry of Health on matters of budgetary control; as yet they have no fiscal responsibility.

Manitoba is divided into eight health districts, now referred to as District Systems. They should soon be responsible for public health, personal health care delivery and eventually social services, housing, education and recreation needs. Most programs are administered at the District level by the branch offices of the provincial Department of Health and Social Development. Programs included are community services (public health nursing, home care, services to the aged), community mental health, mental retardation and many social service programs. In each District System a local board will be established to be responsible for and co-ordinate the public services with medical, hospital and nursing home services. Ultimate fiscal control is contemplated, but not yet implemented. Since 1974, all personal care homes (nursing homes) built in rural communities have been linked physically and administratively to their existing hospitals.

Saskatchewan's regional system of community boards which dates back to the 1940s is now being revitalized. The system is predicated on a two-tiered arrangement in which each of the province's ten health regions is subdivided into districts. Each municipality in a district is represented on that district's Health Council and an allotted number of representatives from each district

council are elected to the Regional Board of Health. Present legislation authorizes these Regional Boards of Health to undertake responsibility for a wide range of curative services; however, the Boards have not exercised this responsibility. Saskatchewan is currently reviewing the entire question of decentralization and public participation in health care. Although the exact role of the Regional Boards in the future has not been decided, the concept of public participation in general is likely to be strengthened.

A study of one Saskatchewan Region has recommended that the District Health Boards be composed of lay people who assume major responsibility for the administration of health programs, eventually including hospitals and nursing homes. The Regional Board would then serve largely in a support capacity to the district boards. The implications for eventual budgetary control by the Districts are apparent. Arrangements in this Region have been discussed as a possible model for a province wide system.

In general, regionalization in Canada is at an early stage. No single organizational structure has yet demonstrated its effectiveness in accomplishing regional objectives. Those provinces that have begun regionalization have done so on a trial and error basis without federal aid. As yet no cost control has resulted, although greater public concern has been generated.

In the United States regionalization is also not new. On a national scale, an early attempt was the Regional Medical Program in 1965. More recently, overall co-ordination has been attempted by establishing Health Systems Agencies (HSAs) across the country under Public Law 93–641. Although such U.S. efforts are firmly grounded in national legislation, and well funded by Congress, Canada does have some natural regionalization advantages. First, its health care system is already significantly decentralized and tailored to 'regional' needs because essentially it consists of 10 separate provincial plans. Second, districts are being defined within existing health regions or other existing political subdivisions. Although the problems of regionalization in Canada should not be minimized, it is probably easier to use these political subdivisions than to define new boundaries as has been the pattern in the U.S. Third, and most significant, there is government control of all health funding.

Coordination and integration

Besides decentralization, a major factor accounting for the interest in regionalized health boards has been the possibility of better co-ordination of local health services. Co-ordination of services occurs at a variety of levels. For decades, hospitals in many provinces have worked through local hospital planning councils to avoid duplication by sharing common support services such as laundries or laboratories. On occasion, hospitals have co-ordinated their activities with local nursing homes or community clinics. Government provided services, such as public health nursing or voluntary services like home care, delivered by the Victorian Order of Nurses, may also be co-ordinated with hospitals or nursing homes.

Alberta, Manitoba, Quebec and the federal government have combined health and social services under single government departments. Such integration has also been proposed at the district level under single boards or councils. The concept has already been implemented in Quebec with its Regional Councils and has been recommended as the final stage of development for district councils in Manitoba, Saskatchewan and Ontario. Alberta has been experimenting with two integrated regional service boards with combined responsibilities for personal health, public health and social services programs. Bill C–37 may also play a role in integration, because it frees financing to fund planning and implementation of all programs.

On the service delivery level, Canada's limited experienc with community health centres encourages similar integration. Provincial government supported centres are being operated in British Columbia, Saskatchewan, Manitoba, Ontario and Quebec. Multi-disciplinary teams deliver a variety of services in these centres. However, with the exception of the integrated local community service centres of Quebec (CLSC) most of these efforts by the provinces are small in size and number and mainly experimental.

Program expansion

Cost containment pressures are not necessarily negative. They can also be credited with encouraging program expansion in some areas. Provinces are increasing the number and scope of programs that provide lower cost alternatives

to high cost acute institutional care. Long term care, especially home care, is being expanded in virtually all provinces. Saskatchewan is gradually implementing home care on a province-wide basis. The community health centres, where they are being supported, deliver care through integrated teams which also stress health promotion and maintenance and disease prevention. In addition many provinces have launched major programs that concentrate on health promotion and maintenance and disease prevention for the entire population. These programs and others such as the "preventive social services" program in Alberta are an attempt to identify and prevent or alleviate health and social problems at an early stage, to take pressure off the crisis care system. While Bill C-37 fiscal arrangements will, it is hoped, encourage this trend by allowing federal dollars to support these alternative programs, many provinces had already begun prior to the new fiscal arrangements.

Cost containment potential, however important, is not the only factor governing health care program expansion by the provinces. Consumer pressure, political popularity and positive social objectives are other causes. Many provinces have recently implemented or are planning expansion of universal programs by increasing categorical benefits, often entirely at provincial expense. For instance, Saskatchewan and Manitoba, without cost sharing, introduced universal prescription drug programs and universal dental care for children.

Saskatchewan has also established a variety of categorical programs for the handicapped (hearing aids, wheelchairs, etc.), cancer patients, alcoholics and mental health promotion. Planning is now underway to provide additional provincial programs in areas such as vision care, chiropody, ambulance services, dentures and more services for the physically and mentally handicapped. These services are being covered despite the fact the Saskatchewan has been over budget in recent years and has had to rely on surplus revenues from previous years to finance some of its new programs.

While Saskatchewan and Manitoba may be considered the leaders in the expansion of new universal programs, they are not unique. Since 1975, virtually all provinces have insured prescription drugs for senior citizens, with the province bearing the entire cost of the program. Nova Scotia and Quebec have recently established province wide children's dental plans and New Brunswick provides such services in underserviced areas. Provinces other than Saskatchewan are also increasing categorical benefits, particularly for the physically and mentally handicapped. There is considerable satisfaction with government funded programs and a demand for further expansion of benefits.

Obviously the picture is far from bleak. Many of the constraints are long overdue. Annual per-capita expenditures of $500 or more are probably sufficient. Planning is possible only when resources are fixed and limited. In all likelihood, insured benefits will be maintained and any spending constraints will not adversely affect the health of the Canadian people. On balance, universal health insurance in Canada has been a good thing. It is obviously here to stay. If we had to do it again, we'd still do it, although we might do it differently. As the Ontario Economic Council said in 1976, "In retrospect, it is apparent that a major error in the development of Ontario's health care system was the failure to rationalize—or even attempt to rationalize—the health care delivery system before public health insurance was introduced; at a minimum, it should have been concurrent with its introduction."

The implications of universal insurance could not have been anticipated by those who enacted it. The program is funded by government which must raise the funds. Under Bill C-37, the Federal role will be decreased and greater responsibility shifted to the provinces. The same government that taxes will have the authority to control costs. Public expectations may have to be reduced and professional perogatives confronted and limited. Without universal health insurance, Canada wouldn't have known what the problems were; the government would have had neither the authority nor the impetus to dealth with the problems. There are dangers inherent in health care decisions which are predicated solely on financial considerations. On the other hand, governments now not only kow what the total health care bill is, they also have to pay that bill and deal with the issues.

Perhaps, in Canada, universal insurance may yet prove to be the mechanism to rationalize the system. The stakes are high—no country has yet fundamentally changed its health care system after adopting universal health in-

surance. However, the economic realities of the 1970s coupled with a growing awareness of the limitations of uncontrolled increases in medical care may yet make rationalization possible in Canada.

Senator KENNEDY. We have the limited services in drugs, home health care is 100 days. Nursing home is 100 days. Mental health is 45 inpatient days and 20 outpatient visits. It is probably the most extensive program, but there are limitations in the amount of benefits provided.

One of the most important and essential parts of our particular programs is the relationship between premiums and income. We use a wage related premium and a mandated premium as the chairman of the committee would understand.

There are three different aspects of the income premium formule. One would be the relationship between the employer and the employee. We set that figure at 7.5 percent of which the employee could be required to pay up to 35 percent. Generally according to the Chamber of Commerce for most industries 5 percent of payroll is spent on health care. We make it 7.5 percent of which 35 percent could be paid by employees.

Second, you have the self-employed. They pay half of the rate of 7.5 percent or 3.75 percent, up to the amount of the value of their particular benefit program: $800 for an individual, $1,600 for a married couple, and $1,950 for a family.

The third is unearned income. If an individual has their total income or part of it from unearned income, you don't count the first $2,000, which basically eliminates the unearned income from most middle income and low middle income people, and then apply the 3.75 percent rate to the remainder but only up to the value of the benefit package.

That is the way the resources are collected. But all Americans are automatically covered. If a patient comes in with his card the doctor is going to treat him. The patient is going to know he is going to be covered and the doctor is going to be compensated.

We collect the resources through that mechanism. The other two elements are the SSI and the AFDC. The SSI, the Federal Government effectively assumes the financial responsibility for the SSI individual for the actual amounts of sickness, illness or treatment of the individual. The States pay for those on AFDC.

The amount that any State would pay would not exceed what is paid today as a part of State contributions through the AFDC or the SSI. They are effectively held harmless. They would pay no more than they are paying at the present time. The reimbursement would be for the amount of actual cost.

All contributions are paid to one of four consortiums made up of the Blues, the private insurance companies, HMO's, and IPA's. Effectively the consortiums are administrative agents for those particular organizations. From an administrative viewpoint this is not a very complex mechanism although it might sound so.

We have it now under the Federal employees health plans. Federal employees pay one premium whether you live in Washington or in Phoenix, Ariz. Because it costs more to treat a person here in Washington than it does in Phoenix, there is an internal mechanism for adjustment.

Individuals themselves make the choice of which of the four consortia they want to deal with. They have a complete option about

which different group or which different individual company they want to deal with. There will be open enrollment. We might have the whole range of 800 different insurance companies in the program. Some companies may get more, and some may get less, of the high-risks patients. There is an internal accounting mechanism to provide extra funds to those particular companies that may need it based upon the nature of the risks of the population that signed up with them.

At the present time you have experience rating not community rating. That is where you have the competition. We retain competition but now we do it on the basis of the risk for the particular company. If a particular company has high risk individuals, it will receive the resources for what it would cost to provide for those individuals.

This is the important point. Now the company itself says, we are covering "x" number of people. We know we are going to need "x" amount of money in order to treat those people. This is the same kind of mechanisms we have at the present time in health maintenance organizations which Dr. Enthoven talked about. The same kind of thing Dr. Enthoven talked about with Kaiser.

You know at the beginning of the year what your population is and what your resources are going to be. This is where you get the competition.

If the individual company can through administrative efficiency or customer service or by working out innovative or creative ways of trying to make contracts with younger doctors in a particular group practice or by using different hospitals, individuals could receive a dividend of say $150 because it would cost less to provide the mandated benefit package. Or, they could expand their benefit package. They could then market their program by saying we will provide additional benefits or we will provide additional dividends to you.

Thus we begin to get the internal kinds of competition which virtually do not exist within the system today. You begin to bring the downward pressures with dividends, the expansion of the benefit package or better customer service. That does not exist and it cannot exist in any of the other NHI programs.

Again, everyone is eligible for the choice of an HMO or other insurer. There is a two month open enrollment period available each year. An efficient insurer could provide additional benefits or a cash rebate for the enrollees.

One other item which is of interest obviously to the insurance companies is the fact that you get the resources for funding this program early in the quarter so that the insurance companies themselves can actually invest the resources. That has an attraction to the companies themselves because all of the money is being built with the private sector.

We have tried to get the competition among the insurers and the providers through the various incentives to enrollees to join HMO's.

How do we do the budgeting? Basically in the area of budgeting we set a national cap on what is going to be allocated for the payment of our health budget. In the beginning, it would be set at least at the level we were at when the program started. We would start in 1983.

All the States have to do in developing their particular programs within the State is to conform with the overall national ceiling. If it

is 9 percent or 10 percent, the States obviously have to conform within that particular ceiling.

Once the States conform within that particular ceiling, the negotiation between the providers and the others would not be a Federal negotiation, not of State negotiation, but rather a private negotiation. Employers, employees, the insurers, the providers would all be sitting around a table negotiating budgets for hospitals and fees for doctors.

States can do whatever they want as long as they fall within the overall ceiling. They may compensate certain doctors for certain kind of procedures in one State at "X" level and at another level in another State. You leave that completely within the overall framework of a particular State.

All the State has to do is conform with the national limitations. The negotiations which take place are not by the State and the doctors. It is not by the Federal Government and the doctors, which now takes place in about every other industrial nation of the world, but between the suppliers and the providers in the area. This is for fee schedules and the hospital budget. You have the exclusion of unproven or nonessential services like cosmetic surgery.

The budget allocations addresses the maldistribution of resources. We have a resource development fund of $500 million to try and help the development of new and imaginative ways for the delivery of care and for the maldistribution which exists. We expand the PSRO program to cover all aspects of the health care program.

We can come back to any of these particular charts, Mr. Chairman. Finally it is my very strong sense that unless we are going to have some really effective cost controls and unless we are going to have the kind of system changes that Alain Enthoven brilliantly spoke about which built into the system alternative delivery system, then I think whatever benefits we provide are going to disappear as we have seen in medicare and medicaid.

That is the prinicpal concern for those that are representatives in this coalition. Particularly senior citizens and others who would immediately benefit from any kind of legislation which would extend benefits.

Chairman LONG. Senator, you have had some experiences in presiding over hearings. You have some very distinguished witnesses here. We will hear them as you wish. I suspect it would be best to hear from them before we start asking questions. Otherwise what tends to happen is when you get through responding to questions, most of the Senators and most of the audience will leave and some of your distinguished witnesses will not have the audience you had to speak to.

How would you like to do business, Senator?

Senator KENNEDY. They could speak very briefly representing the different groups about their concerns and then answer questions.

Chairman LONG. Mr. William R. Hutton, executive director of the National Council of Senior Citizens.

STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. HUTTON. I am here to present the views of my organization which is an organization of some 3,800 older peoples' clubs across

America with a combined membership in those clubs of some three and a half million elderly people.

Only his absence from the city today prevents my friend, Cy Brickfield, the executive director of the American Association of Retired Persons and National Retired Teachers Association and that is an organization of 12 million older people from sitting along side of me and supporting with all his strength the bill which has just been presented to you by Senator Kennedy.

Mr. Chairman, we earnestly believe in the National Council of Senior Citizens that the tragic legislative compromises which took place in connection with the enactment of medicare were penny-wise and pound-foolish and they have carried with them if you like, the inflationary seeds of medicare's erosion.

Today, medicare covers on average only 38 percent of the health care costs of the elderly. It is widely understood by most members of the public that the program while providing modest gains for the elderly at an enormous price has largely been a tremendous boon for doctors, hospitals, and other sick care providers.

The legacy of this frustration has made us realize the folly of too many compromises. We realize we have to make some, Mr. Chairman.

Frankly, I was one of the two public members that pointed to HIBAC in the early days, the Health Insurance Benefits Advisory Council. The two public members were outnumbered 16 to 2 and we did not have much influence within HIBAC. I can tell you although we raised our voices it was really tragic to realize the things which were being recommended and particularly some of the provisions of medicare and I can think of one, the fact that older people who really need home health care could not get that home health care without first having to go to a hospital for 3 days and being sent there by their doctors.

Over the past decade we have poured billions of dollars down the drain on that one provision alone.

It does seem to me when we have some 5 million elderly couples who have got an income of approximately $5,000 a year, they spend about 80 percent of their income on food, housing, and health care and that means they have $1,000 a year left and out of that $1,000, it would cost them almost $100 a month for energy and the rest is spent on transportation, clothing, and personal items. It is very tough to keep body and soul together.

These people really cannot afford the high fees of catastrophic health insurance. They do not have it and particularly the ones who are between the ages of 55 and 65 who do not have medicare either.

We believe the Kennedy bill faces the cost controls firmly and forceably and will adequately protect consumers from financial catastrophy. Unless these controls are in, we are not ever going to be able to benefit. We will never be able to catch up with some of the 60 nations across the world which long ago decided to introduce some form of national health security for their people and we believe this Nation belongs up there with the others.

The CHAIRMAN. Thank you, sir. We will hear from Ms. Althea Simmons from the National Association for the Advancement of Colored People. We are happy to have you here, Ms. Simmons.

STATEMENT OF ALTHEA SIMMONS, WASHINGTON BUREAU DIRECTOR, NAACP

Ms. SIMMONS. Thank you so much for letting me appear before you, Mr. Chairman.

The NAACP through its 1,800 branches and youth units in all 50 States and the District of Columbia favors comprehensive health care of equal quality and quantity for all Americans without regard to race, income or status in life.

We believe that many Americans without regard to color express concern these days regarding a need for a system of health care which will insure freedom from fear of serious illness and costs. The need for adequate health care is so widespread, as a matter of fact, there is not a need, we do not believe, to try to educate the Nation's populace. Even if there were a need to try and educate persons on the need for adequate health care, we do know whenever national priorities, defense, scientific, or social change revealed that the educational process in any given time must be redirected to serve the Nation's need but our Federal Government has always enacted legislation.

I think the most dramatic example of that was when Sputnick was launched some years ago and we sparked an all out effort to get engineers and technologically trained personnel because that became a national priority.

We believe health care and the well-being of our most precious human resource, our national resource, our citizenry, also must become a national priority because Americans deserve comprehensive health care. They need that kind of plan and they should not have to wait until it is considered to be economically feasible.

Blacks and other minorities are people who are constantly short-changed. They just released a report of the Bureau of the Census on the social and economic status of the black population in the United States from 1790 to 1978 and it points out that the mortality rate for blacks is still significantly higher than that of whites. Forty-six percent of all black deaths are caused by malignant cancer and diseases of the heart.

A number of other studies show that blacks, other minorities, and the poor and the elderly lack adequate health care due in part to health care providers, and poverty, and racially isolated neighborhoods and also because of the escalating health care costs.

Our national health committee states that 75 percent more dollars have been spent for white recipients when compared with minority recipients. With medicare, they state 60 percent more is spent for physician services and 20 percent more for inpatient care for whites as compared with nonwhites.

We believe this points out the need to have an universal plan that will assure that low-income persons, the elderly, minorities, and, as a matter of fact, all Americans, can be healthy productive citizens because there is an affordable health care regardless of their status in society.

We urge the committee to resist a fragment or piecemeal approach to health care because we believe that will increase already high frustration rates of a large segment of our Nation's citizens and will

do very little to improve the quality of life for persons, blacks, other minorities, and everyone.

We urge the committee to take the bold decisive step of coming to grips with a problem to provide national health care for all of its citizens now.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Ms. Simmons. We will now hear from Mr. Kenneth Young, director of the department of legislation of the AFL-CIO.

STATEMENT OF KENNETH YOUNG, DIRECTOR, DEPARTMENT OF LEGISLATION, AFL-CIO

Mr. YOUNG. Thank you, Mr. Chairman.

Mr. Chairman, the AFL-CIO is convinced that America must develop a comprehensive national health insurance program if its people are to be relieved of the burden of ever higher costs for medical care.

We recognize there are no quick and easy fixes for this long-standing problem. We have spent untold hours month after month and year after year seeking workable solutions.

It is a matter of record that the AFL-CIO and the CIO separately supported the Murray-Wagner-Dingell bill in 1947 and since the merger of the AFL and the CIO in 1955, we have called for the enactment of a comprehensive and universal national health insurance program at every convention.

Given this long background of interest and study, we are deeply disappointed that this committee apparently has decided not to hold full hearings that could air and explore the host of complex issues and options available to the committee and, of course, to the Nation.

We in the AFL-CIO have studied and worked on this issue for more than two decades. It is no secret that we are fully supportive of Senator Kennedy's proposal, the Health Care for All Americans Act.

We do want to take this brief opportunity to make it clear that the AFL-CIO does not consider a catastrophic insurance proposal to be a viable legislative compromise for a comprehensive program. We believe that catastrophic insurance would greatly accelerate the already unacceptable high inflation in health care costs.

Health care in our country is notably weak in the areas of preventive care and routine medical treatment for common place illness. Because catastrophic insurance is aimed at the more dramatic areas of medicine such as open health surgery and organ transplantation, it would lead to an even greater disproportion of specializing physicians.

In addition catastrophic insurance would underwrite the expansion and proliferation of high cost medical technology. While this technology does save lives, the inappropriate use and the lack of any assessment of the diagnostic or therapeutic value of this technology greatly increases cost.

By contrast, the AFL-CIO supports a comprehensive program because it gives physicians lower cost alternatives to expensive hospitalization, provides effective cost controls, permits alternative delivery systems, and is, therefore, less expensive in the long run.

The AFL–CIO supports the universal program because we believe access to health care should be the right for all citizens regardless of race, sex, color, or creed and the AFL–CIO supports a comprehensive and universal program because in the long run it will be far less expensive than the multiplicity of separate programs for various population groups.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. We will now hear from Mr. Howard Paster, director of the office of legislation of the United Automobile Workers.

STATEMENT OF HOWARD PASTER, DIRECTOR, OFFICE OF LEGISLATION, UAW

Mr. PASTER. Thank you very much, Mr. Chairman and members of the Finance Committee.

On behalf of our president, Douglas Frazier, and the 1.6 million members of the UAW, I want to stress our total support for the Health Care for All Americans Act proposed by Senator Kennedy and several other Senators from both sides of the aisle.

For many years the UAW has been in the forefront of those advocating an universal comprehensive national health insurance program. Mr. Frazier chairs the Committee for National Health Insurance as did his predecessors at the UAW, Mr. Cock and Mr. Ruther.

It is with a long history of involvement with this issue and adherence to the underlying principles of a fair and workable health insurance program that we strongly endorse the position taken by Senator Kennedy and others in the Senate.

The comprehensive approach set out in the Health Care for All Americans Act would control costs, but not—as alternative plans do—by laying a greater burden on the victims of illness. We do not propose copayment requirements or substantial deductibles which price health care out of the reach of many Americans. We seek to control the soaring cost of medical care from the outset through prospective budgeting of health care costs.

We believe there is no alternative that will hold down costs more effectively than the Kennedy proposal, and among the reasons we object to various catastrophic health insurance bills is the very fact that they will only drive costs up even faster.

In approaching this complex issue it is important to emphasize that catastrophic health insurance is not a partial step toward comprehensive health insurance. This is a key factor we believe in the committee's consideration of these issues.

Those of us favoring comprehensive national health insurance do not regard the various catastrophic bills as potential compromises between our position and the position of those who want no action. Comprehensive health insurance and catastrophic health insurance are fundamentally different. The latter is not a half or even a quarter loaf of the former. Very simply for those of us committed to comprehensive health insurance, catastrophic plans are not something that can be brought around to acceptability. They are a direct challenge

to our goals and thus we will oppose enactment of catastrophic health insurance.

I call the committee's attention to the fact that the Health Care for All Americans Act represents a market change from earlier health insurance bills which we supported. The proposal maintains the essential principles of universal and comprehensive coverage with quality and cost controls, and needed system changes. But it also creates a major continuing role for private insurers and thus departs significantly from our earlier financing proposals.

We have listened to the concerns raised by Members of the Senate and others and have brought forth revised legislation that answers a number of these concerns.

We recognize the magnitude of the issues facing the Finance Committee. In many respects national health insurance is a more significant step than even the Medicare Act of 1965 on which the chairman who was the sponsor of that bill will recall the Finance Committee held I believe 11 days of hearings.

For organizations such as the UAW, which have invested many, many years and a great deal of resources, in the drive for national health insurance, the Kennedy bill represents a chance to realize our long-sought goals, while all the other proposals we have seen miss the mark.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Paster. We will now hear from Mr. Robert Barrie, representative of the health care task force of the Interreligious Staff Council.

STATEMENT OF ROBERT BARRIE, REPRESENTATIVE, HEALTH CARE TASK FORCE OF THE INTERRELIGIOUS STAFF COUNCIL

Mr. BARRIE. Thank you, Mr. Chairman and members of the committee.

In addition to representing the Washington Interreligious Staff Council, an organization representing Roman Catholic, Jewish, and Protestant organizations, I also represent my own denomination, the United Presbyterian Church in the U.S.A. I am presenting testimony today on the policies of the general assembly of our demoninations and would like to have made a part of the record a policy statement which our general assembly adopted nearly 8 years ago as well as policy statements of the health care task force of the Interreligious Staff Council.

Mr. Chairman, my appearance here today on behalf of my own denomination and my religious colleagues is based on the concern of religious organizations everywhere for the wholeness of persons as children of God and about their physical and mental health.

I believe by being here and they believe by allowing me to represent them that by my presence here this morning I am responding to God's command to care for and to act on behalf of his children.

Our denominations' policy leads me to say to you that the essential and basic principle which should underly any decisions you make on national health should be this; all persons within the United States of

America are entitled to adequate health care and the Federal Government should guarantee that entitlement because the Federal Government is the only agency that can act for all the people.

That statement is illuminated not only by Judaic and Christian understanding of history, but also by the history of our Nation and its constant striving to adhere to the democratic principles inherent and explicit in the Constitution.

Mr. Chairman, I share your concern that the Nation is in a large and steadily worsening health care crisis. This is especially true with respect to the most frequently mentioned part of that crisis, the rapidly rising health care costs and the growing struggle of thousands to pay for it.

The question is whether or not the Nation can afford a comprehensive health care policy and that is in our opinion no longer a valid question. Our national experience has long since answered it. A mass of data signifies we can no longer afford not to develop and implement a comprehensive policy.

In singling out rising costs for special mention, we underscore the utter futility of dealing with that problem in isolation. It can be successfully dealt with only in conjunction with other components of the health care crisis. First, the inadequate and maldistributed resources for delivering health care services. Second, the poorly organized and grossly inefficient system for delivery of health care services which results in unequal access to health care. Third, the inadequate controls of cost and quality without appropriate accountability to the Government and to the consumers to insure adequate quality and reasonable costs.

In evaluating legislation designed to deal with national policy on personal health care services, we support features which assure a coordinated and comprehensive approach. We reject those which focus only or primarily on a single aspect of the health care crisis.

Catastrophic national health insurance is an example of a limited approach. When we evaluate proposals for catastrophic national health insurance we find they will not achieve the basic goals we have mentioned. Catastrophic national health insurance proposals do not guarantee adequate health care to all persons in the United States. They do not hold the Federal Government accountable for that guarantee.

Adequate legislation to deal with the health care crisis must have at least the following basic commitments. One, a commitment to universal coverage. Two, a commitment to comprehensive benefits. Three, a commitment to emphasis on the encouragement of alternate delivery and financing systems such as health maintennace organizations. Four, assurance of full public accountability and insistence upon consumer participation in the development and administration of any proposed plans.

Inherent in all of the above commitments is our concern that whatever system of national health care is approved, it should deal effectively and equitably with the needs of the poor and the disadvantaged of all ages.

We abhor a two-class system in which there are separate approaches for those able to pay for this care and those unable to do so. We particularly abhor the use of any means test in determining eligibility to receive health care services.

As you are well aware the Congress has before it or soon will have a variety of proposals dealing with national health care policies. We include in this grouping obviously the Health Care for All Americans Act but also President Carter's proposal soon to be introduced and we also think that the congressional debate on national health care policy should include the health security bill reintroduced by Congressman Corman in the House of Representatives and the national health services bill introduced by Representative Badham. All of these measures have much in common of great merit.

We believe that the country as a whole will benefit by a vigorous and extended national debate of all of them. Only in that way can the best possible final decision be made. Early action on the very limited range of catastrophic national health insurance proposals would do a great disservice to the Nation as a whole.

In summary, at the very least we urge delay on any decision on a narrowly conceived piece of legislation dealing primarily or solely with the catastrophic national health insurance approach. We urge instead prompt consideration of all the major health insurance proposals before the Senate and the House of Representatives. That kind of national debate is certain to result in much sounder decisions than the hasty actions within a very limited scope of concern.

I thank you for the opportunity to present this testimony and urge your diligent attention to the basic policy statements which I have presented as part of it. I point out to you that our basic statement has been in effect for 8 years and we believe it is even more pertinent to the needs of the Nation now than when it was first adopted.

Thank you very much.

[The prepared statement and attachments follow:]

STATEMENT OF ROBERT BARRIE, REPRESENTATIVE, HEALTH CARE TASK FORCE OF THE INTERRELIGIOUS STAFF COUNCIL

My name is Robert Barrie. I am Associate Director of the Washington Office of the United Presbyterian Church in the United States of America, and a member of the Health Care Task Force of the Washington Interreligious Staff Council. The Washington Interreligious Staff Council (WISC) is an ecumenical organization composed of representatives of Roman Catholic, Jewish and Protestant Organizations having staffs in Washington.

In presenting testimony, however, I speak for the policies of my own governing body, the General Assembly of the United Presbyterian Church in the United States of America. Nevertheless, in preparing this testimony I have been also guided by a policy statement of the Interreligious Coalition on Health Care which includes representatives of Roman Catholic, Jewish and Protestant Organizations. A copy of that document entitled, "The Need For A New Health Care Policy in the United States," is attached and I ask that it be made a part of the record.

Also attached to my written statement are two policy statements of the United Presbyterian Church in the United States of America. I ask that these, also, be made a part of the record:

1. "Toward A National Public Policy For the Organization And Delivery of Health Services" (A statement of the 183rd General Assembly (1971) of the United Presbyterian Church).

2. "Health Ministries and the Church" (a policy statement adopted by the Program Agency of the United Presbyterian Church in the United States of America and received by the General Assembly of the Church).

My appearance here today is based on the concern of religious organizations for the wholeness of persons as children of God, and therefore about their physical and mental health. I believe that, by being here, I am responding to God's command to care for and to act on behalf of his children.

Our denomination's policy leads me to say to you that the essential and basic principle which should underlie your decisions on national health care should be:

All persons within the U.S.A. are entitled to adequate health care and the federal government should guarantee that entitlement. The federal government is the only agency which can act for all the people.

That statement is illuminated not only by Judeo-Christian understanding of history, but also by the history of our nation and its constant striving to adhere to the democratic principles inherent and explicit in the Constitution.

Mr. Chairman, we share your concern that the nation is in a large and steadily worsening health care crisis. This is especially true with respect to the most frequently mentioned part of that crisis—rapidly rising health care costs and the growing struggle of thousands to pay for them. The question as to whether or not the nation can afford a comprehensive health care policy is, in our opinion, no longer valid. Our national experience has long since answered that. A mass of data signifies we can no longer afford not to develop and implement a comprehensive policy.

In singling out rising costs for special mention, we underscore the utter futility of dealing with that problem in isolation. It can be successfully dealt with only in conjunction with other components of the health care crisis:

1. Inadequate, mal-distributed resources for delivering health care services.
2. A poorly organized and grossly inefficient system for delivery of health care services which results in unequal access to health care.
3. Inadequate controls without appropriate accountability to the government and consumers to assure quality of health care.

In evaluating legislation designed to deal with national policy on personal health care services we, therefore, support features which assure a coordinated and comprehensive approach; we reject those which focus only, or primarily, on a single aspect of the health care crisis. Catastrophic national health insurance is an example of limited approach. When we evaluate proposals for catastrophic national health insurance we find that they will not achieve the basic goals we have mentioned. Catastrophic national health insurance proposals do not guarantee adequate health care to all persons within the U.S.A. They do not hold the federal government accountable for that guarantee.

Adequate legislation to deal with the current health care crisis must have at least the following basic commitments:

1. A commitment to universal coverage.
2. A commitment to comprehensive benefits.
3. A commitment to an emphasis on the encouragement of alternate delivery and financing systems such as health maintenance organizations.
4. Assurance of full public accountability and insistence on consumer participation in the development and administration of any proposed plan.

Inherent in all of the above commitments is our concern that whatever system of national health care is approved it should deal effectively and equitably with the needs of the poor and the disadvantaged of all ages. We abhor a two class system, in which there are separate approaches for those able to pay for their care and those unable to do so. We particularly abhor the use of any means test in determining eligibility to receive health care services.

As you are well aware the Congress has before it (or soon will have) a variety of proposals dealing with national health care policy. We include in this grouping, not only the Health Care for All Americans Act, soon to be introduced by Senator Kennedy, but President Carter's proposal, also soon to be introduced. We think that congressional debate on national health care policy should include the Health Security Bill, re-introduced by Congressman Corman in the House of Representatives, and the National Health Service Bill, introduced by Representative Dellums.

All of these measures have much in common of great merit. We believe that the country as a whole will benefit by a vigorous and extended national debate on all of them. Only in that way can the best possible final decisions be made. Early action on the very limited range of catastrophic national health insurance proposals would do a great disservice to the nation as a whole. More specifically, in addition to lacking the total comprehensive insurance approach, which we regard to be essential, we believe that catastrophic national health insurance will be inflationary because of its built-in incentive to "spend up" to the level at which catastrophic national health insurance will take over; or indeed to "spend down" to the level at which catastrophic national health insurance will take over for

the poor and the near poor. We believe that these incentives to "spend up" and "spend down" will be costly and inflationary, and by their very nature will contribute to poor quality of care and the unnecessary risks always involved in unnecessary medical care procedures.

In summary, we urge at the very least, delay on any decision on a narrowly conceived piece of legislation dealing primarily, or solely, with the catastrophic national health insurance approach. We urge instead, prompt consideration of all the major national insurance and national health service proposals before both the Senate and the House of Representatives. That kind of national debate is certain to result in much sounder decisions than a hasty action within a very limited scope of concern.

I thank you for the opportunity of presenting this testimony and urge your diligent attention to the basic policy statements which I have presented as part of this testimony. I point out to you that our basic statement has been in effect for eight years and we believe it is even more pertinent to the needs of the nation now than when it was first adopted.

THE NEED FOR A NEW HEALTH CARE POLICY IN THE UNITED STATES

A Statement of the
Interreligious Task Force on Health Care

Representatives of:
Jewish
Roman Catholic
and Protestant
organizations

September, 1972

FOREWORD

In June 1971 a group of staff people responsible for services and social action in the area of health and welfare from several religious groups was convened by the National Council of Churches to discuss mutual concerns about health care in the United States.

At that time each organization was at some stage in the process of developing or implementing a policy statement on health care in the United States. Religious organizations are concerned about the wholeness of persons as children of God and therefore about their physical and mental health. For this reason the emergence of health care as an urgent national concern confronted religious groups with an imperative to care and to act.

Without losing sight of the crucial importance of human problems affecting health—such as pollution, hunger, poverty, and war, and of ethical issues arising out of new biomedical technology—this statement will be directed to the provision of personal health care. This choice is made because of the imminence of federal legislation dealing with this subject.

Our regular meeting served to keep us informed about the content and process of policy development in our respective organizations and steps being taken to implement policies.

In order to test the extent of agreement among us, Edward Krill of the U.S. Catholic Conference very generously agreed to formulate a composite statement based on positions already adopted by our organizations. While we expected general agreement on the nature and extent of the problem, we were encouraged to find that there was also substantial agreement on the goals toward which efforts at solution should be directed.

It seemed feasible, therefore, to attempt to prepare a document which would represent the best judgment of members of the Task Force. While this document draws heavily on policy statements of several organizations, it does not speak for our respective organizations. Rather, its purpose is to speak *to* members of our organizations, particularly to those who influence decision-making in churches, synagogues, health and welfare agencies, and in communities. Members of the Task Force are committed generally to the point of view expressed here and we believe that it is consistent with policies of religious organizations which have adopted policy positions on health care.

A RELIGIOUS PERSPECTIVE

Our vision, illuminated by the Judeo-Christian understanding of history, sees that God's holy purpose is for mankind to be of worth and to be well, to be healthy and to nurture health for one another. The vision of faith sees the present reality in the light of what might be. Pain that is unavoidable can be accepted but ill-health that we have the knowledge and resources to avoid is intolerable. We acknowledge a commitment under God, to exercise public compassion and justice for all people of our land and to increase the well-being of all.

The pivotal issue, underlying discussions of all proposals for national health programs, deals with an emerging social philosophy regarding health care. This philosophy affirms that the availability of good health care is a right, to be enjoyed by all citizens—rather than a privilege to be limited by considerations of race, religion, political belief, or economic or social conditions. Therefore, our goal is that each person receive sufficient health care of good quality as a right and as a recognition of the dignity of man.

In an affluent society the provision of adequate health care is feasible. Therefore, unimpeded access to it should be a legal right of all citizens, a corollary to the right to life itself. The responsibility for fulfilling this right rests with both the individual and society.

We recognize that we are each involved in self-health care, in mutual health care in our primary social groups and in supporting health care services at home and abroad. What happens to our neighbors' health happens to us. An epidemic knows no political or economic or social boundaries. Residents of Keokuk or Chicago suffer ravages of Hong Kong flu just as residents of Asian cities and hamlets.

The development and preservation of good health requires a national commitment with well defined purposes and explicit goals. We believe that health care in the United States, though now substantially an endeavor of private and independent sectors, cannot be left to private resources and private initiatives alone. We believe the general public has direct responsibilities for designing and developing a comprehensive, publicly-oriented national health policy, which will make real the rights of individuals and the responsibilities of society.

The development of a comprehensive, morally defensible health care policy in the United States is not solely the responsibility of health care providers, whose knowledge and skill and art make superior health care possible for many. Our whole society gives priority to the production and consumption of goods, to profit-making and the defense of wealth, neglecting basic human needs. Therefore, all members of this society share responsibility for determining what objectives and priorities should be in health care.

Health Care Crisis

President Nixon, in July of 1969, said, "We face a massive crisis in this area (of health care) and unless action is taken, both administratively and legislatively, to meet that crisis . . . we will have a breakdown in our medical care system which could have consequences affecting millions of people throughout this country."

In 1971 the report of the Citizens Board of Inquiry into Health Services for Americans stated (inter alia):

"Americans are angry and frustrated about health services. . . . The anger is intense. It springs from frustration with efforts to obtain health services from doctors, hospitals, health departments and a host of programs and agencies that are involved with the delivery of health care. Anger also comes from exasperation that conspicuous deficiencies are met by a succession of studies and, at best, ineffectual efforts at reform. Let there be no mistake. The anger is well-founded. The deficiencies are real."[1]

Dr. Herman E. Hilleboe, in the 11th Bronfman Lecture to the American Public Health Association attributes to the late Walter Reuther speaking in 1968 the following: ". . . thirty million Americans live in poverty even though we have a Gross National Product of one thousand billion dollars. Let's face it; the poor are shut out of affluent society. Few other aspects of American life than health display a greater gap between promise and performance—reason enough for a high priority for health. The American consumers are subsidizing a non-system that fails to deal with basic health needs at a cost of two-and-one-half times the general price level. No amount of mental or moral gymnastics or clever Madison Avenue public relations can hide the ugly facts about the failure of our health system."[2]

Although the United States spends a larger percentage of its Gross National Product and more money per person on health care than any other nation, we are slipping in our ranking among the nations on key health indexes. Since 1950 we have gone from first to seventh in maternal mortality, from seventh to fourteenth in infant mortality, and presently rank eighteenth in male life expectancy. In 1970 white infant mortality declined, while non-white infant mortality, nearly twice that of whites, rose significantly. Non-white mothers die four to five times as often in childbirth. A poor person is four times as likely to die by age 35. Clearly, Americans are not getting the health care they have a right to expect.

Specific Problems

1. *Shortages, misuse, and maldistribution of personnel and facilities*
   There is inequitable distribution of health care resources, severe short-

ages of some kinds of health care personnel, and lack of medical facilities in many communities. Important sectors of the community are not able to obtain adequate health services; these groups include the poor, people in rural areas, and in recent years they increasingly include middle-income families. There are severe manpower shortages in the health service fields: primary care physicians, nurses, technicians and supportive services. The number of physicians providing *primary patient care* has decreased from 103 per 100,000 population in 1950 to 90 in 1971, although there is an increase in the number of physicians in all forms of service and the total number per 100,000. Moreover, health professionals are not equitably distributed geographically. In California there is a practicing physician for every 625 persons, twice as many as in seven other states. There are over 100 counties in the United States with no physician. Urban ghettos have lost most access to personal physician care.

Inadequacies in health care are not entirely due to a shortage of facilities and professional personnel. There is inefficient utilization of personnel and facilities that do exist.

2. *Costs and financing*

a) Spiraling costs have placed adequate medical care beyond the grasp not only of 45 million persons below or near the poverty line but also of many middle-income families. The cost of health care has been rising much more rapidly than other items in the consumer price index. In terms of 1967 dollars, for example, food that cost $74.50 in 1950 cost $119.20 in 1971. The total bill for personal health care for Americans (combining private and public payments) rose from $12.1 billion in 1950 to $26.4 billion in 1960 to $75 billion in 1971.[3]

One factor in inflating costs is lack of coordination and planning in acquisition of expensive equipment. One study[4] showed that almost one-third of those hospitals with expensive open-heart surgery facilities had not used them in a year. Unless there are adequate mechanisms to control the factors producing higher costs, larger and larger segments of our population will not be able to afford medical care.

b) Financing—There is no comprehensive system for financing health care in the United States, one which equitably distributes costs. There are many governmental and private systems, each reaching a segment of the population with varying degrees of effectiveness. During the decade of the 1960's approximately one-third of consumer health expenditures were met by health insurance.[5] One program, Medicaid, designed to provide care to the medically indigent failed to do so to a substantial extent. An HEW Task Force on Medicaid and Related Programs in 1970 reported: "only about one-third of the 30 to 40 million indigent and medically indigent who could potentially be covered (by Medicaid) will in fact receive services . . .", "the cost of covering less than one third has exceeded earlier estimates of the cost of covering the whole medically deprived population."[6]

Especially vulnerable in the under age 65 population are 13% not covered by hospitalization insurance, 20% without surgical insurance, and 57% who have no insurance to cover visits to doctor's offices or home calls by physicians. Insurance policies are designed with the company's rather than the consumer's interest in mind.[7] In 1969, 17 cents out of every dollar paid to an insurance company in health insurance premiums were retained for operating expenses, additions to reserves and profits. The comparable figure for Blue Cross-Blue Shield plans was 4 cents.[8] The cost of administration of public programs from fiscal 1968-1971 was 2.6% of total expenditures.[9]

Policy-holders in private insurance companies, including Blue Cross and Blue Shield, are unprotected or under-protected when they most need help: when they face extraordinary medical expenses or when they seek preventive care to avoid future expenses. This distorts priorities of care and interferes with effective functioning of the health care system.

3. *Inadequacies in the delivery system*

Health services are fragmented, with wide gaps in service, failing to provide continuity of care. This is particularly true when the patient may require attention by his family physician, one or more specialists including surgeons, convalescent care, and post-hospital follow-up care. Even a person with substantial resources now has trouble making effective use of a fragmented system. A low-income person finds it well-nigh impossible.

The current emphasis in medical care is on treatment of crisis illnesses, with relatively limited attention to "health maintenance" which would include prevention, early detection, and treatment during the initial phase of the illness.

Many factors contribute to denials of health care: inability to pay, distance from resources, discrimination based on race or ethnicity, place of residence, and ignorance regarding rights. Treatment of disease for a fee has all too often preoccupied providers to the neglect of health promotion and prevention of illness.

4. *Lack of controls for assuring quality care*

There are substantial variations in the quality of medical care. One is impelled to conclude that existing mechanisms are inadequate to assure quality control at reasonable cost, particularly for health services given outside a medical institution. Hospitals have medical reviews by peer groups, supervision by chiefs of staff, or other internal controls. The effectiveness of these controls varies widely and in many cases is seriously deficient.

For patients outside a hospital, controls tend to be limited to consultation or malpractice suits. There is no unified control system, but rather an agglomeration of relatively independent, self-regulating and diverse enterprisers and enterprises. The accreditation of hospitals, for example, is carried out by the Joint Commission on Accreditation of Hospitals, which is mainly supported by and controlled by The American College

of Physicians, American College of Surgeons, the American Hospital Association, and the American Medical Association. All four are organizations of providers. The Joint Commission itself has no effective voice of consumers in its policy-making and standard-setting decisions. Blue Cross Associations, which are supported by its subscribers, are governed by Boards of Directors consisting mostly of health service providers or their representatives.

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These problems are individually identifiable but interrelated. They reflect the fact that there is no national health policy that provides for the development, organization and delivery of comprehensive health care. In the absence of such a policy, unified goals and coordinated plans for meeting the nation's health needs do not exist. What is needed first is a national policy, which is based on the interrelatedness of relevant factors and which in turn furnishes the basis for a comprehensive health-care plan.

The following principles and recommendations are presented in an attempt to indicate some bases for such a plan.

FOOTNOTES

1. "Heal Yourself" Report of the Citizens Board of Inquiry Into Health Services for Americans, Frontispiece (University of North Carolina).
2. Hilleboe. H. E., M.D. "Preventing Future Shock", American Journal of Public Health, Feb., 1972, pg. 140.
3. Social Security Bulletin, U.S. Department of Health, Education and Welfare, Sept., 1971, pg. 52.
4. H.E.W. White Paper: "Towards a Comprehensive Health Policy for the '70s" (May, 1971).
5. "Why Health Security," Committee of National Health Insurance, July 7, 1970, pg. 19.
6. U.S. Department of Health, Education and Welfare, Office of the Secretary, Report of the Task Force on Medicaid and Related Programs, June, 1970, pg. 2.
7. "Heal Yourself" op. cit., pg. 24.
8. Social Security Bulletin, H.E.W., Feb., 1971, pg. 17.
9. Social Security Bulletin, H.E.W., Jan., 1972, pg. 9-11.

PRINCIPLES AND IMPLEMENTING RECOMMENDATIONS

I. The World Health Organization has stated:

> Enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being

without distinction of race, religion, political belief, or economic and social conditions.

Programs in the United States for financing and delivering health care should meet this standard.

II. Since health care systems vitally affect everybody, rich and poor, they must be accountable therefore to the general public at all levels of policy formulation and administration. Consumers (i.e. non-providers) of health care must have a primary role in defining goals and establishing guiding policies of the system.

1. Local communities should be empowered, under a national health policy, to define goals and to obtain services they need. Responsibility should be vested in a community health care policy-making body which will be composed in such a way that the dominant voice in decision-making shall be that of consumer representatives. These representatives should be accountable to organizations of people who do not derive any part of their income from provision of health care or the health industry.
2. Professional judgments and responsibility of physicians for diagnosis and treatment of individual patients should be assured.
3. Patients' right of choice among alternative providers and treatment plans should be protected.
4. There should be systematic efforts to develop an informed public that has increasing competence to make wise decisions and to create systems conducive to personal and corporate health.
5. The national health care system should provide for flexibility and pluralism in policy-making organizations to allow for regional differences and local self-determination of health priorities, for changing consumer demands and provider services.

III. The Health Care System should be comprehensive with respect to services and facilities provided and to participation of all relevant groups in planning and administration.

1. The following personal health services are essential and should be made available to all people in the United States:
   a) ready access to primary health care and ready referral for preventive and curative services, without exclusion.
   b) Emergency care.
   c) Hospital inpatient and outpatient services, clinic service for diagnosis and acute short-term care for both physical and mental illness.
   d) Long-term hospitalization or other extended care in facilities which provide nursing, therapeutic and rehabilitative services for both physical and mental illness.
   e) Dental care.
   f) Prescribed drugs.

g) Home health services, outreach and intake service, including transportation, nutrition consultation, personal and family health education, medical social services, physical therapy.
h) Family planning services. (It is to be understood that such services should protect the voluntariness of parents and that abortion is not considered a method of birth control. Moreover, the rights of health care personnel to refuse cooperation in family planning efforts should be respected.)

2. There should be comprehensive, coordinated planning and administration of health care, with publicly disciplined participation of practitioners and support personnel (such as health technicians, paraprofessionals, volunteers, etc.) to provide for maximum appropriate utilization of neighborhood ambulatory care units, general hospitals, medical research and teaching centers, and other specialized formal and folk resources, and to achieve functional cohesion.
3. Provision should be made for continuity in keeping and using medical and social records.
4. There should be appropriate community action to stimulate and develop competence for self-care and mutual primary group care.
5. New incentives should be developed to increase the availability and integration of health practitioners with diversified competence and for local comprehensive community care programs.
6. Physical and mental health programs should be integrated.
7. Provision should be made for regional health structures providing and appropriately relating essential research, training, specialized services, primary ambulatory care, hospitalization, preventive and health promotion programs.
8. Isolated persons and small communities should be provided all needed regular services through local health care units with transportation furnished to enable persons to have services of specialists and specialized facilities when they are needed. Such communities should have effective voice in deciding how the full range of services should be made available to them.
9. The quality of services should be controlled through organized and objectively administered consumer and professional medical evaluations. These mechanisms should include an effective form of peer group review, with adequate input from consumers and other non-professionals.

IV. Funds to support the health care system should be secured through means that are fair and equitable. Social insurance principles which spread the risk among a large population should be operative. Funding devices which discourage good personal health practices essential to health maintenance and preventive care should be avoided.

1. A National Health Fund should be established and maintained at

the optimum level by taxes levied according to ability to pay.

2. Direct payment to providers for health services at the time care is given should not be required of the individual patient or his family, except as there is ability and desire to secure services beyond the comprehensive quality care available to all people covered by the National Health Fund. If it is deemed necessary to provide for deductibles (i.e. payment by patient of a stated sum toward each service utilization) in the years of transition to a national health insurance system, the amount should be reasonable and consistent with ability to pay.

V. The health care delivery system should be designed to implement the principle that health care is a right to which every person is entitled.

1. There should be state, regional, or community health authorities, each serving a population large enough to require all the facilities and personnel for comprehensive health care, but small enough to enable communities through individuals and representative groups to design and control their delivery system.
2. Each state or regional health agency must arrange for the provision of essential personal health care to all people in its jurisdiction, using whatever agencies for service delivery and methods of payment will most effectively meet these needs. Federal guidelines shall provide incentives to support programs of prevention and early diagnosis and to assure essential services to isolated individuals and small communities.
3. The national health authority shall require that mechanisms and procedures shall be established in each state or region to assure that both quality of care shall be maintained and the circumstances of delivery shall be acceptable to the people served
4. In selection of staff and in provision of services all forms of discrimination shall be eliminated: of race, creed, ethnic background sex and age. Staff able to speak the language of consumers of the service should be provided.

VI. All necessary components for the provision of health care shall be planned for and adequately supported.

1. *Manpower.* There shall be effective utilization of all types of health manpower: professional, paraprofessional and non-professional. In areas where some types are in short supply, provision should be made for professional education, technical training of additional persons, or relocation of an existing surplus from elsewhere by providing appropriate incentives and career opportunities. This will involve:

   a) Making an inventory of existing health manpower as to number types of competences, and location;
   b) Identifying shortages and surpluses, maldistribution and inefficient use of manpower;

c) Improving and making better use of educational resources already available and, when necessary, creating new educational programs to fill shortages in health personnel;
d) Eliminating shortages caused by limited access to professional education;
e) Utilizing health personnel from other countries with due concern for the health needs of the countries from which they come.

2. *Research.* A certain proportion of the National Health Fund should be earmarked for research into causes and cures for diseases threatening the health of Americans and for studies to explore more effective methods of delivering health care. The national health agency should contract with national, state, or local agencies or institutions for stipulated research projects, according to a national plan based on information from all regions of the country, from all professional health disciplines, and from consumers representing all economic and ethnic groups.
3. *Facilities.* The development of facilities for provision of health services should reflect community-determined needs for services. This will call for health planning agencies (cf. II above) at local, regional, and national levels which are given responsibility and authority to do the following:

a) review service programs of all health providers in their areas;
b) determine needs for service independently of existing service patterns;
c) make public the information about differences between needs and services;
d) formulate a plan for facilities and services which will functionally correlate facilities, services, and needs.

Role for Churches and Synagogues

Members of the Task Force believe that churches and synagogues, [illegible] because they are religious organizations, have a responsibility [illegible] in the great national debate on changes in the health [illegible] system. Human rights and the dignity of persons are ill-[illegible] the present health establishment. This is a violation [illegible] and calls for thoughtful and determined action on the [illegible] organizations.

[illegible] Christian faiths are founded on convictions about man as [illegible] beliefs about God. These convictions must be made relevant [illegible] a program of legislation which will make possible the [illegible] mental health of the people of the United States, and by [illegible] with others in achieving the same goal for all people.

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THE NEED FOR A NEW HEALTH CARE POLICY

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HEALTH POLICY

A Statement of the 183rd General Assembly (1971) of the United Presbyterian Church

TOWARD A NATIONAL PUBLIC POLICY FOR THE ORGANIZATION AND DELIVERY OF HEALTH SERVICES

Introduction

"I have come that men may have life, and may have it in all its fullness."
John 10:10 (NEB).

A. **Our vision,** illuminated by the Judaeo-Christian understanding of history, sees that God's holy purpose is for mankind to be of worth and be well, and to be in health and nurturing health for one another, in institutions and with the whole world. In faith our vision sees both the promise and the present realities and faces up to ill health and its causes, because it knows a well-being, a life in which we share despite disabilities and illness. We acknowledge a commitment under God, to exercise public compassion and justice for all citizens of our land, and therefore, to increase the public well-being.

We know health is a mutual enterprise, "everybody's business." We recognize that as Presbyterians we are each involved in self health care, in mutual health care in our primary social groups and in supporting health care services at home and abroad among and for our neighbors. What happens to our neighbors' health happens to us. We are all involved directly and indirectly in meeting health care needs, just as significantly as we are each consumers of health care. By the same participation, we are each both shapers of societal and governmental policies concerning health care and recipients of the fruits of those policies.

In the face of those mutual responsibilities, we confess mutual culpability for the fractured and ailing condition of health care delivery in our nation, today, and for the shortsightedness of our nation in failing to participate appropriately in the development of effective health care for all the peoples of the earth.

We do rejoice in the care and devotion, the art and skill of a growing company of health care providers, as we rejoice in the explosion of medical science and technology, and in the innovative institutional and systemic efforts that lead toward a more effective delivery of health care.

B. **We find** that our society is giving highest priority to the production and consumption of goods and to profit-making and to the defense of wealth to the neglect of basic human needs including health.

President Nixon, in July of 1969, said, "We face a massive crisis in this area (of health care) and unless action is taken, both administratively and legislatively, to meet that crisis within the next two to three years, we will have a breakdown in our medical care system which could have consequences affecting millions of people throughout this country."

Fortune, in January, 1970, described the crisis: "American medicine, the pride of the nation for many years, stands now on the brink of chaos."

The worsening health care crisis is characterized by the continuing lack of a comprehensive national health policy and program reflected in inequitable distribution of health care resources, severe shortages of health care personnel, lack of medical facilities, spiraling unbearable costs for services, and an inadequate definition of health care for our time.

National Priorities and Health Policy

A. We believe that good health is one of the nation's most valuable resources, important not only to the well-being of individuals but also to the nation. The development and preservation of good health requires a national commitment with well defined purposes and explicit goals. We believe that health care, though now predominantly an endeavor of private and independent sectors, cannot be left to private resources and private initiatives alone. We believe the general public has direct responsibilities in redesigning and developing a comprehensive, publicly-oriented national health policy.

B. We find that there is no national health policy that provides for the development of the organization and delivery of comprehensive health care. In the absence of such a policy, unified goals and coordinated plans for meeting our nation's health needs do not exist. The confusion over goals is the major obstacle to an effective system of organization and delivery of quality health care. It is crucial, therefore, that there be a national policy to guide the restructuring of responsibility and accountability within the health care enterprise.

C. **Therefore, we recommend that:**

1. There be developed a national policy leading to a comprehensive system of health care which shall:
   a. Be accountable to the general public;
   b. Make all services and benefits available to all persons in the United States;
   c. Be administered by a single national health agency with power to enforce standards to provide the highest quality health care possible.
2. The purview of the national health agency include, within the full range of public, private and voluntary health facilities, service and agencies:
   a. Health promotion, health maintenance, prevention of illness, diagnosis and treatment of disease, and rehabilitation;
   b. Research and planning:
   c. Manpower development and deployment;
   d. Financing;
   e. Evaluation and assessment of needs and services, and recommendations for improvement and their implementation;
   f. Optimum development of each phase of daily activities, such as school and place of work, as the setting for health care.

etc., neighborhood ambulatory care units, general hospitals, medical research and teaching centers, and other specialized, formal and folk resources to maximize the appropriate utilization of each and to achieve functional cohesion;

3. There be appropriate community action to stimulate and develop competence for self-care and mutual primary group health care;
4. New incentives be developed to further the availability or group practice by health practitioners with diversified competencies for local community comprehensive care;
5. State laws prohibiting group practice be repealed;
6. Group practice units be linked with hospitals and other back-up units to offer prepaid, health promotion-oriented care on a per capita basis;
7. Physical and mental health programs be integrated;
8. Regionalization of the system be established with each region providing and appropriately relating essential research, training, specialized back-up services, primary ambulatory care, hospitalization, preventive and health promotion programs;
9. Health care units be established as needed to serve isolated persons as well as local communities with provision for community self-determination of priorities and full care guaranteed all community residents;
10. Appropriate programs be instituted to stimulate optimum local community development of health care.

Personnel Resources for Health Care

A. **We believe** that the recruitment, preparation, and utilization of health manpower deserve high priority. Responsible management and efficient delivery of quality health care requires competent health professionals and allied personnel, well-distributed, and optimally utilized. Health careers should assure opportunity to exercise humanitarian and social responsibility, and provide both lateral and vertical career mobility. Opportunities must be open equally to all regardless of age, race, sex, or ethnic origin.

Practitioners must be able and encouraged to keep abreast of new knowledge, technology, and delivery systems. They must participate in continuing research and improvement of their professions, and must be adequately remunerated with due regard to their usefulness and personal need. And they must be accountable to the general public and the consumer community they serve.

B. **We find** that there is a serious shortage of health personnel and no rational system to develop and employ adequate manpower, nor to assure maximum utilization and appropriate development. The U.S. Public Health Service estimates that we face current shortages totalling 481,000 including 48,000 doctors, 17,000 dentists, 150,000 nurses, 105,000 environmental health specialists, and 161,000 other health professionals. By 1980, this personnel shortage will probably climb to an estimated 775,000, yet approximately 15,000 applicants are annually rejected from medical schools, primarily by lack of space. We import 8,000 doctors a year, mostly from underdeveloped countries, who need them even more than we do; and still there are 11,000 hospital residencies unfilled. Because of migration of doctors to the suburbs, doctor shortages are most acute in the areas of greatest need--the central cities and remote rural areas.

While extraordinary efforts must be made to significantly increase the number of doctors, the increased use of allied professionals and paraprofessionals (many already trained in the military, peace corps, etc.,) offers a means of improving and expanding health care more rapidly and more adequately than by increasing the number of doctors alone.

Intelligent planning and action is needed now not only because of the present shortage of manpower but, also, because of the expanding number of health occupations, problems of accreditation, deficiencies in educational programs, and the requirements of future programs to provide essential health care.

C. **Therefore, we recommend that:**

There be a national health agency to formulate and administer public policy such as to:

1. Determine how the medical personnel resources of the nation might best be apportioned and related to develop programs to assure the just distribution of such personnel through voluntary choice;
2. Establish guidelines for expanding, organizing, and utilizing the supply of health manpower, including all levels of needed knowledge and skill;
3. Foster the creation of new health careers and new training resources for assistants and aids;
4. Provide functional, national licensure criteria for all health occupations:
   a. Facilitating unrestricted opportunities for career enlargement and advancement;
   b. Facilitating geograpnical mobility within the nation;
   c. Fostering optimal use of time in preparatory education and facilitating early placement.
5. Develop criteria and establish programs to encourage educational institutions to:
   a. Extend their capability to develop qualified health personnel for all categories of need in sufficient number to meet current and future demands;
   b. Increase enrollment and training in health professions and occupations;
   c. provide continuing education and training for health personnel and opportunities for career mobility;
   d. Stimulate through incentives and other means the recruitment for health professions and occupations from sections of the population that have been excluded because of economic or racial barriers or because of masculine or feminine discrimination.
6. Develop new educational institutions in areas where they can be of most service to people needing health care.

Financing Health Services

A. **We believe** each citizen should be eligible for comprehensive and continuous health services regardless of his ability to pay. Such universal coverage implies universal participation in the financing of that care. We believe that the public should get full value for the investments made in health care. We believe the economic arrangements should favor promotion of health and prevention of illness. We believe that the economic rewards in the health care system should be so distributed as to compensate all workers equitably, to promote equitable distribution of health resources among the population, and to cause optimum collaboration among health agencies.

B. **We find** that there are formidable and sometimes insuperable financial barriers to adequate medical services and health care for large numbers of people in the United States. Spiraling costs of such services, which continue to skyrocket at a rate of increase approximately two and one-half times faster than the general price index, threaten to exclude even larger numbers.

Money alone cannot be the answer, particularly if it is used to support the present fragmented nonsystem of delivering health care services. The present arrangement of financing is not adequate to achieve the objective of establishing a unified, coordinated system capable of increasing availability and continuity of care and enhancing its quality, promoting health and preventive medicine as well as the treatment of illness, improving the utilization and effectiveness of all services, and strengthening personnel and financial controls to restrain the escalating costs while providing fair compensation for those providing the knowledge, service, goods,and facilities.

The creation of a viable system and improved financing must take place simultaneously and in parallel.

C. **Therefore, we recommend that:**

1. There be such public investment in financing health care services that every person may be assured quality comprehensive health care, independently of an ability to pay, and without discrimination because of economic status, color, sex, religion, or political affiliation;
2. Public financing be utilized simultaneously both to facilitate access of every person to essential health care and to create a rational, well organized, economical, and balanced health care system designed to service all persons adequately;
3. A national health agency be empowered to provide leadership in developing and progressively refining objectives, standards, and methods of financing health care, and to regulate the financial operations of the health care system, so that appropriate economics may be realized and accountability to the consumer communities assured.

Enabling Health Services

In the face of the current health crisis, our Lord's concern for the health of all persons confronts us with an immediate urgency. His was a spirit that reached out alike to the leper and the centurion's son, that they might recover wholeness.

A new level of commitment and involvement is required of the Christian community today if we are to be faithful to the example of our Lord's healing ministry.

The varied legislative proposals, which are now before the Congress, dealing with the crisis in health suggest new health care opportunities for many persons. But the wide divergency of possible application demands a greater level of public determination in order to assure a system of comprehensive health care that serves God's purpose for all persons.

The Delivery of Health Services

A. **We believe** that the value of persons requires that each person have full access to essential services without regard to ability to pay and on terms that enhance the dignity of individuals. We believe that the needs of the whole person must be addressed in the context of his whole milieu. We understand such care to include attention to physical and dental, mental, social and environmental needs. We believe that only with a continuity of personal relationships in a health providing community and a continuity of access through comprehensive health services will adequate care be achieved. We believe that an understanding of what a person can do individually and in his primary social group to promote and protect his own health has high priority for developmental assistance. We believe that personal and local self-determination of health priorities is necessary for the proper correlation of needs and resources.

B. **We find** our medical system to be preoccupied with disease and crisis care, which is costly in lives, social relationships, and money. A recent study showed that almost one-third of those hospitals with expensive open heart surgery facilities had not used these in a year. We find that although the United States spends a larger percentage of its Gross National Product and more money per person on health care than any other nation, we are slipping in our ranking among the nations on key health indexes. Since 1950 we have gone from first to seventh in maternal mortality, from seventh to fourteenth in infant mortality, and presently rank eighteenth in male life expectancy. An inequality exists and is growing in our country. Last year white infant mortality declined, while non-white infant mortality, nearly twice that of whites, rose significantly. Non-white mothers die four to five times as often in childbirth. A poor person is four times as likely to die by age 35. And the National Urban Coalition, supported by data from the Social Security Administration, states that spiraling medical costs have placed adequate medical care beyond the grasp of at least 45 million persons below or near the Census Bureau's poverty line.

We find that people are not receiving the care they need. Specialized practitioners and specialized facilities have focused on isolated conditions with services that leave unattended the other commonplace acute and chronic individual and family disorders, much less their causes. Inability to pay, distance from resources, discrimination regarding race and ethnicity, place of residence, and ignorance regarding rights have all contributed toward denying health care that is a rightful human heritage. Treatment of disease for a fee has all too often preoccupied the providers to the neglect of health promotion and prevention of illness. We also find that available services are fragmented and uncoordinated, and often perilously concentrated in some locals.

C. **Therefore, we recommend that:**

1. Comprehensive health care for all persons include at least these elements: aid in growth and development, nutrition, prevention of illness, periodic diagnostic evaluation, treatment of disease, extended and home nursing care, rehabilitation, long term care for chronic disorders, and the appropriate social and economic provisions to make these feasible in the life of a person and his household;
2. There be comprehensive, coordinated planning and administration of health care with publicly disciplined participation of practitioners, support personnel such as health aid technicians, paraprofessionals, volunteers,

Process of Accountability in the Health Care System

A. **We believe** that health care is everybody's business, a mutual enterprise. Health care must be accountable to and under the control of the general public with decentralization of authority to make it responsive to the needs and desires of local communities and effective in providing consumer care.

Of paramount importance in the development and implementation of public health policies is the involvement of the consumer community. The involvements of the consumer stems not only from his self-interest in sharing the benefits of health sciences, technology and skills, but also from a concern for the right of all men to adequate health care based on need rather than on the ability to pay as the present system requires.

New frontiers in health care should develop a system that will achieve participation of all segments of society in defining objectives and priorities, guiding change and development in health care resources and services, and in surveillance of the performance and responsiveness of the health care system.

B. **We find** no unified control system, but rather an agglomeration of relatively independent, self-regulating and diverse enterprisers and enterprises. Some are harmfully competitive, and almost none is effectively accountable to the general public and consumers of health services. There are current vested interest groups that resist redefining purposes and goals. The consumer must help redirect policies and procedures. Therefore, the empowerment of consumer groups as a distinct element in policy-making and program development is essential. Otherwise, the current arrangements for delivering health care will continue to be dysfunctional. We will continue to have a shortage and improper utilization and maldistribution of health personnel and facilities, and we will continue to have costs spiraling beyond the reach of the vast majority of people.

C. **Therefore, we recommend that:**

1. The complex issue of health and health care be redefined as a public issue, affecting rich and poor alike, rather than a professional and management problem to be solved by a few, whether in public or private capacities;
2. The organization and delivery of medical and other health services be directly accountable to the general public at all levels of policy formulation, determination, and administration;
3. Local consumer groups be empowered, under a national health policy, to define goals and obtain what they need, as well as to check and balance the providers of health care services;
4. There by systematic efforts to develop an informed public that has increasing competence to make wise decisions and to create systems conducive to personal and corporate health;
5. Quality control of services delivered be established through organized and objectively administered consumer and professional medical evaluation;
6. There be flexibility and pluralism in the policy-making organization of the system to allow for regional differences and changing definitions of consumer demands and provider services;
7. There be established national guarantees and mechanisms for the execution of policy to protect the right of the patient and physician to make free decisions about medical treatment.

Therefore, the 183rd General Assembly (1971):

1. Calls upon all boards, agencies, judicatories, and members of the United Presbyterian Church to initiate and vigorously support actions affirming the recommendations of this statement.

2. Requests the appropriate agencies of the church to provide resources that will help United Presbyterians to deal knowledgeably and constructively with problems of health care and medical services.

3. Urges federal, state, and local governments to take prompt action to affirm, through appropriate legislative and administrative action, the right of all persons to full access to comprehensive health care without regard to ability to pay, and on terms specifically accountable to the public.

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Health Ministries and The Church

THE PROGRAM AGENCY

The United Presbyterian Church in the U. S. A.

Contents

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THE PROGRAM AGENCY, THE UNITED PRESBYTERIAN CHURCH IN THE U. S. A.
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Preface

The Presbyterian Church has a long and memorable history in medical missions. Responding to the biblical injunction to heal the sick, the early mission boards found an acceptance of medical mission in many countries otherwise closed to Western missionaries. The names and deeds of famous medical personnel and hospitals in Asia, Africa, and Latin America are a permanent part of our early history in spreading the Gospel to lands previously unreached.

As the world and human societies have changed through the past 150 years of mission involvement, so has our mission strategy in health ministries. Governments have assumed a primary responsibility for medical education and for determination of hospital standards. At the same time there has developed an increasing awareness of the limitation of the specialized hospital in providing for basic health needs of poor rural areas of the world. A growing concern to help people meet their own basic sanitation, food, and primary health needs has brought health mission into closer contact with community development efforts.

As a result, the Program Agency, acting for the UPCUSA in mission, established a task force from many areas of health care to help it restudy the strategy of health missions during the next ten to twenty years. After eighteen months of study and discussion, the following report evolved and was adopted by the Board of the Program Agency as its guideline for the future in health mission at its regular meeting in October 1977.

C. William Metcalf MD

C. William Metcalf, M. D.
President, Program Agency, UPCUSA

Recommendation and Conclusions

The Board of the Program Agency approved the recommendation that emphasis and priority in the health ministries of the church be given to:

A. Basic health services reaching to communities, supported by community organization, involving new types of health personnel linked to supporting capabilities in the health care system.

1. The development and improvement of basic health services accessible to all is an immediate priority.
2. Programs of community organization and education, primarily developing out of the community, are needed to begin, strengthen and sustain basic health services.
3. New types of health personnel and new roles for them in training workers and providing services should be strongly emphasized.
4. New and expanded responsibilities for hospitals in providing outreach and support services for community health programs should be encouraged.

B. The development of the unique capabilities of the church in restoring and maintaining health, in the broadest sense, of individuals, families and communities.

1. Church congregations need to recognize and develop their unique ministry in health.
2. The church in all its structures should continue and increase its role as advocate in health matters with a concern for equity, justice, and the preservation of human values.
3. The church needs to continue and advance its involvement where human value questions exist and arise.
4. The church should continue and increase its ecumenical approach in health ministry, and also continue consultations with health organizations in the public sector from the community to the world level.

Introduction

The changes that are occurring in the health field are seen to have significant bearing upon the health mission of the church. In fact, the extent and character of these changes compel thoughtful consideration of how best to proceed in health mission. While the changes occurring clearly impose mounting difficulties in continuing health ministry in ways which have served in the past, they also create new and greater need for the church's witness and influence in the health care of people in this and other nations. Not only does this pose new challenge to the church, it presents significant opportunity for renewal and revitalization of the church's health mission. This calls for the development of new and innovative dimensions in health ministry involving the unique potential of the church as a supporting community, reinforcing individuals in the attainment, maintenance and restoration of health. It calls for health program strategies which are sensitive to the culture and developmental status of local areas and which increasingly utilize local resources, with emphasis on developing the capabilities and self-determination of the areas served. In short, effective health mission in the changing world, both at home and abroad, entails new and modified approaches, adjustments in orientation and style, and redirection of priorities and resources.

The Theological Mandate for Ministry in Health

The church's involvement in health care and services is its response to a mandate of the Gospel. God's will, as revealed in Jesus Christ, is clearly for the wholeness and health of the Children of God both in this life and the life to come. That is what the biblical concept of salvation clearly implies.

The Bible knows nothing of a truncated salvation in which people's souls can be saved and their bodies neglected. Human beings are regarded as unitary beings whose souls and bodies are one. For this reason, the Christian faith focuses not on the immortality of the soul, but on the resurrection of the body. For this reason also, Jesus' ministry of healing was not merely a "spiritual" exercise. The lame were to walk, the blind to see, and the poor were to hear good news. Jesus' ministry was directed toward the good health of humankind not only in a hoped for hereafter, but here and now. This also is the ministry of the church.

It is quite possible to view life differently. If being human is only a biological existence, the control of genetic structures is open to all kinds of arbitrary experimentation, simply on the basis of biological interest. If a person is only an economic animal, the focus on this center in one's life will jeopardize existence the moment one loses the promise of productivity. If a person is only a political animal, the interests of state have an absolute right to define the boundaries of one's existence.

We have not so learned Christ. People are living souls. God has breathed into them the breath of life. They are born and they die to celebrate the mystery of that miracle. Procreation which neglects the possibility and centrality of that celebration, and simply sanctions all breeding, has lost sight of the center.

Health care in the biblical mandate means the positive support of the promise of life. Health care is a theological matter involving spiritual, physical, and social factors because the biblical vision sees not only healthy individuals but a celebrating and healing community in the present and coming kingdom. In fact, the healthy individual is the person whose life is significant and meaningful insofar as it becomes a contribution to the ultimate fulfillment of life in God's Kingdom. Life lived to the glory of God is life lived for the coming of that kingdom—hence the care of life means concern for and participation in the promise for a full life for all—the care and healing of society. Individual life and death finds its meaning in

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that total vision—a theo-centric and not ego-centric vision.

The implications of this basic insight are clear. It is not enough for the church to be concerned that individual bodies are protected and their life span extended, it is not enough that individuals find wholeness and meaning for themselves. It is the calling of the church to minister to "life together," to promote the communion of humankind to the glory of God. Such social concern is signified in the central sacrament of the Christian community—the Lord's Supper.

Health care has to do therefore with the nurture of individuals *and* society of which they are a part from promise to fulfillment by pursuing the biblical vision of the fullness of life of the God who created us. The church is called to something more than the amelioration of suffering in times of crisis (though that too is its task). It is called to the promotion of health and well-being in the broadest possible scale, for the love of life, and not the fear of death, is the church's primary and empowering motive.

Trends in Health Problems and Opportunities for the Church

Health, sickness, and death are matters of constant concern to the human race. Throughout the world there are debilitating diseases of many forms, infections, malnutrition (even in affluent countries), accidents, degenerative diseases and conditions, mental illness and a variety of causes of unnecessary afflictions and death at all ages.

There are a number of ways by which societies have responded to the threats to health. There seems to have always been a family or folk medicine which frequently has a religious aspect. Societies have greatly conditioned people's conduct, eating habits, travel, and have developed various instrumentalities and patterns of dealing with health needs. Health professions have emerged, hospitals and other institutions have been established, knowledge and technology have been advanced through research, and special educational systems for health workers have been developed. The interventions that can be made in disease patterns by inoculations, drug therapies, operations, and other capabilities of modern medicine are widely known and increasingly used in most areas of the world.

However, there are many problems involved in the system which society has developed to provide for health needs, and an adequate response to human illness is restricted in many ways. In broad perspective, the basic one is ineffectiveness in dealing with the root causes of health problems because of lack of understanding and many other factors. Poverty, inadequate living conditions, infested or contaminated environments, large and poorly spaced families, ignorance of the needs of sanitation, poor and insufficient food, unhealthy life styles, and personal values or socially determined behaviors, all with inherently unhealthy factors, are some of the root causes of illness, suffering, and death that are neglected as priorities of the health enterprise here and abroad. In addition, the effectiveness of health care systems in meeting human need is hampered severely by other inadequacies. Limited resources in money, personnel, and facilities frustrate health services; commonly there is maldistribution of resources which adds further to inability to serve needs effectively and equitably; inefficiencies in planning and organization, in educating, monitoring and evaluating lead to inadequate performance; and there is resistance to needed change and to correction of deficiencies where powerful vested interest is advantaged by the status-quo—all these contribute to health systems in both rich and poor nations that are lacking in sensitivity, responsiveness, efficiency, and ability to accomplish the purposes which they exist to serve.

Around the world human suffering is immense. The great majority of people in the world have no access to modern health care; simple diseases untreated lead to chronic sickness and an early death for large numbers of people; malnutrition reaps an extensive harvest of human lives; unhealthy environments, life styles, working conditions, and cultural attitudes and responses to health problems contribute continually to suffering, depression, and death.

The greatest hope in fundamental widespread reduction of this problem with its overwhelming dimensions is seen to lie in the new awareness of causal factors related to sickness and health. There is now a growing understanding world-wide of the importance of placing greater attention and emphasis on the root causes of health problems. New knowledge and skills have been developed that lead to reduction of disease and its toll. The place of social and family planning is increasingly accepted. There has been a heightened awareness of the need for balance between medical care in its hospital-based, disease-oriented form and other forms of health care in which the individual, the family, and the community have the major and

essential role in attacking environmental, social, and behavioral causes of sickness and death.

This new awareness leads to the importance of developing health services that reach to and are based in communities. Implied in this are new types of community-based health workers who are able to educate people and provide care in simple matters of health care and prevention, who are competent in basic maternal and child care, who can recognize and advise regarding environmental hazards and nutritional deficiencies, who can enlist the support of the community through community organization and education, and who are linked to a support system beyond the community both for guidance and referral. These basic health workers need the acceptance of the community, an awareness of the community culture, an ability to integrate modern medicine and traditional folk medicine in simple forms, and skills at making needed change.

New roles for health personnel are also needed beyond the community level. Community programs need effective supporting services which can be provided by personnel based at health centers and hospitals. There must also be regional managers, planners and practitioners who, in effect, do for the region what a basic health care worker does for the community. Hospitals and hospital-based staff can be a source of leadership for area-wide programs, of services upon referral of complex illness, and of training and supervision for a wide range of health personnel.

New relationships among various types of health personnel at all levels and of health personnel with the public are implied in these new directions. Instead of health workers functioning independently, there is a possibility of teams providing care. In place of a traditional separation between providers and consumers and unilateral responsibilities, there are implied factors of mutual responsibilities of providers and individuals, families and community, of coordination among community, regional, and national levels in collaborative planning, of ecumenical relations in the broad sense between churches and public and private agencies, and multinational approaches as being necessary for world health.

For the church committed to meeting spiritual and physical needs of people there have been many factors that already have brought changes in the patterns of ministry which traditionally were hospital-based, doctor-oriented service functioning in isolation and independently from other churches and governments. Rising costs of care and difficulties in recruiting trained personnel have been factors in change. But also there have been political and social de-

velopments in the independence of nations, the importance placed on self-determination, and, in many areas, nationalization of health personnel and services, all of which necessitate changes in the church's role and approach in health ministries. In addition, the church has been accumulating experience in new modes of providing health care and has become aware of the importance of the role of the congregation in support and healing and also of the place of the church in helping to deal with social, ethical, and theological issues in the changing conditions and technical capabilities of health care.

There is then a challenge to the church to become more fully involved in the new problems related to health care in a suffering world. There is the need for the church to respond to problems and trends, assess the resources it has available, identify the style and place for effective engagement, know the allies with whom it can work, and with enthusiasm and vigor to present its witness.

In the premises and direction seen for health ministry, this report does not differentiate specially between the health ministry in more developed and less developed countries. The problems in a broad sense are remarkably similar perhaps because the needs of humanity are consistent. Nor does this report in its recommendations seek to become specific either with regard to health care institutions or the specific responsibilities of local and regional or ecumenical church bodies. There will be urgent local specific matters that will vary from town to town and country to country. Leprosy or clean water may be the focus and concern and action in one area, in another it may be drug use, teenage pregnancies, or environmental contamination. At various places and times the national and regional church may be involved in studies and support of national health insurance or of the problems of poverty or international engagements; other church groupings might be assisting in a broadly based educational program on nutrition, child care, agricultural development, family planning or the education and supervision of basic health workers.

But while the report and its recommendations are spelled out in broad terms, applicability to these specifics and numerous others is implied. It is expected that the church in its various groupings will respond to its mandate of the Gospel and identify the tasks most suitable for its place and its capabilities.

Recommendation for the Church's Health Ministry

In light of the preceding sections on the theological mandate and the discussion of health-related problems and opportunities, the Health Advisory Committee recommends that emphasis and priority in the health ministry of the church at home and abroad be given to:

A. Basic health services reaching to communities, supported by community organization, involving new types of health personnel linked to supporting capabilities in the health care system.

1. Basic health services.

Proposition: Despite all the advances in medical knowledge and medical technology, unmet health needs remain and people in all parts of the world have yet to be reached. Especially is this true among the poor. New systems of health care which include basic health services can make a great contribution to the well-being of people if the appropriate plans for health care are made, education in preventive health measures developed, and easy access to frequently needed health care provided. A number of models which demonstrate these facts are in existence that could, with adaptation, be useful in guiding developments in other settings.

Substantiation: It is estimated that, in developing countries, 80 percent of the people do not have access to modern health care. Traditional wisdom and traditional medicine are there; but many of the simple facts of sanitation, nutrition, and reproduction are not known. Increasing population creates its own tragedy in a vicious cycle of famine and death. Those who survive are often the victims of continuous poverty and chronic disease and seek to produce more children so that at least one will live to maturity and be some support for the parents later. "The absolute poor are severely deprived human beings struggling to survive in a set of squalid and degraded circumstances almost beyond the power of our sophisticated imagination and privileged circumstances to conceive." . . . "Malnutrition saps their energy, stunts their bodies and shortens their lives. Illiteracy darkens their minds and forecloses their futures. Simple preventable diseases maim and kill their children. Squalor and ugliness pollute and poison their surroundings." (McNamara, R. S., *Address*

to the Board of Governors, World Bank, Washington, D. C., 1976, pp. 5, 35)

The World Health Organization (WHO) has just initiated a special program of research into several tropical diseases. The magnitude of these and other problems almost defeats the imagination; diarrhea kills between five and eighteen million children a year; one billion people live in areas where malaria is endemic; sleeping sickness is a permanent risk to thirty-five million people south of the Sahara; Chagas' disease affects ten million people in Latin America; two hundred and ninety million people are affected by filariasis.

The knowledge of how to bring great relief to the masses of the world's poor is available. The main need is to bring the knowledge to where the diseases are. During the last few years, new ways of doing this have been tried in pilot settings with success. A number of church organizations and others have been involved in village health care employing new types of basic health workers, who are generally resident in the community, chosen by the community, and specially trained for a few weeks or months for their roles. Some of these have been reported in *Health by the People* by K. W. Newell (W.H.O. 1975). Additional descriptions of such health services have been published in *Contact* (Christian Medical Commission) and also in *Here's How: Health Education by Extension* by Ronald and Edith Seaton.

Such basic health workers provide the point of access to the health care system. Basic health workers, involved as they are in community life and activity, can work directly with the root causes of disease.

Since they are often part-time and may be volunteers, they constitute a limited economic burden to the health care effort. The problems of poverty, infested or contaminated environments, large and poorly-spaced families, ignorance of sanitation, poor and insufficient food, unhealthy life styles and unhealthy socially determined activities are matters which the basic health workers can present to the community for action and assist in the education which is needed for individual and community understanding. Basic health workers provide preventive, curative, and rehabilitative care but also a link to supporting health care services for referral of more difficult problems.

Conclusion: THE DEVELOPMENT AND IMPROVEMENT OF BASIC HEALTH SERVICES ACCESSIBLE TO ALL IS AN IMMEDIATE PRIORITY.

2. Community organization and education.

Proposition: In conjunction with the first priority of providing basic health services, another immediate need is to promote good health practices and to educate people with regard to adequate nutrition, sanitation, and family planning. Integral to all this is the need to assist in community organization and the economic and social development of the poor in rural or urban situations. Even in more developed and affluent communities the importance of education in relation to the diseases of the time must be emphasized. Education and social development for rich and poor imply a change of life style by which disease is prevented.

Substantiation: Where the new types of basic health care services have been introduced most successfully, community organization and education have been conducted simultaneously.

One of the key factors in a reduction of the infant death rate is the adequate feeding of both the mother and child. In a rural setting this means a knowledge of nutrition and an adequate food supply produced by local agriculture to provide a nutritious diet. This in turn implies the introduction of improved farming methods, often using new types of seeds or crops and adequate water. Skills, new knowledge of social involvement, and appropriate community action are needed. In urban settings the needs differ but the problems are similar.

Also, in all countries there are social, cultural, economic, and ecological factors which are determinants in the health or sickness of the people of that country or region. Community involvement, education, awareness, and action are necessary for change in order to deal with the root causes of disease.

Conclusion: PROGRAMS OF COMMUNITY ORGANIZATION AND EDUCATION, PRIMARILY DEVELOPING OUT OF THE COMMUNITY, ARE NEEDED TO BEGIN, STRENGTHEN, AND SUSTAIN BASIC HEALTH SERVICES.

3. Health personnel.

Proposition: With the growing recognition of the many types of service that are needed for effectiveness of health care systems, the need of new types of health personnel is great particularly for those personnel who are engaged in basic health services.

Substantiation: The place of doctors and nurses in the hospital setting is well known. The churches are well experienced in training and deploying professionals to provide health service. However, more and more the responsibility for the training function is being taken up by the governments of countries in their health services. Less well known is the way to select, train and maintain people in the structures of community health programs. Governments are also seeking ways to educate and maintain such health workers upon whom rest the tasks of day to day education of the public for prevention as well as caring for basic health needs. In various countries councils of churches have become involved in assisting government programs that are in beginning stages, in encouraging groups in the public sector to develop such programs, or in supporting demonstration programs on their own. In all these cases, the selection of health leaders who can identify directly with the people they seek to serve, their adequate training for the specific tasks they are given, and the provision of necessary supplies and support systems are of great importance.

Conclusion: NEW TYPES OF HEALTH PERSONNEL AND NEW ROLES FOR THEM IN TRAINING WORKERS AND IN PROVIDING SERVICES SHOULD BE STRONGLY EMPHASIZED.

4. Responsibilities for hospitals.

Proposition: Established hospitals can serve as a base for the development of community health programs in their district or neighborhood. While hospitals are involved with the inpatient care of serious illness, they can serve in a broader role through operation or linkage with other types of health care such as outlying clinics, which are oriented to providing primary care, in order to meet health needs not requiring hospitalization, to provide emphasis on prevention, continuity and accessibility, and to support basic health workers with back-up services.

Substantiation: Hospitals form an important part of any health system. They are required for care of difficult cases of illness. In a rational health care system, services of a simple nature are performed at the community level, more complex cases may be sent to a health center, and cases that are not able to be treated adequately there are sent to the hospital. The hospital has a dual role in providing medical care: namely, to provide primary care in its immedi-

ate vicinity and to provide referral care in support of basic services in a broader area. In further support of basic health services, the hospital accepts or shares responsibility for the staffing of health centers and community-based programs for the training and supervision of community health care workers.

Hospitals and related schools for the education of doctors and nurses have been moving towards a community orientation at various centers around the world. A number of hospitals which are supported by the missionary work of the United Presbyterian Church are doing so.

An important aspect of this emphasis is concerned with the development of basic health workers and the orientation of other health personnel—physicians, nurses, paramedical, and auxiliary personnel—toward development and support of community-based programs. This is where the need for health personnel is the greatest. This is where the greatest gap exists between the health needs of people and the health system. There is need for health personnel to train people who will work as rural or urban community workers to promote and provide health knowledge and services in their communities. One of the main tasks for present health personnel is to provide education and support for these new types of health workers.

Conclusion: NEW AND EXPANDED RESPONSIBILITIES FOR HOSPITALS IN PROVIDING OUTREACH AND SUPPORT SERVICES FOR COMMUNITY HEALTH PROGRAMS SHOULD BE STRONGLY ENCOURAGED.

B. The development of the unique capabilities of the church in restoring and maintaining health, in the broadest sense, of individuals, families and communities.

1. The congregation's ministry in health.

Proposition: The congregation is the place where the people of faith gather and receive their communion together. In a very meaningful way, this is also the place where "wholeness" is received, shared, and understood. The renewal of the congregation as an agency in the ministry of health is of immediate importance.

Substantiation: The congregation has been described as having a central place in the health ministry of the church because it is a fellowship of love, a fellowship of worship, a fellowship of reconciliation, and a fellowship of prayer. These four elements of the congregation's life—love, worship, reconciliation and prayer—are profound forces for reinforcement and restoration of the health and the well being of the person.

In the spiritual vacuum of the present world and of our own society, the church has powerful, spiritual gifts that provide a supportive community to the lonely, reinforcement to individuals and families in anxiety, tension, and need, education to persons concerning their well being, and a perspective on life and death that gives direction, comfort, and support to people of all ages. The congregation can extend its healing influence beyond its own members.

Conclusion: CHURCH CONGREGATIONS NEED TO RECOGNIZE AND DEVELOP THEIR UNIQUE MINISTRY IN HEALTH.

2. The church as advocate in health policy.

Proposition: There is continuing need for advocacy in areas dealing with social and public health policy and human needs. This advocacy, in its appropriate form, should be a normal part of the life of congregations, presbyteries, synods, the General Assembly, and its agencies.

Substantiation: Major problems including the right to health care, access to the health care system, adequate and appropriate care within the system, the equitable distribution of health care resources and services, the balance of human and technical values, the education and placement of health personnel, the financing of health care, and the responsibility of government in assuring that needs are met are a continuing concern.

The 183rd General Assembly in its "Health Policy" statement entitled "Toward a National Public Policy for the Organization and Delivery of Services" set policy guidelines with regard to health care services which continue to need implementation.

The General Assembly and its agencies, synods, presbyteries, and congregations need to identify these problems as they appear in their own context of responsibilities and develop strategies in conjunction with other church bodies and public and private agencies to deal with them. International, national, regional, state, and local strategies are required so that this advocacy be effective and pursued

even when it encounters opposition in society or within the church itself.

Conclusion: THE CHURCH IN ALL ITS STRUCTURES SHOULD CONTINUE AND INCREASE ITS ROLE AS ADVOCATE IN HEALTH MATTERS WITH A CONCERN FOR EQUITY, JUSTICE, AND THE PRESERVATION OF HUMAN VALUES.

3. Human value concerns in health.

Proposition: In the rapidly changing scene of medical knowledge, technology and their application in health services, human values need to be asserted constantly. Knowledge is not necessarily applied humanely and new information continually raises problems affecting human rights and dignity.

Substantiation: The development of new knowledge through research and the application of this knowledge is constantly opening up new areas which are of great importance to the health and well-being of people and communities. With each advance new human problems arise which need an equal degree of interest, vigilance, understanding, and action as is applied to the development of those advances.

The problems of genetic manipulation and genetic counseling are immediate. Complex problems related to the use and misuse of drugs for behavior control are now constantly present. The prolongation of life by artificial means is regularly reported. Questions related to abortion, euthanasia, and the control of human experimentation are in the arena of public debate. Life and death decisions with regard to the abnormal newborn, accident victims totally disabled, and persons afflicted with gross senility have to be made daily by health personnel. Problems of allocation of health resources so as to reach the poor and neglected are matters of recurrent concern.

In all of these types of matters the church and church people need to be informed and involved both for their own ability to respond as they may personally be affected and so that the influence of Christian concern may be brought to bear on social policy.

Conclusion: THE CHURCH NEEDS TO CONTINUE AND ADVANCE ITS INVOLVEMENT WHERE HUMAN VALUE QUESTIONS EXIST AND ARISE.

4. The ecumenical approach in health ministry.

Proposition: The involvement of the church in health and wholeness in the changing world is too large and complex a task to be

undertaken by one denomination. Moreover, this task calls for the continued engagement in study, consultation, planning, and action of the churches in as broad collaborations as possible including ecumenical, governmental, and intergovernmental agencies.

Substantiation: The United Presbyterian Church has been strongly involved in the support of the Christian Medical Commission of the World Council of Churches since its beginning. This broad ecumenical base has been a most suitable context for the development of new understandings, plannings and strategies in the health field. National and regional bodies are now functioning ecumenically in the development of health programs. New types of health service have been begun, especially in the area of basic health services, as demonstration models which have informed and guided both church and government planning. A similar broad ecumenical context has proved to be most valuable in work with health professional education in this country through the United Ministries in Higher Education's Society for Health and Human Values and in other health care projects that are regional or local in scope. A significant aspect of all these ecumenical endeavors in health care has been the inclusion of representatives of health planners and policy makers having local, national and world involvement. This has resulted in an exchange of ideas and development of programs that have been mutually beneficial. It is also recognized that while there has been considerable exchange of ideas there is a great need for much more extensive cooperation between church bodies in health concerns.

Conclusion: THE CHURCH SHOULD CONTINUE AND INCREASE ITS ECUMENICAL APPROACH IN HEALTH MINISTRY AND ALSO CONTINUE CONSULTATIONS WITH HEALTH ORGANIZATIONS IN THE PUBLIC SECTOR FROM THE COMMUNITY TO THE WORLD LEVEL.

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The CHAIRMAN. Thank you.

Now, let's hear from Professor Rashi Fein, Center for Community Health and Medical Care, Harvard University.

STATEMENT OF RASHI FEIN, CENTER FOR COMMUNITY HEALTH AND MEDICAL CARE, HARVARD UNIVERSITY

Mr. FEIN. Mr. Chairman and members of the committee, I want to thank you for the opportunity to appear before you. Perhaps I ought to begin by noting that I, of course, do not represent the center, which is a part of Harvard University. It would be inappropriate to attempt to speak for a part of the university.

I can only represent myself and my family, which is large, not all of them residing in Massachusetts, I might point out.

I am an economist and I would like to touch base on a few matters that I think fall within the range of economics, particularly inefficiency, inequity, or distribution criteria. I think I may begin by reminding ourselves that the vast bulk that are already being spent, the vast bulk of the dollars involved in any new program, already are being spent. We are not talking about a youth sector that needs economic development. We have a rich and thriving medical care system.

The question, then, is are those dollars being spent efficiently, and are they being spent and raised equitably?

Under efficiency, three things. The efficiency of administration of any program. Some of you may have read recently a column on the "Outlook" page of the New York Times by Anthony Lewis where he recounts his difficulties in dealing with the hospital that had treated his son who was over 18 but a full-time student and therefore, unlike others over 18, was covered.

The efficiency of administration depends heavily on the number of categories, the number of classifications, the number of slots that individuals can fit into.

It would be a pity, indeed, a tragedy, if we spent our time as citizens having to deal in the future as we have had to deal in the past, with multiple categories and an inefficient system, a system in which on a bill that was $12 last year for services rendered for my daughter, I ended up paying—and the physician—a total of $1.80 in postage stamps alone. How many transactions there were between the physician and Blue Cross-Blue Sield. Almost 10 percent in postage stamps alone.

So we deal, one with the efficiency of administration, heavily dependent on the number of categories; second, the efficiency of the system. The medical care system will respond to the flow of dollars. It will produce what we are willing and interested in paying for. It will tip the system—if we develop a catastrophic plan only—it will tip the system in the directions that we can already see in a recent article in the New England Journal of Medicine by researcher Steve Schroeder out of the University of California and San Francisco on catastrophic expenditures.

Almost 50 percent of the individuals involved were there incurring catastrophic expenditures because of chronic care in very high-priced institutions.

If that is what we want to cover, then we ought to recognize the system will respond. It will respond by allocating resources in that direction, away from preventive care, early diagnosis, early treatment, and other things that are at the fundamental base of medical care.

The third, on efficiency—a question on inflation.

We now have inflation in the health care system, in the health care sector. The costs are rising. Unless we do something—and by "something" I do not mean "anything"—unless we do something to control resources, to cap with budgets, not to talk about resources are scarce, but behaving as if they are not scarce, not to call upon people to conserve when, in fact, there is no economic motivation to do so, unless we do something to control those costs, we will have the continued inflation ever getting worse.

There is a technical matter, as an economist. Because we tend to be interested in efficiency that we talk about, there is a second branch of economics, and that is equity. I would like to say a word in that arena.

Where we move in terms of comprehensive care, in terms of comprehensive insurance, in terms of system reform and in terms of inflation control depends in part on the kind of vision of America that we have. My vision and that of others, I would hope, is that equity requires that we not ration medical care in relation to income, that pain and suffering not be visited only upon, or primarily upon, those who cannot afford to get the medical care that might relieve that pain and suffering.

The premiums for such kind of care be related to income, that we not build further regressivity into the system.

I conclude then, by stressing that the program to be adopted has to meet efficiency and equity criteria, and that, to me, answers the question that is implicit in the phrase "can we afford it?"

"Can we afford it?" means that there is doubt, and that means that if we say we cannot afford it, we are, perforce, saying that we want to continue to ration medical care in relation to income and we want to operate without cost controls, thus insuring that the problem will get worse.

In my view, and in that of others, I am sure we are a young country, we ought to be willing to undertake new programs that continue to advance the general welfare.

I want to thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Professor Fein, for your testimony.

Now we have Mr. Max Fine, spelled F-i-n-e, executive director of the Committee for National Health Insurance.

Mr. Fine?

STATEMENT OF MAX FINE, EXECUTIVE DIRECTOR, COMMITTEE FOR NATIONAL HEALTH INSURANCE

Mr. FINE. Thank you very much, Mr. Chairman.

The Committee for National Health Insurance originally appeared before you about 8 years ago, after our technical committee had completed what became the original Kennedy-Corman bill.

We supported that for many years.

About 18 months ago, the administration suggested that we try to develop another bill, one that would have an important role for the private insurance companies and one that would minimize budgetary impacts.

The technical committee, augmented with people who have since emerged as high technical and qualified, worked for many months on this new approach, along with Senator Kennedy and his staff, and only now have we completed this plan.

It is called the Health Care for All Americans Act. I am here to urge that the type of hearing that you are giving to this plan be continued in full, because there are many other groups of experts who would like to be heard on the plan.

I might say that the chairman of our technical committee, Prof. I. S. Falk, formerly of Yale, would have liked to have been here today, but he is recovering from an illness.

Senator Mathias recently said it is easier to get a heart surgeon in my State of Maryland to do a coronary bypass than it is to get a doctor to treat your strep throat to prevent the heart condition in the first place, and I think that is true.

Our concern about catastrophic health insurance is that it would create a whole additional incentive for the medical schools and for individuals in medicine to choose heart surgery and other high-technology medical care, shifting the funds away from the preventive care that we think ought to be entering the system in a large way.

If you are going to mandate catastrophic health insurance on people who do not have health insurance today—and we are talking about the fellow who works in the pizza parlor, the lady who cleans and presses your suit, the shoemaker, the waitress—these are the people who have no health insurance today, and there are millions of people like that. If you are going to say by mandate you must pay 25 percent of the premium for a private health insurance policy, that does not even cover any of your costs until you also have expended $2,000 or $3,000 or $4,000, then you are not doing those people any favors.

I think it is very important that the committee take the full time necessary to examine the impact that catastrophic health insurance would have on health care delivery systems as well as the Health Care for All Americans Act.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Now, we will hear from Miss Mildred Jeffrey, national chair, National Women's Political Caucus.

STATEMENT OF MILDRED JEFFREY, NATIONAL CHAIR, NATIONAL WOMEN'S POLITICAL CAUCUS

Ms. JEFFREY. Thank you, Senator, and members of the committee, and thank you for the opportunity of being heard today.

The National Women's Political Caucus is a multipartisan group—we have both Democratic and Republican arms—with local chapters in 200 towns and cities across the country. For some time, and certainly this year, one of our top legislative priorities is the enactment of comprehensive health insurance that meets the specific health needs of this country's 84 million women.

We thank you, Senator, for holding these hearings on the catastrophic health bills, because we believe it is vital for the committee, and all the Members of the Senate, to know that these health insurance bills will not solve the problems that women face in obtaining adequate health insurance coverage.

They will, in fact, be a disaster for women, because they do not cover the preventive and routine care that are a substantial part of women's health needs. The nub of the problem for women is that our present system of health insurance in which private carriers determine who is covered, and for what illnesses and conditions, flagrantly discriminates against women.

First, of the 18 million women in this Nation who have no health insurance at all, the vast majority are the widowed, the divorced, and the abandoned women living on fixed incomes or meager salaries. Ineligible for medicare or medicaid, no longer dependents and lacking insurance, these women fall between the cracks in the system.

The catastrophic bill will offer no aid or relief to these women, who cannot even afford a routine checkup or the cost of minor surgery.

Seond, although the enactment of the pregnancy disability bill ended the longstanding practice of allowing insurance companies to exclude or offer minimal coverage for maternity care, gender-based discriminatory practices still abound. Higher rates are often charged to women, and working women are often not entitled to the same benefits as the spouses of working men.

Private carriers consider women poor risks and hence offer them less coverage at higher rates than men. Women feel ripped off by the current system that permits these discriminatory practices to be commonplace.

So, we believe Senator, and the committee, that the catastrophic insurance bill in no way addresses the basic problem of fix discrimination in insurance. We believe that only a comprehesive national health insurance that outlaws current unfair practices and offers total care to all women, regardless of employment or marital status, will benefit women.

We hope that you will continue your studies and hearings, and we will be happy to testify at greater length on some of the problems which women face in what we believe is an inequitable system.

Thank you.

The CHAIRMAN. Thank you very much.

Now, I am going to ask, in the first round of questions, that each Senator be limited to 5 minutes. After that, we will see how much further we want to go, on the 5-minute rule or the 10-minute rule.

Senator KENNEDY. Mr. Chairman, if I could make one additional comment.

In your various packages, there is a sheet on the issue of costs that might come up. When I was speaking earlier, I meant to mention it.

If the members could open their envelopes, there is a single sheet that addresses the questions of cost. This was the part of the appendix that was a part of HEW's estimate and I would just like to comment on it.

The CHAIRMAN. Does it have the numeral "11" on it?

Senator KENNEDY. Yes, that is right. This is a copy of the page provided by HEW. HEW's estimate of the cost of our program.

[The material referred to follows:]

APPENDIX: COMPARISON OF THE COSTS OF PRESIDENT CARTER'S NATIONAL HEALTH PLAN LEGISLATION (PHASE I) WITH THE HEALTH CARE FOR ALL AMERICANS ACT

The Administration's legislative proposal and the proposal announced several weeks ago present their costs in two difference ways. In order to understand the differences between the two proposals it is helpful to compare them both ways. This is done below assuming 1980 dollars and 1980 population counts.

(When the Health Care For All Americans Act was announced it was costed in 1980 dollars using estimated 1983 population counts. By using 1980 population counts, the estimates below reduce the costs of the Health Care For All Americans Act slightly.)

The Administration's approach looks primarily at net Federal budget and employer costs because taxpayers and employers are the ones being asked to shoulder the cost of new benefits. The costs to employers are especially vital in determining the employment and inflation effects of National Health Plan proposals. When viewed this way, the net costs of the two proposals are as follows:

[In billions of dollars]

	Phase I	Health Care for All Americans Act
Federal	+18.2	+30.7
Employer	+6.1	+33.1
Cost	+24.3	+63.8

The approach taken by the advocates of the Health Care For All Americans Act is to look at these and other costs now borne by individuals and state and local governments as well in order to determine the effect of National Health Plan proposals on total health system costs.

[In billions of dollars]

	Phase I	Health Care for All Americans Act
Federal	+18.2	+30.7
Employer	+6.1	+33.1
Individuals	−4.0	−25.4
State/local	−2.0	−2.7
Cost	+18.3	+35.7

Note: Includes reduced out-of-pocket and premium costs

Senator KENNEDY. What I am directing your attention to was included in some of the presentations that were made by the administration. You can note that the administration's phase I would be $24.3 billion and ours would be $63.8 billion. This represents additional Federal and employer costs.

I refer you to the next line, which identifies the employee and the relief of the individuals and the State and local costs. The sum of all these elements gives the total cost of our program. The cost of the Health Care for All Americans Act, as determined by the administration, is $35.7 billion if fully implemented.

Part of the increase is on the Federal budget, which is approximately $30 billion. That provides for the upgrading of the medicare program. It also provides some supplement for offsetting the additional hardships of some employers.

We effectively, however, have relieved the American taxpayer of the present sickness tax in the form of out-of-pocket payments. I call

that relief of the sickness tax. That means a reduction of $25.4 billion of individuals. It also means a reduction of $2.7 billion out of the State and local government expenditures. All of these costs are in 1980 dollars.

These projections are close to our own estimates of $40 billion.

As far as I am concerned, this is a judgment question of whether you provide that amount of relief to individuals, or that amount of burden in terms of the employers.

We have information on insurance payments paid by employers for health benefits. These data are provided by the chamber of commerce. You will find variation by different industries, but all industries now pay an average of 5 percent. Manufacturing firms, for example, contribute 6 percent. Other firms are in between, but we are basically talking about adding 2.5 percent more to employer contributions. That amount could be reduced up to 35 percent as the employer passing on part of the premium to an employee. It is important to note there are no out-of-pocket expenses by an individual.

The point that I want to make, just in putting this in some kind of perspective, is that the administration's projections of our total program is $35.7 billion, and our own estimate would be $40 billion. These projections are for the fully implemented plan.

The final point I would just mention, as I mentioned at the outset, is that we do not object to phasing the program. Our program would be phased in over a period of years.

If you look, for example, at the first concurrent resolution, the estimates are a surplus of $500 million in 1981. With a tax cut of $55 billion in 1982, we are to have $700 million. With a tax cut in 1983 of $75 billion, we are supposed to have a surplus of $44 billion. These estimates are under the concurrent resolution of the Senate Budget Committee report.

We are talking about beginning to phase our program in. We could take some of that surplus, or the judgment of the Congress in terms of the tax cut, and modify that surplus to some degree. We are not talking about increased taxes for the payment of national health insurance.

The other feature we are talking about is the crossover point which the administration does not have. With the cost controls and benefits fully implemented, you have a crossover at the end of a 4-year period. Therefore, total health insurance costs would be less in 4 years than our current policy. All of these costs should be scrutinized from an actuarial point of view. But I do believe the assumptions of the Budget Committee are reasonable assumptions.

The CHAIRMAN. Let me ask that the table about which the Senator spoke, appear in the record at this point.

[The material referred to follows:]

SENATE BUDGET COMMITTEE REPORT, FIRST CONCURRENT RESOLUTION FOR 1980

COMMITTEE RECOMMENDATION

[In billions of dollars]

Fiscal year	Tax cut	Surplus
1981		$0.5
1982	$55.0	.1
1983	75.0	44.7
1984	100.0	86.2

Assumptions

1. Achieve balanced budget in fiscal year 1981.
2. Real growth in defense spending.
3. Expansion in certain other high priority budget functions such as community development and welfare reform.
4. Reductions in most other programs to reduce outlays to 17.5 percent of GNP in fiscal year 1984, compared to 21.1 percent of GNP in fiscal year 1980.
5. No restraint in tax expenditures.

Interpretation

Under the Budget Committee's 5-year projection through 1984, the Federal budget will begin accumulating large surpluses (rising from $0.7 billion in fiscal year 1982 to $44 billion in fiscal year 1983 to $86 billion in fiscal year 1984). These surpluses will exist after major tax reductions in those years of $55, $75, and $100 billion, respectively.

The CHAIRMAN. You are using an additional table, other than the one to which you are referring?

Senator KENNEDY. I am using this one here, which we distributed, the others which I had asked to be made part of the record as chamber of commerce estimate of the insurance payments for health benefits, which gives the different industries.

That, I would like to include, and the Senate budget resolution with the spelled-out figures going into the period of the 1980's that show the surplus.

[The material referred to follows:]

Insurance payments for health benefits, 1977

Industry group	*Average payment for health insurance benefits as percent of payment*
Total, all industries	5.0
Total, all manufacturing	6.0
Manufacture of:	
Food, beverages and tobacco	4.8
Textile products and apparel	4.5
Pulp, paper, lumber and furniture	5.9
Printing and publishing	4.3
Chemicals and allied products	6.3
Petroleum industry	3.7
Rubber, leather and plastic products	7.7
Stone, clay and glass products	6.0
Primary metal industries	8.5
Fabricated metal products (excluding machinery and transportation equipment)	6.0
Machinery (excluding electrical)	7.1
Electrical machinery, equipment and supplies	5.5
Transportation equipment	6.6
Instruments and miscellaneous manufacturing industries	5.1
Total, all nonmanufacturing	3.7
Public utilities (electric, gas, water, telephone, etc.)	4.1
Department stores	3.5
Trade (wholesale and other retail)	3.5
Banks, finance and trust companies	3.8
Insurance companies	3.1
Hospitals	3.5
Miscellaneous nonmanufacturing industries (research, engineering, construction, transportation, mining, hotels, etc.)	3.6

Senator KENNEDY. And we believe, very clearly, that our program could be phased in, given the estimates in the cost of it, without any additional tax increase.

Finally, we are prepared to having the phasing in conditioned on the fulfillment of the requirements of the first phase. What we do object to is setting of the conditions for the implementation of the second, third, or fourth phase that are unrelated to the administration of health policy.

There may be a basic philosophic difference on that.

We would condition, and we would work out language on that.

That was the only other point that I would make.

The CHAIRMAN. Now, I will ask that those charts and the exhibits from which the Senator spoke be included in the record.

[The material referred to follows:]

STATEMENT OF SENATOR EDWARD M. KENNEDY AT A PRESS CONFERENCE INTRODUCING THE "HEALTH CARE FOR ALL AMERICANS ACT"

I am proud to stand here today with Congressman Henry Waxman and so many colleagues and friends to announce that the fight for comprehensive, universal national health insurance, with strict cost controls, begins anew this morning with the announcement of the Health Care for All Americans Act.

For the past ten years the Coalition for National Health Insurance has sought to make quality health care a matter of right for all Americans. The five basic principles of this coalition have always been, and remain today:

(1) comprehensive benefits,
(2) universal coverage,
(3) the strongest possible cost controls,
(4) system reforms to encourage preventive medicine and prepaid group practice,
(5) quality controls.

The Health Care for All Americans Act meets each of these principles. In addition, it gives a meaningful role to the private insurance sector. It limits federal expenditures primarily to payments for the poor, the elderly and the unemployed. In fact, no comprehensive plan meeting these principles will cost less.

Finally, this plan minimizes the requirements for a new administrative bureaucracy. No plan will have a simpler federal administrative structure than this one.

There are those who believe that comprehensive national health insurance, however desirable, is inconsistent with today's budgetary politics. They believe a piecemeal approach which enacts the lowest common denominator will relieve the political pressure from the constituents and defer the tough, central issues of cost controls and systems reforms for another day.

They are wrong on both counts. The plain truth is that another day may be too late. The American health care system is now strained to the breaking point by runaway costs. The issue of cost controls must be faced now, and it can only be faced as part of a comprehensive system. The Health Care for All Americans Act represents the best chance to avoid national bankruptcy and ot bring spiralling health costs under control. In fact, within four years of passage, the nation would begin to spend less on health care under this plan than if no bill is passed.

The tens of millions of Americans represented by the groups in this room are the constituency for national health insurance. They are the working men and women of this land, the senior citizens, the minority groups, the religious community, the nurses, the young physicians—to name just a few. This constituency is not and never will be satisfied by the lowest common denominator. Where is the constituency for catastrophic health insurance? Where is the constituency for a limited approach without comprehensive system reforms and cost controls? It's no wonder the Health Insurance Association of America supports piecemeal reform. It's no wonder the American Medical Association supports the lowest common denominator. But where are the citizens' groups that support it?

The Health Care for All Americans Act sets the standard against which any other legislative proposal will be measured.

It is not a standard set for ideology's sake.

It is not a standard set for political reasons.

It is a standard set to show what must be done to make the health care system work for all Americans at a cost the nation can afford to pay.

I don't minimize the uphill road to enactment that lies ahead. But the difficulties we will face do not call for lowering of the standard; they do not call for abandonment of the principles; they do not call for accepting the lowest common denominator. They call for leadership that holds up the standard and moves the political process to it. That is what this coalition is about. That is what we intend to do. And we call on President Carter to join with us to make quality health care a right for all our people.

HEALTH CARE FOR ALL AMERICANS ACT OF 1979—IN BRIEF

Universal coverage.—Every resident of the United States will be covered for mandated health insurance plans, with federal financing of coverage for the poor and the aged.

Comprehensive benefits.—There will be full coverage of inpatient hospital services, physicians' services in and out of hospital, home health services, X-rays, and lab tests. Costs of catastrophic illness will be covered since there will be no arbitrary non-medical limits on number of hospital days or physician visits. Medicare will be upgraded for the elderly and will also cover prescription drugs.

Cost controls.—Prospective bugdeting of hospital and negotiated fee schedules physician will become the principal method of cost control.

Budgeting costs.—Hospitals and doctors will be paid on the basis of prenegotiated amounts. They will not be permitted to charge patients more than the insurance plan pays. National, area-wide and state budgets for health services will be set and any increases will be tightly controlled.

Administration.—The program will be administered by a National Health Insurance Board whose members will be appointed by the President, subject to Senate confirmation. A majority will be consumer representatives.

State role.—The Board will contract with each state and territory to help administer the national health insurance program.

Insurance plans and HMO consortia.—Most Americans will be insured by an insurer of health maintenance organization which is certified and regulated by the federal government. The insurer must be a member of a consortium of (1) insurance companies, (2) Blue Cross/Blue Shield plans, (3) federally qualified health maintenance organizations, or (4) Independent Practice Associations. There will be a special consortium of plans such as those providing direct or those jointly administered by unions and employers.

Medicare.—The elderly and eligible disabled people will continue to be covered by Medicare which will be upgraded. Physicians will no longer bill Medicare patients but will be paid directly by the insurance plan. Prescription drugs will be covered for the elderly.

Medicaid.—The poor and near-poor will be covered by the national health insurance plan for all mandated benefits. Medicaid will cover only those services such as long-term nursing home care which are not incorporated in the national health insurance program. The states will contribute only what they are presently spending for Medicaid, and no more.

Health insurance card.—Every resident of the United States will be issued a health insurance card. If a patient receives medical care without proof of insurance coverage, the provider will bill the state agency which will pay the bill and later determine the source of payment. With or without a card, every person will have a right to receive treatment.

Federal regulations.—In order to be included in the program, an insurer will require federal certification and will be subject to ongoing federal regulation. The effect of certification and regulation will be to eliminate such long-standing practices as "risk selection" and discriminatory pricing, and to bring existing private insurance expenditures into conformity with public policy on cost controls and equity of benefits and financing.

Financing.—Employers will pay a premium related to total wages. The premium will cover the full costs of the covered benefits. The wage-related amount will mean that employers paying high wages will pay more for health insurance than employers paying low wages, although the rate will be the same. Unless other arrangements are made, employees may pay up to 35 percent of premium costs. This means, for example, that unions may negotiate for employers to pay the entire costs.

Self-employed.—The self-employed will be guaranteed comprehensive coverage at income-related group rates not to exceed the value of the benefits covered.

They will no longer have to purchase individual policies (if available) at high risk-related premium rates.

Costs.—Total costs of health care will be less within a few years of the national health insurance program than they would be under current programs because of the immediate and long-range cost controls applied. New on-budget costs for coverage of the poor and for improving Medicare, would be $28 billion in 1980 dollars.

Quality controls.—Quality controls will be strengthened and the states will be required to implement these quality standards as a condition of participation in the program.

Health maintenance organizations.—HMO's and other non-traditional forms of health care delivery, such as neighborhood health centers, will be fully supported and their development encouraged through incentives.

Competition.—Insurers and HMO's will compete for enrollees, but not by selecting "risks." They will know what premium they will be entitled to receive for each person or family covered. They will compete on the basis of administrative efficiency and for supplemental coverages.

Equalization program.—To assure that no consortium member will be able to profit by selecting "risks," there will be an equalization fund to counter-balance member companies and consortia. The program will protect individual companies or plans against unforeseen costly events.

Existing employer/employee arrangements.—An employer will be obligated to maintain existing contractual or other arrangements for health benefits. If the employer's present costs exceed mandated premiums, the excess will be applied to other employee benefits, subject to negotiation with employee representatives.

Preventive medicine and health promotion.—Services for the prevention and early detection of disease will be covered, including immunization and health education.

Resource distribution.—A Resource Distribution Fund will be used to improve services for underserved populations and to develop new services for the full population's changing needs, in particular for home care of the elderly and chronically ill.

Consumer and provider advisory councils.—A National Health Insurance Advisory Council and State Councils with consumer majorities will advise Federal and State Public Authorities.

COALITION OF NATIONAL HEALTH INSURANCE ORGANIZATIONS PRESENT AT THE PRESS CONFERENCE

1. Amalgamated Clothing and Textile Workers.
2. Amalgamated Meat Cutters.
3. American Association of Retired Persons.
4. American Council of the Blind.
5. American Federation of Labor-Congress of Industrial Organizations (AFL–CIO).
6. American Federation of Teachers.
7. American Nurses Association.
8. American Phychological Association.
9. American Public Health Association.
10. Americans for Democratic Action.
11. Association of Federal, State, County and Municipal Employees (AFSCME).
12. Bakery and Confectioner Workers.
13. Baptist Joint Committee.
14. Bridge and Construction Workers.
15. Building and Construction Trades Department.
16. Center for Community Change.
17. Chemical Workers Union.
18. Citizens Against High Blood Pressure, Inc.
19. Coalition of American Public Employees
20. Coalition of Labor Union Women.
21. Consumer Federation of America.
22. Food and Beverage Trades.
23 Group Health Association of America.
24. International Association of Machinists.
25. International Brotherhood of Electrical Workers.

26. International Brotherhood of Teamsters.
27. International Ladies Garment Workers.
28. International Longshoremens Association.
29. International Printing and Graphics Communications Union.
30. International Union of Bricklayers and Allied Craftsmen.
31. International Union of Operating Engineers.
32. League of Women Voters.
33. Mexican-American Legal Defense Fund.
34. National Association for the Advancement of Colored People.
35. National Association of Counties.
36. National Association of Farmworker Organizations.
37. National Association of Neighborhood Health Centers.
38. National Association of Social Workers.
39. National Coalition for Children and Youth.
40. National Coalition of Hispanic Mental Health and Human Services Organizations.
41. National Conference of Catholic Charities.
42. National Congress of American Indians.
43. National Consumers League.
44. National Council of Jewish Women.
45. National Council of Senior Citizens.
46. National Education Association.
47. National Farmers Union.
48. National Urban League.
49. National Women's Political Caucus.
50. Newspaper Guild.
51. Oil, Chemical and Atomic Workers Union.
52. Physicians National Housestaff Association.
53. Pipefitters Union.
54. Population Resource Center.
55. Retail Clerks International Union.
56. Service Employees International Union.
57. United Auto Workers (UAW).
58. United Church of Christ.
59. United Methodist Church.
60. United Presbyterian Church.
61. United Steelworkers.
62. U.S. Catholic Conference.
63. Women's Lobby.
64. Workmen's Circle.

SUMMARY

This national health insurance plan is designed to assure every American choices among the best health plans our Nation has to offer and free choice of provider of health care at a cost that employers, individuals, and government can afford to pay.

1. The plan preserves and builds on the best in private health insurance and health care

Private health insurance carriers and HMOs would be a mainstay of the program. They would be called on to provide insurance plans which meet or surpass Federal standards and to administer the insurance according to insuring practices now in use. The benefit standards for the insurance program would be modeled after the best private plans now available through employers and labor unions, without deductibles and coinsurance. Under this plan insurers and HMOs would be able to compete for business, both on the basis of their efficiency and service to customers and on the basis of the range of benefits they offer above the standard benefits or the actual price of their program for the employee or individual. Employers and unions would continue as at present to negotiate with insurers and HMOs for the best possible plan and pay premiums to these insurers. Individuals who are not employed, including those currently on Medicaid programs, would also be provided choices among the same insurers.

The program depends on private doctors, hospitals, health centers, and other health care practitioners to provide the care it covers. In return for caring for the program's beneficiaries, providers would be guaranteed fair payment from

the participating private insurers, HMOs, or Medicare. Doctors, hospitals, and other providers would be parties to negotiations to establish fair budgets and fees in every State or area. Negotiations would also relate to improvement in the accessibility, efficiency, and quality of care.

2. The plan preserves and strengthens the Medicare program for the elderly and disabled—and reforms Medicaid

Medicare would be extended to all Americans over 65 or disabled and would be improved to include the same broad coverages as the standard private insurance plan, with no deductibles and coinsurance. In addition, Medicare and private insurance plans would operate identically in how they pay doctors, hospitals, and other providers, and how they administer their activities. Medicare eligibles would receive additional benefits beyond those covered for the general population.

The private health insurance plan of their choice would be provided to people formerly on Medicaid, including all people who receive Supplemental Security Income. No means test would have to be met any longer by any American to receive these private insurance benefits. The Medicaid program would be reduced to residual State programs to provide service not covered by the private insurance plan.

3. The plan assures freedom of choice

Employers, unions, and individuals would have the freedom to choose their private insurer or HMO, and to choose their physicians. Medicare eligibles also would enjoy a broadened choice of HMOs or other health care arrangements. Most Americans could choose the same insurer, HMO, or physician they have today, but would find other options open to them—if they want to change—as the program develops.

Likewise, insurers and health care providers would be free to participate in the program or not, and to choose their styles and place of practice or business. Through four national consortia, insurers and HMOs would regulate their own affairs within broad Federal regulations. Through elected representatives, doctors and hospitals would negotiate fees, budgets, and other provider concerns under the plan.

The basic rules of the plan, such as requiring everyone not eligible for Medicare to choose insurance coverage, requiring payment of income-related premiums, requiring participating physicians to accept plan fee payments as payment in full for all patients, and requiring open enrollment and community rating by insurers, are necessary to assure that all Americans are provided full insurance coverage and quality health care. Most restrictions in the plan, such as those resulting from yearly limits on national, state, and area expenditures for health care, maximum doctor fees and hospital budgets, and community insurance rates would be based on good faith negotiations among providers, insurers, employers/unions, consumers, and government aimed at assuring good health care for all, at reasonable costs with fair payment to providers.

4. Every American could choose the best in private insurance or HMO plans, privately or through Medicare in the case of the aged and disabled, regardless of whether he is employed, whether he is part-time or full-time, what his health status may be, or any other factor

All employers must contribute toward a plan meeting at least the Federal standard for all of their employees. Self-employed and non-employed individuals would enroll in these same plans and pay a premium related to their incomes. Individuals would enroll or change enrollment with the insurer or HMO of their choice during an annual open enrollment season. No one could be turned away or charged more than the premium set by law. People who change jobs or are unemployed might stay with their same insurer or elect a new one, but their coverage would never stop.

Government agencies would help small employers and individuals shop for insurance and enroll in the plan of their choice.

Finally, no one can ever be deprived of their right to insurance. Even if individuals default on their premiums, the insurance continues, with bad debts paid to insurers by government and collected through the existing government system for collecting amounts owed to it.

5. All Americans would be guaranteed that their doctors or hospitals would be paid in full by insurance for covered health services—from birth to death—with no gaps between jobs or waiting periods

Under the plan, the government would guarantee doctors, hospitals, and other providers that they would be paid at negotiated rates. For patients who have forgotten to enroll, lost their health care, or do not know who their insurers are, the doctor or hospital would bill a public agency, which would identify the appropriate insurer or enroll the individual with an insurer and require that the provider be paid.

Neither the doctor, hospital, nor insuring organization would need to know whether the patient is rich or poor, employed or unemployed, self-sufficient or on welfare. The health insurance card indicates only with whom they are enrolled—and even without the card, payment is guaranteed.

HEALTH CARE FOR ALL AMERICANS ACT

INTRODUCTION

This proposed new national law has been developed using the social insurance principles that were embodied in the Health Security Act and supported by a broad coalition of institutions, including labor unions, health providers, religious organizations, social agencies, and others. The Health Care for All Americans Act proposes to implement these social insurance principles through private insurers, rather than government. This new act proposes, indeed, a progressively financed comprehensive health insurance program for all Americans using government-regulated private insurance.

Major features of this program include:

Income-related premiums.

Maximum on premium payments of individuals equal to the value of the protection received (most individuals will pay considerably less).

Limits on the rise in health costs through budget controls and reimbursement reforms.

Fair, negotiated, reimbursement rates.

Incentives to individuals, insurers, States, and providers to keep down rates.

The redress, over time, of the maldistribution of resources.

Reform of Medicaid, eliminating the means tests as a condition of eligibility for covered benefits.

Retention and improvement of Medicare.

The Health Care for All Americans Act would rely heavily on private health insurers, health care providers, employers, unions, and the American consumer. Most of the costs of the improved insurance coverage and most of the administrative responsibility is left with these private institutions and individuals, and outside of government.

The government's role is to guarantee that every American is provided comprehensive health insurance coverage, and to assure that private institutions work to make good health care available to every American at costs that the individual, employer, the taxpayer, and the Nation can afford to pay. The government performs these roles by presiding over negotiations on private insurance premiums and doctor and hospital payments, by regulating private insurers and setting budgetary limits on total health care costs, and by encouraging competition. Finally, the Federal Government would operate an improved Medicare program covering all elderly and disabled Americans, and States would operate a residual, reformed Medicaid program.

This proposed new law, in short, proposes to implement Health Security principles by building on the best in both private institutions and government. The new Federal costs for this broad program, with no deductibles and coinsurance, would approximate $30 billion when implemented in 1983.

6. All employers and individuals are assured they will pay a fair and affordable premium for health insurance

Traditional insurance premiums are set on the basis of an individual or group health care experience, and the same flat premium is charged to employers and individuals for everyone in the same group or with the same experience. Indi-

viduals with low incomes and employers with less profitable businesses find it hard to pay such a flat premium per person and usually buy minimal insurance or none at all.

Under this new national health insurance plan, employers and employees pay premiums related to wages—and individuals with non-wage income over $2,000 per year pay an income-related premium. The maximum paid by an individual would be the negotiated community-rated premium, which would not exceed the actual value to the individual of health insurance coverage.

This approach allows all employers and individuals to afford to buy the best in health insurance or HMO coverage, paying a premium based on wages or income, without regard to past health care experience or any other factor. It also means that virtually every person with income makes a contribution toward the cost of the plan—proportional to their income.

As is the case at present with the best insurance plans in the Nation, the employer would pay most of the total premium, with the employee sharing up to 35 percent, or less based on labor/management agreements. In order to be fair to higher-income individuals, a limit is set such that the employee or other individual's premium share never exceeds the actual community insurance rate for their insurance coverage.

In order to be fair to employers, if the premiums for this new insurance exceed their current premium as a percentage of wages by more than three percent—and if their profits are adversely affected by it—the government will credit their taxes for part of the excess.

The burden of health costs of people on welfare would not be placed on employers or individual premium payers. Instead, the premiums for insurance for people who are on welfare (including those receiving Supplemental Security Income) would be paid by the State and Federal Government based on the actual costs of health care provided to these individuals. The States' costs for these premiums and residual Medicaid would be limited to no more than would have been the Medicaid cost in the absence of the plan. The States would, overall, experience lower costs under the plan, especially if the costs of State-owned facilities are taken into account.

All wage-related and income-related premiums are paid to the insurers' consortia. The premiums would then be allocated by the consortia to individual insurers on an experience-rated premium basis for each insurer's enrollees. In most cases, the insurers would be the same ones people deal with now. The government would guarantee that the wage-related and income-related premiums raise enough revenue to pay for all health care covered by the plan except for those persons eligible for Medicare, SSI, AFDC.

Financing for the separate and improved Medicare program would be as now, except that participation in the full program would be mandatory, and Medicare taxes would apply to all wage earners.

7. All Americans would be assured they can afford the health care they need

The plan would cover everyone for a broad array of unlimited health services, with provisions for developing expanded long-term care, home health care, and other benefits over time. These services would be paid for by the insurer or HMO at no additional cost to the individual beyond the income-related premium.

Doctor, hospital, and other health care bills would be sent directly to the insurer based on the patient's health card, and the insurer would pay them directly at negotiated rates. The patient would never have to pay the bill and then be reimbursed—nor would there be any additional charge to the patient over and above what the insurance pays. The payment system itself would be easier and less costly for both providers and insurers.

These provisions virtually eliminate the fear of unaffordable health care costs from Americans' lives.

8. The plan would work to make the best in American health care more accessible in every community

The plan aims, over time, at getting adequate numbers of physicians, health centers, and other needed services actually available in every community—while discouraging still more services where there is already an excess. The plan would encourage a redistribution of health services by slowing growth in hospital budgets and total expenditures in oversupplied areas and encouraging more rapid growth in shortage areas. Consistent with State plans for health care, health care providers, employers, unions, and consumers would develop state and na-

tional health budgets that allocate available resources to the communities where need is greatest; and they would negotiate fee schedules and budgets for individual physicians, hospitals, health centers, and other providers consistent with these budgets.

The plan would also establish a Health Resources Distribution Fund to make grants to start up needed services and would establish programs of data collection, research, and demonstration to identify problems and find ways to furnish good health care to everyone in the country over time. Special studies would focus early on the needs of special populations, such as the elderly, disabled, migrant workers, American Indians, the poor, and women.

9. The plan would work to slow down the rise in costs of health care and insurance premiums in the Nation for employers, for government, and for individuals

The plan aims at slowing rising costs through competition, through negotiations, and through budgeted limits.

Competitive incentives for insurers and HMOs.—Insurers and HMOs are given competitive incentives to operate efficiently, to assure provider fee schedules and budgets are complied with, and to offer health care in more cost-effective ways. First, they are free to market their plans to everyone in the Nation, and the more people who enroll because of the advantages of their plan, the more the insurer stands to benefit. This creates an incentive to control costs in order to offer broader benefits at the negotiated community rates, or the standard benefits at a reduced rate. The plan allows insurers to do both by permitting "rebates" or "dividends" to be paid to enrollees when the plan's costs are lower than the community rate.

Second, insurers and HMOs would have to absorb any financial losses incurred if their negotiated community rate fails to cover the costs of health care services to their enrollees—i.e., they are "at risk." This creates further incentive for efficiency and careful monitoring of claims, fee schedules and budgets.

Third, insurers and HMOs would be permitted to make special arrangements with doctors, hospitals, or other providers to pay amounts less than the amounts that would result from following the negotiated fee schedules or budgeted rates. They would then offer such special arrangements to everyone who enrolls with them, with any savings from the community-rated premiums converted into more benefits or premium rebates.

Finally, incentives for insurers to compete by experience rating or risk selection—which aggravate the overall costs of care problem by increasing costs to the ill—are eliminated by careful government regulation of open enrollment, how plans are priced and advertised, and other marketing practices, and by the insurers and HMOs self-regulating efforts within consortia.

Incentives for providers of health care and payment negotiations.—Providers of health care would be given *incentives* to assure fair billing and good medical practice in order to keep health care costs to the levels they helped budget for the State, and for which they negotiated fee schedules and budgets. This is accomplished by putting providers "at risk" for any cost overrun. That is, doctors would have to renegotiate or "pro rate" fees for the remainder of the year if, based on reports to the government by the insurers, fee payments were being made at rates that would exceed the budget (except for epidemics and other explainable causes). Hospitals also would be required to absorb any such overruns. In addition, providers would be encouraged to form HMOs and would be free to make desirable arrangements with insurers or HMOs for new forms of care at payment rates at or below the costs that would result from following the negotiated fee schedules and budgets in order to compete for patients.

Negotiation of fee schedules, hospital and other provider budgets, and national and state community-rated premiums are critical to the plan's approach to cost control. Under the plan, providers of health care negotiate with those who ultimately pay for health care—namely, employers, unions, individual consumers, and government—to agree on what payment rates and budgets are fair and reasonable. In turn, based on these fee schedules and budgets, the government negotiates with insurers and HMOs to establish fair and reasonable community-rated premiums to cover services in every State, and to set national wage-related and income-related premiums adequate to pay these community-rated premiums.

Incentives for employers, employees, and State governments.—Employers, unions, governments, and individuals are given incentives to negotiate to keep costs down by a provision that allows the actual wage-related premiums for a

State to be reduced below the national rate if the State spends less on health care than its budget limit allows. The State's premium for AFDC beneficiaries would also be reduced by lower health costs.

All of the negotiations, both those with providers of care and those with insurers, are based on a joint effort to plan needed services in each State, project their realistic costs, and make necessary choices under the budget limits set for the Nation and each State by formulas in the law.

Budget limits.—The overall national and state budget limits in the plan are designed to slow cost increases to the rate of overall increase in the rest of the economy, and to encourage some services and areas of the country to increase faster than others. They are not designed to stop increases in health care costs, and are generous enough to allow improvements in the quality and accessibility of care. These budget limits would be firm and stated specifically in the law. They could not be exceeded by the wage-related or income-related premiums set under the plan, or by the community rated premiums negotiated with insurers and HMOs.

The combined effect of these incentives, negotiations, and budget limits would result in providing more and better health care, which after just a few years would be provided at lower costs than if our health system were left unchanged.

10. American citizens would be assured that private insurance and health care institutions would retain most of the responsibility for this plan—and would be required to meet higher standards set by government to assure every American obtains the best in insurance and health care

Under this plan, government at the Federal and State levels would act as a convenor of private institutions to plan, budget, and negotiate, and as a regulator to assure all parties participate by agreed-upon rules designed to assure fairness, competition, and individual and institutional rights. In addition, the elderly and disabled would be served by a government-run Medicare program responsive to their special needs—and as a standard for other insurance.

The plan would result in more responsibility being placed with insurers and providers than ever before in the history of the Nation, and would define a new government role in health care, putting government at a considerable distance from the actual day-to-day provision of health care.

HEALTH CARE FOR ALL AMERICANS

I. STATEMENT OF PURPOSES

A. Make comprehensive health services available to all Americans through the application of social insurance principles to a system utilizing private health insurance.

B. Provide the same comprehensive health benefits to everyone without consideration of means.

C. Contain the total costs of health care at a rate of increase no faster than the rise in the GNP.

D. Distribute the cost of health care equitably.

E. Keep the costs of health care borne by the Federal Government, the States, employers, and others at moderate levels.

F. Create improvements in the organization and methods of delivery of health services.

G. Enhance the distribution and quality of care.

H. Encourage health protection and preventive medicine.

I. Provide protection and preventive medicine.

J. Provide reasonable compensation to those who provide health services.

K. Assure full public accountability of all aspects of the plan and its operations, as well as consumer participation in its development and administration.

II. RIGHTS AND ELIGIBILITY PROVISIONS

A. The National Health Care for All Americans Program Statement of Rights

1. Rights of patients.

(*a*) Patients shall have the right to obtain the wide range of benefits covered under the program from any approved provider of health care services they choose, including the right to choose a provider from among all those who have joined the program (unless they have, by enrolling with certain insurers, agreed to limit their choice of provider).

(*b*) Patients have a right to expect that health and other information collected about them shall be held confidential and used only for purposes absolutely necessary to the effective management of the program.

(*c*) Patients shall have the right to prompt and accurate handling of all decisions made about their status under the program.

(*d*) Patients shall have the opportunity to be heard on grievances they may have, related to their care or insurance related to that care.

(*e*) Patients, either individually or collectively, shall have the right to make their views known (and have them considered) on all actions of the program which affect them.

2. Rights of providers of health care service.

(*a*) Providers of health care services shall have the right to decide whether or not to participate in the program.

(*b*) Providers of health care services shall have the right to receive prompt and accurate payment for services rendered.

(*c*) Physicians shall have the right to choose their mode and place of practice.

(*d*) Providers of health care services, either individually or collectively, shall have the right to make their views known (and have them considered) on all actions of the program which affect them.

3. Rights of eligible insurers.

(*a*) Eligible insurers shall have the right to decide whether or not to participate in the program.

(*b*) Insurers shall have the right to carry on a health insurance business covering health care services supplemental to the benefits covered under the program.

(*c*) Eligible insurers, individually or collectively, shall have the right to make their views known (and have them considered) on actions of the program which affect them.

B. Universal eligibility

1. Every individual shall be eligible under the program who:

(*a*) Is a citizen of the U.S. or an alien admitted for permanent residence or other alien permanently residing in the U.S. under color of law;

(*b*) Is a legally admitted alien who is not a permanent resident but is an employee or family member of an employee of a foreign embassy or international organization and is present for extended periods, and whose employer enters into an agreement for participation in the program; or

(*c*) Is a foreign visitor legally admitted for a period of short duration, but only under the terms of a treaty or other international agreement between the U.S. and the nation of the visitor.

2. Eligibility would continue whether or not premiums are paid, or even whether the individual enrolled.

3. All people eligible under 1. shall be entitled to the following:

(*a*) To have payments made on their behalf to meet in part or in full their obligation to pay for covered health care services (described in III);

(*b*) The right to enroll with an approved insurer, including insurers which offer financial or benefit advantages for enrollment;

(*c*) The right to change their enrollment from one insurer to another, where such a choice is available, during the national general enrollment period each year; and

(*d*) A health insurance card (issued by the insurer with which they enroll) identifying them as eligible under 1, (but which will not indicate the sources of any funds paid to the program with respect to them.)

C. Enrollment

1. All employers shall, during the first general enrollment period under the program (defined below), offer to each of their employees (other than those eligible for medicare, including those eligible because they have end-stage renal disease) in such period a choice of health insurance plan or plans, at least one from the insurer members of the non-HMO consortia and one from the members of the HMO consortia which offer such a plan or plans for the areas in which each of their employees works. With respect to HMO plans, the employer shall first offer any plan to any representative of the employees according to definitions and procedures of Sec. 1310 of the P.H.S. Act regarding "Employees' Health Benefits Plans." The employer may offer one or more supplemental benefits, but any additional cost to the employee of electing the supplemental benefits shall be made clear to the employee.

2. Employees shall choose a plan from among those offered to them to cover them and their dependents (defined below), which shall be in effect at least until their next enrollment period.

3. In cases where an individual, including such individual's spouse, is offered a choice of plans from more than one employer, the family unit may exercise only one choice from among all choices.

4. Dependents would be spouse and children (under 22) as defined for personal income tax exemption purposes.

5. Members of the armed services and their dependents. The Defense Department would act as both employer and consortium (defined in Part IV) for active members of the armed services. Members of the armed forces may be assessed a premium within the limits applied to other wage workers. The Department would retain as premiums funds appropriated for this group, finance such services provided to the group as are covered under the Defense Department Plan, and issue identification cards. Members and dependents of members of the armed services would be offered such enrollment choices as the Defense Department finds consistent with its policy of requiring use of Defense Department facilities. The Defense Department would pay the costs of services covered under this Act when furnished outside its facilities, and recover (as it determines appropriate) from its enrollees any costs it pays for such services that are not reimbursable under the Defense Department plan.

6. Medicare group enrollment. Every individual who has attained age 65 in a month, or who is entitled to disability insurance benefits for a month, or who has end-stage renal disease shall be entitled to benefits under both Part A and Part B of the Medicare program as amended by this act. All insured status requirements for the aged would be deleted.

7. All individuals not included above who are eligible for NHI benefits would have the choice of enrolling under any certified insurer in their state or area.

(*a*) *SSI enrollment.*—Enrollment as SSI eligibles (and residents of federal institutions not otherwise covered): All SSI recipients under age 65 and not eligible for medicare and residents of federal institutions not otherwise covered, would receive enrollment information from social security district offices during the first general enrollment period and would enroll directly with insurers.

(*b*) *Enrollment of AFDC eligibles (and residents of state institutions not otherwise covered).*—States would be required to furnish enrollment information to recipients of AFDC (and AFDC-U) and residents of state institutions not otherwise covered during the first general enrollment, and subsequent enrollment periods.

(*c*) *Individual enrollment.*—It would be the responsibility of the State Board to furnish enrollment information to all other individuals. For individuals who did not enroll during the first general enrollment period, the State Agency would get up a procedure under which the enrollment would take place when the individuals sought and received health care but did not have an identification care, or at the point when they file an annual income tax return without shoring health insurance enrollment. Providers of health care or insurers would notify the State Agency of all unenrolled individuals who seek care.

8. Voluntary participation group. All foreign persons who do not meet the basic eligibility provisions and reside in the United States for extended periods could become eligible under the terms of treaties and other international agreements between the United States and foreign governments and international organizations.

D. Open enrollment period

1. There would be a first general enrollment period during June through November of the year before the basic benefit plan became effective.

2. There would then be a general open enrollment period during the period September through November of each year to be effective the January 1 following.

3. First enrollment (after the first general enrollment period) could occur when an individual reaches age 22 or enters the country and becomes eligible. People would be disenrolled from private insurance when they become eligible for Medicare.

4. Changes in enrollment would be allowed if an individual or family changed areas (or a new employer did not offer their current insurance plan).

5. Upon enrollment, the insurer with which the individuals are enrolled would issue them NHI cards identifying their choice (so the providers would know whom to bill).

E. Definitions of wage, employer, and employee

1. The definition of wages for purposes of the plan is identical to that used for personal income tax withholding purposes.

2. The definitions of employer and employee, for purposes of the plan, are identical to those used for purposes of determining who must withhold personal income tax payments, but would not include those eligible for Medicare.

III. HEALTH CARE SERVICES COVERED

A. Required benefits under both Medicare and Private Plans

1. Hospital services (as defined in Medicare except that the services of hospital based physicians, as defined, would be incorporated in the definition) including inpatient and outpatient services (as defined in Title XVIII) without limit as to number of days or visits (subject to exclusions set out below, including the requirement for medical necessity). (Medicare benefit would be made the same.) Except that inpatient psychiatric services in a hospital shall be limited to 45 consecutive days of active treatment beginning with the first day of hospitalization which begins more than 60 days after the most recent such period. Physician services provided to in-patients of a psychiatric hospital by physicians under contract with the hospital would be included without limit as a hospital service in addition to services of physician consultants that may, as determined appropriate, be covered under 2.

2. Physician services, without limit and regardless of where performed (except for services provided for a mental condition). Physician services in home, hospital, or office for a mental condition would be limited to 20 visits, as defined by the Board, per year. The term "physician" would remain as at present for Medicare and for other purposes would include doctors of medicine and osteopathy, dentistry or dental and oral surgery, podiatry or surgical chiropody, and optometry—all as defined in Medicare.

3. Home health services, as defined in Medicare for 100 visits in a year.

4. Skilled nursing facility services for 100 days per year following a hospitalization of three days or more (as in Medicare).

5. Preventive services covered would include at least basic immunization, pre- and post-natal maternal care, and well-baby care. Physicians, as a part of their medical practice, should maintain a special interest in and watch over workers and other populations at high risk because of past exposure to environmental and occupational hazards. The NHI Board, after receiving advice from a panel of experts, would be authorized to add additional preventive services which it determines, based on substantial evidence, would be cost effective and whose cost would not in the first year exceed $500 million, adjusted in line with program costs for the second and following years. In the event that the costs are found to exceed the limit, appropriate reduction in the services covered would be required. The Board would also be authorized to establish the conditions under which the services would be covered.

6. Medical and other health services would be the same as in Medicare, as follows:

(*a*) Services and supplies incidental to a physician's professional service in his/her office;

(*b*) Hospital services incidental to physicians' services rendered to outpatients;

(*c*) Diagnostic services furnished in outpatient departments;

(*d*) Outpatient physical therapy services;

(*e*) Rural health clinic services. Services of other clinics would be covered, provided the clinics met standards set by the Board;

(*f*) Diagnostic X-ray tests, laboratory tests, and other diagnostic tests;

(*g*) X-ray (and related) therapy;

(*h*) Surgical dressings and splints, casts, and other devices for treating fractures;

(*i*) Durable medical equipment used outside an institution;

(*j*) Ambulance service;

(*k*) Prosthetic devices (other than dental) which replace an internal organ, including lens after cataract surgery;

(*l*) Leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including necessary replacements.

7. Outpatient drug benefits for Medicare eligibles only for chronic illness. The Board would establish a list of diseases and conditions found to be chronic and

the drugs which are covered with respect to each disease and condition listed.

(*a*) Only drugs which require a prescription (plus insulin) would be covered, and only those listed in a formulary developed by the Board with the advice of the appropriate advisory panel.

(*b*) Require generic prescriptions whenever generic equivalents are available.

(*c*) Reimburse dispensing pharmacies on the basis of the cost of the drug supplied or the lowest cost generic equivalent generally available plus a professional's dispensing fee.

(*d*) HMOs (or other insurers) may use this formulary approved by the NHI Board, but could also use their own formulary provided that: (1) The Board approved it; (2) Members and potential members are informed that its formulary differs from the national one, and what these differences mean to members.

(*e*) The Board would also have authority to set maximums and minimums for the amount of a drug prescribed.

8. Mental health day care services—two days a year for each day of inpatient psychiatric benefits not used. Electroshock therapy covered only in cases of severe depression and only where prior approval has been obtained through an arrangement established by the area PSRO.

9. Outpatient physical and speech therapy services as in Medicare, plus short-term occupational therapy where the promise of improvement is substantial.

10. Audiological examinations and hearing aids limited to one examination a year and one hearing aid every three years. Paid on the basis of cost of the hearing aid plus professional fee. The cost of hearing aids would be covered only up to amount of those on a list of those hearing aids whose costs are found reasonable by the Board.

11. Outpatient services provided by a community mental health center, except that the total amount payable during a year for a patient could not exceed the estimated equivalent of the negotiated fee for a psychiatric visit for that year times twenty, with the amount reimbursable under their budget for each outpatient visit or service adjusted to reflect the type and salary level of personnel involved. Where an individual receives outpatient services for a mental condition from two or more centers or from one or more noncenter physicians and one or more centers, the maximum reimbursement on behalf of a patient shall be the equivalent of a negotiated fee for a psychiatric visit times twenty.

B. Exclusions

The following exclusions would be made to the basic set of benefits:

1. Services or items which, except for preventive services, are not reasonable or necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

2. Services or items which are not provided within the United States (except under the conditions used in Medicare, related to the closest convenient hospital and travel between parts of the U.S., but only for Medicare). "United States" includes, in addition to the several States, only the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, American Samoa, and the Trust Territory of the Pacific Islands.

3. Services or items which constitute personal comfort items.

4. Orthopedic shoes or other supportive devices for the feet (other than for Medicare eligibles).

5. Custodial care.

6. Cosmetic surgery except for prompt repair of trauma-induced injury or improvement of the functioning of a malformed body member.

7. Items or services furnished by immediate relatives or members of the household of the patient.

8. Treatment of flat foot conditions and the prescription of supporting devices therefore, treatment of subluxation of the foot or routine foot care, including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care, unless prescribed by a physician other than a doctor of podiatry or surgical chiropody as seriously handicapping or a danger to general health for a patient with a diagnosed case of diabetes mellitus.

9. Services provided by practitioners who are excluded from Medicare because they have been found to have abused the program or have been convicted of crimes (under sections 1862(d) and (e)).

C. Medicare changes

1. Remove limitations on days of coverage in section 1812(a)(1). Retain spell of illness provision for post hospital extended care services only.

2. Remove deductibles and coinsurance for inpatient hospital services and post hospital extended care services in section 1813, including the three pint blood deductible.

3. Remove section 1814(g) related to payment for services in a teaching setting to a fund. This would be handled by normal budget reimbursement considerations under hospital reimbursement.

4. To provide that all persons age 65 and over would be eligible for medicare, section 1818 (dealing with people not otherwise eligible for Medicare) is amended by striking out "to enroll in" in subsection (a) and inserting "under" in lieu thereof and by repealing subsections (b), (c), (d), (e), and (f).

5. Modify section 1833 (Part B of Medicare) so as to remove the deductible and 80 percent coinsurance (except for subsection (c) dealing with treatment of mental conditions), and to remove the three pint blood deductible.

6. Modify sections 1836, 1838, and 1840 to make enrollment under Part B mandatory. Where deduction from benefits is authorized, it would be made mandatory. The Federal government would pay the premium on behalf of those eligible to receive SSI benefits. Where there is no Federal benefit payable to the individual from which the premium can be deducted, he/she shall be subject to a tax of 115 percent of the amount due, unless he/she pays the premium out of pocket. All provisions for late enrollment in the future would be removed.

7. Repeal section 1843 related to State agreements for coverage under Medicare of persons eligible for medical assistance.

8. Add drug benefit to Medicare covered services listed in 1861(s).

9. Amend section 226 of the Social Security Act so as to make Medicare entitlement begin with the month for which an individual is entitled to disability insurance benefits, rather than 24 months after.

10. Repeal section 1867 (Health Insurance Benefits Advisory Council).

11. Remove all references to Secretary throughout Title XVIII and insert National Health Board instead. Specifically, modify section 1874 so as to use National Health Board.

D. Effective Dates

Basic benefit for the non-Medicare population would go into effect January 1 of the third year following the year of enactment.

E. Incentive payments

1. Any person who chooses a plan of an insurer (from any consortium) which offers expanded benefits at the state or area community rate or a cash rebate payment from this rate, would be eligible to receive the full amount of such benefits or payment, except that, under rules promulgated by the National Board, a portion of the rebate may be allocated to employers in return for services in arranging for the availability of cost-effective insuring plan if the portion is negotiated in accordance with the procedures of Sec. 1310 of the PHS Act, regarding "Employers Health Benefit Plans" and the role of employers and employee representatives regarding HMO arrangements. Insurers may limit the services they cover to those offered by selected providers to offer coverage at rates beneath the community rate for the State or area, but all NHI benefits would have to be provided or covered.

2. As indicated, enrollment incentive payments could be in the form of increased benefits (but if they are, the insurer must state the actuarial value of such benefits) or in the form of cash payments (and such payments shall not be taxable income for income tax purposes, shall not offset welfare payments, and shall not reduce any credits due under provisions establishing a maximum on premiums.)

3. The full amount of such incentive payments shall be rebated to the enrollees, except as described in E.1. above.

IV. ADMINISTRATION

A. Administrative Functions

1. The program would be administered primarily by certified private insurers and HMO's operating within regulations and negotiated agreements established and administered by National Health and State Health Boards with the involvement of state government, private health agencies, providers of care, employers, and individuals.

2. Certified private insurers and HMOs would:

(a) Negotiate community rated premiums on a national, state and area level with the National Board for insuring all services covered by this Act;

(b) Participate in negotiations of the State Board with providers of care to establish budgets and fee schedules;

(c) Market insurance or HMO programs to all eligible persons for all covered services at the negotiated community rates, or for enhanced services at that rate, or for that rate reduced by a rebate.

(d) Enroll and issue health care cards to all persons eligible for coverage under this act who enroll with them during annual open seasons and at other specified times;

(e) Underwrite the costs of insuring all services covered by this Act to their enrollees in exchange for the community rated premium;

(f) Pay health care providers for covered services under this Act at rates equal to or less than those negotiated by the State Board. Payment may be less than the negotiated level provided that these rates have been agreed to by the provider and are consistent with the objectives of the program and contribute to price competition;

(g) Establish national consortia which perform administrative and representative functions on their behalf, including:

(1) Collecting wage related and other mandated premiums and payments sufficient to pay the negotiated community rate for all enrollees;

(2) Paying individual insurers and HMOs community rated premiums on behalf of their enrollees (see Part V, F, 5 for more details);

(3) Paying providers of care at negotiated rates and apportioning the costs paid among member insurers in accordance with National and State Board provisions for doing so;

(4) Representing insurers and HMOs in state and national planning, negotiating, and other activities;

(5) Exceptions would be made in anti-trust statutes with respect to functions which insurers are required to perform under the plan.

3. The National Health Board would:

(a) Establish national policy guidelines and standards for the implementation of all aspects of this Act, and oversee implementation of its provisions by providers, insurers, employers, and other affected institutions and individuals;

(b) Establish national and state Annual NHI Budgets within the authority for leeway provided by the legislation, negotiate with insurers and HMOs to establish national and state premiums, assure payment of established income related and other mandated premiums necessary to finance the community rated premiums, establish one or more systems for apportioning among insurers the costs of payment to providers reimbursed on a budget basis, and negotiate with providers regarding policy and processes for establishment of provider budgets and fee schedules and for payment mechanisms;

(c) Establish a national Health Resource Distribution Plan and administer health resource development and health service programs as well as budget distributions by type of service and area to increase accessibility of covered services where it is inadequate;

(d) Certify insurers, HMOs and their consortia, and perform all other functions required by the Act with respect to insurers, HMOs, and their consortia;

(e) Extend fiscal relief to impacted employers, as defined in Part V;

(f) Collect data required for the planning, budgeting, and monitoring activities under this Act, and for evaluating its effects on health and health care in the nation (See Part VI.D. for details);

(g) Be responsible for administering the Medicare program as amended by this Act;

(h) Contract with the public corporations established by the states to perform the functions described for the State Health Board.

4. The State Health Board would, under contract with the National Board:

(a) Submit State Annual NHI Budgets (within the overall budget allocated to the State) to the National Board and implement Budgets as approved by the National Board;

(b) Negotiate prospective budgets and fee schedules for the payment of providers within the approved budget and State Health Resource Distribution Plan;

(c) Select the system for apportioning bugeted costs among insurers in the event that the apportionment process developed by the National Board provides such a choice;

(d) Administer grants from the states' allocations of the Health Resources Distribution Fund in a manner consistent with the State Plan for Health Resources Distribution approved by the governor;

(e) Review State administration of its residual medicaid program for conformance to federal standards as a condition of federal assumption of the administrative costs of the program;

(f) Facilitate the enrollment process by employers and individuals, guarantee payment to providers for covered services to persons without health cards, and assure enrollment of all eligible persons;

(g) Certify providers of care under this Act (or oversee their certification by private or state agencies approved by the National Board) and perform other functions required by the Act with respect to providers of care;

(h) Perform such other functions as specifically delegated to it by the National Board.

5. State Governments would:

(a) Nominate members of the State Board;

(b) Propose to the State Board, based on the health planning process described in Title XV of the PHS Act, Five Year Plans for Health Resources Distribution describing expansion, redistribution, or curtailments of health facilities, personnel, and other resources for review in the context of the proposed Annual NHI Budget for the state;

(c) Implement certificates-of-need (and related provisions incorporated in Sec. 1122 of the Social Security Act and Title XV of the Public Health Service Act) or other such programs as exist in the state in a manner consistent with the Annual NHI Budget for the state;

(d) Participate in negotiations of provider budgets and fee schedules for the state or area;

(e) Pay group rated premiums to insurers for non-employed AFDC eligibles in the state;

(f) Be responsible for administering a "residual medicaid" program for the State.

6. Private agencies:

(a) Professional Standards Review Organizations would be expanded to review all covered health services by all providers, including the establishment of norms and criteria for medical practice and perform all the other functions now assigned to them under Title XI, Part B, of the Social Security Act;

(b) The JCAH (and comparable private agencies) would continue their present Medicare role for certifying provider compliance with requirements under this Act.

7. Providers of health care would be invited to offer services on a participating basis in the program, and to send elected representatives to national and state negotiations to establish budgeting procedures and fee schedules.

8. Employers would:

(a) Negotiate with insurers and HMOs and offer a choice of insurance and HMO arrangements to their employees consistent with the definitions and procedures of Sec. 1310 of the PHS Act, regarding the role of employers and employee representatives regarding HMO arrangements;

(b) Facilitate enrollment of the employee and his/her dependents in the plan of his/her choice;

(c) Make wage related premium payments, including any employee share withheld (based on labor-management negotiations in organized companies), on behalf of the employee;

(d) Issue a statement to the employee at year end of employee premiums paid;

(e) Apply to the National Board for financial relief from excessive economic impact of mandated premiums, if any;

(f) Participate, through representatives, in the negotiation of provider budgets and fee schedules for their state or area;

(g) Participate through representatives as members of the State Board.

9. People (except those who are members of the armed forces, Medicare eligibles, or in Federal or state institutions) would:

(a) Choose from among and enroll themselves and their dependents in one of the insurance or HMO plans available to them through their employer, or if they are self-employed or non-employed, any of the plans available to residents of their state;

(b) If an employee, pays a wage related premium (subject to labor-management negotiations) through their employer or an income-related premium to their HMO or insurer if not employed (or if employed with substantial non-wage income);

(c) Present their Health Card to all providers of care for covered services;
(d) Participate, through representative groups, in the negotiation of provider budgets and fee schedules for their state or area;
(e) Participate, through representative groups, as members of the State Board.

B. Certified insurers and HMO's

1. Any insurer or HMO may be certified (and recertified) to insure services covered by this Act if it—
(a) Meets any applicable legal standards required by the state(s) in which it operates;
(b) Makes available a program of insurance or benefits covering all services covered by this Act at the negotiated community rate;
(c) Accepts, within the resource capacity of the HMO or similar arrangement and consistent with requirements of cost-effective administration with limits appropriate for plans negotiated or arranged between employers and employees that are self-insured, for enrollment in the required program of insurance all employee groups or eligible individuals at the negotiated rate.
(d) Provides the same added benefit to the required program of insurance, or the same premium rebate, to all enrollees, except that a portion of this rebate may be allocated to employers in return for services in arranging for the availability of a cost-effective insuring plan if the portion is negotiated in accordance with the procedures of Sec. 1310 of the PHS Act regarding the role of employers and employee representatives regarding HMO arrangements.
(e) Complies with all regulations of the National Board regarding advertising, customer service, standard claims forms and procedures, rights of privacy of enrollees and providers, and other areas authorized by this Act;
(f) Is a member of a consortium and complies with all rules and procedures of the consortium considered reasonable by the National Board;
(g) Makes no departure from those methods of marketing, organizing, or paying for health services which the National Board recognizes as consistent with the objectives of this Act without special approval from the National Board, which may issue such approval only upon convincing demonstration that such departure will not damage the objectives of this Act.
2. The National Board would certify four national corporations, called "consortia" in this Act, with state and area subsidiaries, one formed from Blue Cross and Blue Shield Plans, one formed from commercial insurance carriers, one formed from Prepaid Group Practice HMOs, and one formed from Independent Practice Association HMOs, to receive and distribute public and private funds as insurance premiums, dispense funds to providers of care, and to perform certain functions on behalf of insurance and HMO plans which are certified under this Act. Each consortium would:
(a) Represent its member plans in activities of the National Board in preparation of National and State NHI Budgets and in negotiations of community rated premiums on a national, state, and area basis, to finance services covered under this Act, and in negotiations related to methods of apportioning provider budgets and costs among insurers;
(b) Represent its members on a negotiating committee (see Part VII) established by the State Board to negotiate all budgets, fee schedules, capitation rates, salaries, or fee for time rates, or other rates (as well as definitions or conditions of payment for services or other matters which may require negotiation under this Act) for the reimbursement of participating providers to the end of paying for needed services to their enrollees within the budgets approved for the state or area and the revenues anticipated by the insurers and HMOs for that state or area through the negotiated community rated premiums to be paid them by the national consortia;
(c) Collect and place in a fund all premiums which the National Board advises it are due from employers, individuals, and state and federal governments, on a monthly, quarterly, or "annual round up" basis on behalf of all enrollees of a member insurer;
(d) Notify the National Board of employers or individuals who are in default on premium payments for payment by the Board and collection as a federal debt as described in Part V.
(e) Pay community rated premiums from the consortium fund to the member plans on behalf of each plan's enrollees on such schedule and bases, and adjusted to reflect such risk and/or area cost of services factors, as is mutually agree-

able to the member plans and is approved by the National Board as appropriate to eliminate any financial incentive to member plans to practice risk selection or experience rating or otherwise to prevent attainment of the objectives of this Act;

(*f*) Acting in concert, and with the approval of the National Board, establish an arrangement for transferring mandated premiums and other payments among consortia on a schedule and basis mutually agreeable to assure each consortia's receipts reflect the size of its members' enrollments and such risk and/or area cost of services factors as they consider warranted;

(*g*) Make payments to all participating providers of care on behalf of their member plans according to the costs of the negotiated budgets apportioned to their members, fee schedules, capitation rates, salary or fee for time rates, or other payment rates, or at lesser rates when special agreements have been negotiated by member plans;

(*h*) Monitor payments to providers of care, notify the State Board if rates of expenditure exceed projected expenditures in the Annual NHI Budget for the state or area, and participate in discussions or negotiations to reduce or pro rate payments to remain within the budget;

(*i*) Conduct such programs of claims review, and collect such data as is required by the National Board;

(*j*) Facilitate smooth transfer of enrollment and premium collection in the same or different geographic areas, or between consortia, during open enrollment seasons or between seasons under circumstances prescribed by the Board.

3. Conditions for certification of consortia:

(*a*) The consortium of Blue Cross and Blue Shield plans and the consortium of commercial insurers must have member plans in all states and major areas sufficient, in the judgment of the National Board, to cover the population.

(*b*) The consortia must accept into membership any insurance or HMO plan certified by the National Board applying for membership.

(*c*) The consortia must possess resources and present a plan of operations to the National Board which demonstrates intent and capacity to carry out all consortia functions specified in this Act.

C. Structure of the National Health Board

1. An independent agency of the Federal government reporting directly to the President.

2. Managed by a five member, full time National Health Board (herein called the National Board) appointed by the President and confirmed by the Senate:

(*a*) Chairman to be appointed by President.

(*b*) Members to have staggered five year terms.

(*c*) No more than three members from the same political party.

3. The National Board would:

(*a*) Approve all policies under the Act and oversee the activities of the chief administrator and staff;

(*b*) Establish staff offices to the board for an Ombudsman and Advocate and appoint directors;

(*c*) Appoint a chief administrator at the Executive III level;

(*d*) Organize bureaus and other staff and operating units within the Board and appoint such staff as required to implement this Act.

4. The Board's jurisdiction would include the current Health Care Financing Administration and other DHEW programs or elements of other current DHEW agencies which are:

(*a*) Developing or distributing health care resources through grants or contracts that are fundable from the Health Resources Distribution fund and will provide health services a significant portion of which are covered services under this Act;

(*b*) Providing direct services, a significant portion of which are covered services under this Act;

(*c*) Collecting data conducting health services research, or evaluating new technologies relevant to the objectives of this Act.

5. The Board would administer the Health Resources Distribution Fund (described in Part VI).

6. The Board would include a Bureau of Appeals to which providers, insurers, individuals, or others may make final administrative appeal and obtain a hearing upon grounds established by the Board after opportunities for appeal at the State Board or, as appropriate, the consortium level have been exhausted.

7. The National Board would be served directly by staff offices of the Ombudsman, the Advocate, and the Inspecter General.

(*a*) The Ombudsman and staff would investigate and report to the Board on complaints about the operation of the program in the light of its objectives, and recommend changes in regulations or practices.

(*b*) The Advocate would assist consumers in defining, protecting, and asserting their rights under this Act—focusing on the needs of minorities, the elderly, the disabled, other disadvantaged groups, and women.

(*c*) The Inspector General and staff would perform functions, with respect to health, like those now performed by the HEW Inspector General. The Inspector General would conduct investigations into fraud and abuse, and, acting through the State Board, would contract with state fraud control units established under Sec. 1903 of the Social Security Act to conduct the activities defined in Sec. 1903 with respect to all health services covered and all health care providers reimbursed under this Act.

8. The National Board would be directed to establish standing Commissions on Benefits, Quality, Access, and Health Care Organization to continually review and advise the Board on ways to improve the program to better attain the objectives of the Act—

(*a*) More than one half the members of each Commission would represent consumers—which would mean, for purposes of this Act, purchasers of health insurance (such as employers or employees), or any person who is not a member of a health profession, official of a health care organization, or otherwise associated associated with health care providers in ways the National Board considers inappropriate for this purpose. Consumers may choose to be represented on the Commission by a provider of health care by making a direct selection of such a person.

(*b*) The Commissions would include representatives of the various health care professions and provider institutions and their employees, and insurers, as the Board considers warranted for the purposes of the Commissions.

(*c*) Each Commission would be allotted full time staff, with staff support specifically assigned to consumer members.

D. Structure of the State Health Insurance Board

1. A state chartered public corporation (herein the State Board), established by the governor at the request of the National Board, to carry out specific functions under this Act under agreement with the National Board.

2. Managed by a five member State Health Board (herein called the State Board), whose members and chairman are appointed by the governor subject to approval of the National Board:

(*a*) Representatives of major purchasers of health insurance (employer groups and labor unions) must hold two seats on the Board, and at least one other must be a consumer, as defined by this Act;

(*b*) Five year staggered terms;

(*c*) No more than three members from the same political party.

3. The State Health Board would:

(*a*) Make all policies delegated to it by the National Board;

(*b*) Appoint an ombudsman and advocate reporting directly to the State Board;

(*c*) Appoint a full time chief administrator;

(*d*) Under terms of their contract with the National Board, organize such bureaus and other staff and operating units as required to carry out the functions specified in this Act.

4. The State Board would include a Bureau of Appeals to which providers, insurers, individuals, or others make formal appeal and obtain a hearing upon grounds established by the National Board.

5. The Ombudsman and his staff would perform for the state the same functions described for the Ombudsman to the National Board.

6. The Advocate and his staff would perform for the state the same functions described for the advocate to the National Board.

7. The State Board would be authorized to appoint such standing commissions or short term commissions as are approved for funding under thir agreement with the National Board. Such commission would include representatives of consumers and providers as specified for commissions for the National Board.

8. In state where the governor proposes, and the National Board concurs, the establishment of more than one Area Health Board within the State, rather

than one state wide agency, each of the Area Boards will be treated, for purposes of this Act, like state Boards, but the State government functions would apply to all of them.

E. The Annual NHI Budget

1. The National Board will annually prepare a comprehensive budget establishing all public and private expenditures for health services covered by this Act and for the administration of the program, and all revenues from mandated premiums and other sources for financing these expenditures and limiting the total annual increase over the preceeding year in health expenditures under the Act to a maximum of the average rate of increase in the GNP over the last three years:

(*a*) This annual Budget would be presented to the President and Congress, and to the State governments, in adequate time for funds to be appropriated to cover the premiums and other government payments mandated by this Act, including funds for Health Resources Distribution as authorized by this Act.

(*b*) The Annual Budget will balance all revenues to be paid to insurers and all expenditures to be made by insurers pursuant to this Act:

(1) Revenues will be shown from: (a) Wage related premiums; (b) Premiums related to non-wage income; (c) Group rated premiums paid by State and Federal governments on behalf of AFDC and SSI eligibles. (d) Payments by the Federal Board to compensate for delinquencies in the payment of required premiums; (e) Taxes, premiums, and interest paid to medicare trust funds.

(2) Expenditures will be shown for: (a) Administrative costs for the National and State Health Boards, consortia, and insurers; (b) Health services costs by types of provider and/or service as determined by the National Board; (c) Costs of accumulation of assets for capital investment, education, and research as described in the approved Health Resources Distribution Plan; (d) Over or under expenditures from previous year; (e) Expenditures from medicare trust funds; (f) All other costs under the Act as specified by the National Board.

Percentage allowances as established by the Board will be shown for the transfer of expenditures among categories by the State without approval of the National Board.

(*c*) The proposed Annual Budget will balance all revenues projected to be paid to the Medicare program and all expenditures to be made by Medicare pursuant to this Act.

(1) Revenues will be shown from: (a) Part B, premium payments; (b) Payroll taxes; (c) General revenues; (d) Interest on Trust Fund Assets.

(2) Expenditures will be shown for categories identical to insurer expenditures.

(*d*) The Annual Budget will establish expenditures for each state or area. (See V 14a for methodology.) The State Boards, with the approval of the National Board, may establish areas within the state, and the National Board, in agreement with the governors involved, may establish areas which cross state boundaries, which areas will be treated as "states" for purposes of this Act.

(*e*) The Annual Budget will establish premiums required to be paid to insurers to finance the negotiated national community rated premiums for all enrollees in the nation, showing variations in these rates achieved in each state and will present analyses of economic impact on employers and employment of the premiums, as well as on Federal and state budgets.

(*f*) The Annual Budget will include the amount to be requested of Congress for the Health Resources Distribution Fund (described in Part VI) and for each of the authorized programs administered under this Act by the National Board in relation to this Fund.

(*g*) The Annual Budget will reflect annual budgets of the States and the advice of advisory commissions to the National Board, and will be based on agreements with providers negotiated by State Boards and approved by the National Board and agreements with consortia on national community rated premiums required to underwrite the covered services in the year ahead.

(*h*) The State budgets submitted to the National Board will reflect the advice of state advisory commissions, the Health Resources Distribution Plan for the State, and representatives of the consortia and providers in the state, and will be based on negotiations by the State Boards with providers concerning budgets and fee schedules.

(*i*) The Congressional Budget Office would submit an annalysis to the relevant committees of Congress each year of all aspects of the proposed Annual Budget.

(*j*) The Annual Budget will be implemented by the State Boards, with the State Boards renegotiating provider budgets and fees if required to stay within the revenues approved. Negotiated national community rated premiums in the approved Annual Budget would be caps on revenues to consortia for payment or covered services under this Act, and could only be increased by a subsequent act of the National Board.

(*k*) The State expenditures approved would be the basis for the negotiation (or renegotiation) of prospective budgets, annual adjustments of physician fee schedules as necessary, and other provider reimbursements as described in Part VII.

(*l*) The Annual Budget will be accompanied by projection of the Annual Budget for five years, showing the effect of Health Resource Distribution efforts and the limits on increases in expenditures nationally and by state and area.

F. Negotiations with providers

1. For purposes of establishing prospective budgets, fee schedules, and other payment mechanisms as described in Part VII, providers would be invited to send elected representatives to negotiate with committees convened by the National and State Boards.

2. The State Negotiating Groups: The National Board would establish categories of providers from which representatives to the various negotiations with the State Board would be elected in each state, and establish general guidelines for the election process in each state.

(*a*) The categories of providers to compose the state negotiating group regarding prospective budgets would include, but not be limited to:

(1) Classes of hospitals; (2); (3) Hospital based physicians; (4) Hospital employees of various professions and occupations; (5) Community Health Centers, Community Mental Health Centers, and other providers reimbursable on a prospective budget bas's under this Act.

(*b*) Factors to be taken into account in establishing the negotiating group regarding fee schedules and other payments mechanisms would include, but not be limited to:

(1) Medical and osteopathic specialties.

(2) Geographic area of practice, ex., rural, urban.

(3) Style of practice; solo, group, institution based.

(*c*) The general guidelines for the state election process shall be developed and revised as necessary by the National Board in consultation with any existing negotiating groups and other provider associations and institutions and shall include:

(1) Range of sizes for the negotiating groups.

(2) Proportional representation of categories of providers on negotiating groups in terms of their numbers in the state, the percentage their services represent of the total reimbursed under this Act, and any redistributions described in the Health Resources Distribution Plan.

(3) Three year terms of office with eligibility for reelection.

(4) Various methods of nominations and election for use by the State Board, assuring full public information and opportunity to nominate candidates and vote by all relevant providers (and their employees) in each category.

(*d*) The State Boards, in consultation with any existing negotiating groups, and with provider associations and institutions in the state, would establish and revise as necessary the size, composition, and other characteristics of the state negotiating groups, and the detailed nomination and election process—within the guidelines of the National Board—and would conduct or oversee the conduct of elections of the state negotiating groups every three years.

3. The National Negotiating Groups: The National Board would conduct an election among the state negotiating groups to elect representatives from the state groups to the national negotiating groups, and may, in consultation with provider associations and institutions, appoint up to five additional non-voting members to each group to represent provider interests that are not represented on state groups.

(*a*) Categories of providers would be represented on the national negotiating groups (except for the up to five additional members appointed by the Board)

proportional to their numbers on state negotiating groups, and any redistributions described in the five year projection of the National Annual NHI Budget as the effect of the State Health Resource Distribution Plans and of the limits on increases in expenditures nationally and by state and area.

(*b*) The terms of elected and appointed members would be three years.

4. Both the elections of negotiating groups and all negotiating sessions of the groups will be matters of public record, except that elections will be conducted by secret ballot.

G. Negotiations with Insurers and————

1. Insurers and ———— would be invited to send representatives to negotiate on their behalf with the National Board regarding the community rated premiums described in Part V.

2. The manner of selection of those representatives would be established by the insurers and ———— through their consortia, but should provide representatives of such categories of insurers as the Board may require.

3. The number of representatives to the negotiating group from each consortia would be proportionate to the total number of enrollees of each consortium, with no consortium represented by fewer than two.

4. Consortia shall not participate in the negotiations on state or area community rates in which they have no member plans.

5. Negotiating sessions of the Board with the representatives of insurers and HMO's will be matters of public record.

H. Apportionment of the costs of a provider's budget among insurers

1. The National Board would establish rules for apportionment of the costs of a budget among the insurers after consultation with the insurers.

2. Payment amounts by insurers would be established on an interim basis initially, paid at such time as may be determined, adjusted from time to time, and settled after the close of the year.

I. Start-up of administrative structure and processes

1. Upon enactment of this Act, and prior to the effective date of benefits, the National Board shall establish and test administrative structures and processes needed to implement the Act on the effective date of benefits.

2. The Board shall report to the Congress 18 months after enactment on its progress, and on any technical changes or authorizations of any temporary administrative structures or proceedures that would facilitate the implementation of the Act.

3. The General Accounting Office will review the progress of the Board in starting up administrative structures and processes under the Act and report the progress or lack of progress to the Congress 18 months after enactment.

4. (For ———— physician cost controls established before benefits become effective, see Part VII).

J. Federal back-up for state and insurer functions

If a state fails to establish a public corporation to serve as the State Board, or if insurers fail to establish consortia or acceptable plans for their operation, or if there are states or areas in which no insurers qualify for certification under this Act, the National Board will perform the functions of these agencies.

K. President's Commission on the Health of Americans.

1. The President would appoint a group of nine distinguished citizens to serve at his pleasure.

2. The Commission would be directed to review the health status of the nation, the opportunities for improving it, and the cost for doing so.

3. The Commission would make its findings on steps that should be taken near and long term and coordinate its activities with those of the National Board.

V. FINANCING

A. Structure of support of program

1. Income to support the program will come from seven primary sources:

(*a*) Wage-related premiums paid by employers, with sharing by the employee possible;

(*b*) Payments by people with substantial amounts of non-wage income, related to that income;

(c) Payments by States for the AFDC and State institutional population;
(d) Payments by the Federal government for SSI beneficiaries and the Federal institutional population;
(e) Voluntary payments for employees in the U.S. of foreign governments and international organizations;
(f) Medicare taxes and premiums;
(g) General revenues.

2. The wage related premium and other income related premiums paid by persons with nonwage income would be computed as a percentage of the income from the given source.

(a) The percentage rate which would be applied in full to wages and one-half of which would be applied to non-wage income (subject to a maximum for an individual, see 3. below), would be computed so that the costs of NHI benefits for the entire population—except the Medicare, SSI, and AFDC groups—would be fully covered by the total of all wage-related and income-related premiums.

(b) The prospective percentage rate would vary from State to State in accordance with actual budgeted cost increases in the State, because of adjustments as provided in F.4.d. If sufficient information is not available in one or more initial years to establish the State variable rates, State-by-State estimates or a single national rate may be employed on an interim basis.

3. A maximum would apply on premiums withheld from employees' wages or paid by recipients of non-wage income. The maximum out-of-pocked payment for premiums for an individual could not exceed the negotiated community-rated premium for his/her family type (i.e., self only, couple, or family) for the State or area in which he/she is employed.

B. Income sources

1. Wage related premium.

(a) Employers would be responsible for the entire payment, but would be authorized to require payment of x% (25-35%) of each employee's wage, up to the maximum premium base, by employees. The employee payment would be subject to labor/management negotiations.

(b) The wage-related premium would consist of the result of applying the percentage rate to the total payroll of the employer.

(c) The payment by an employer (including a State or local government) would be subject to an impacted employer limit, and a credit would be payable to impacted employers upon application.

(1) An impacted private employer would be defined as one whose required payments for NHI (excluding any that may be paid by employees) exceeded his/her former payments for private insurance by more than 3% of payroll and whose net income as a percentage of gross and abolute net income declined compared with the year before the NHI premium payment was mandated. Only the 3% of payroll maximum would apply in the case of State and local governments.

(2) Upon the filing of a claim showing the existence of the defined impact, the Natioanl Board would certify as a tax credit (or pay from general revenues in the case of a non-taxpaying employer) an amount equal to one-half of the least amount by which an increase in insurance costs of the employer not permitted to be borne by employees exceeded 3% of payrolls or the decline of either of the two measures of net income. In the second year one-third would be credited, in the third year one-sixth would be credited, and in the fourth year and later, nothing.

(d) Payment of premiums on behalf of employees of state and local governments would be required on pain of deduction from all Federal grants-in-aid payable to the State of an amount equal to one and one-half times the amount the Board estimates as the amount of the premiums otherwise due. Such deduced amount would comprise NHI income.

(e) Medicare beneficiaries would be exempt from paying wage-related premiums and their employers would be exempt from paying wage-related premiums on their behalf.

2. Non-wage income premium.

(a) This premium would be paid by recipients of self-employment and unearned income at one-half the rate paid by employers and employees together.

(b) Only income in excess of $2000 for each adult recipient of such income (individual $2000, couple filing jointly $4000) per year up to the maximum on

income subject to premium payment requirements specified in A. would be subject to this premium requirement.

(c) The payment would be made quarterly in conjunction with filing estimated income tax returns. Failure to make timely payments would make the individual subject to a late premium penalty, at a 15% annual rate, unless the delay in payment were excused.

(d) In the case of pensions received by persons under 65, the non-wage income premiums may be paid by withholding, and part or all of the premiums may be paid by prior employers. The employer premium payment would not be considered income for tax or premium payment purposes.

(e) Medicare beneficiaries would be exempt from paying premiums on the basis of unearned income for any month they were beneficiaries. If they were beneficiaries for part of the year, the portion of unearned income exempt would consist of the number of months of Medicare eligibility divided by 12. In the case of a couple, only one member of which is a Medicare beneficiary, the premium would be calculated for each member separately, and joint income would be proportioned equally between the members.

3. Group rated premiums on behalf of SSI recipients and residents of Federal institutions for whose health care the Federal government takes responsibility.

(a) The premium would be paid by the Federal government for persons who are not Medicare beneficiaries.

(b) The premium payment per individual would be based on the experience of the group; i.e., the premium would be a group related premium and not income related.

(c) The Federal premiums would be paid monthly to insurers (or their consortia) with whom recipients or residents were enrolled in the appropriate premium amounts.

(d) Cost experience for members of the group would be obtained from a sample of beneficiary data records for the entire population reported by the consortia. These records would be matched against SSI payment records to identify the recipients in the basic file. Insurers would not be given information on which enrollees were eligible for SSI. On the basis of the sample data, each year experience rated premiums could be estimated for payment in the ensuing year using the experience and other pertainent factors in an estimating process as the Board may determine after obtaining the advice of the consortia. A deduction may be made for estimated other premiums payments made by or on behalf of SSI recipients.

(e) The SSI program would be amended to provide that health insurance premiums paid on behalf of its beneficiaries for NHI benefits would not be considered as income in determining AFDC cash benefits eligibility, and the fact that some income received by the beneficiary would be required to be paid toward NHI premiums could be taken into account in determining the SSI benefits.

4. Premiums on behalf of AFDC recipients and residents of State institutions for whose health care the State government takes responsibility.

(a) The premium would be paid by the State as a condition for AFDC matching.

(b) The premium would be group rated by family type and not income related.

(c) The State premiums would be paid monthly to each of the insurers (or their consortia) in which this group's members were enrolled, in the appropriate premium amounts.

(d) Cost experience for members of the group would be obtained from a sample of beneficiary data records, as would be done for SSI, with premiums calculated in a similar fashion as well. Information would not be given to insurers on which enrollees were eligible for AFDC. A deduction may be made for estimated other premium payments made by or on behalf of AFDC recipients.

(e) The AFDC program would be amended to provide that health insurance premiums paid on behalf of its beneficiaries for NHI benefits would not be considered as income in determining AFDC cash benefit eligibility, and the fact that some income received by the beneficiary would be required to be paid toward NHI premiums could be taken into account in determining the AFDC benefits.

5. Voluntary participants.

(a) Long term U.S. residents who are employees of foreign governments or international organizations.

(1) The employing unit could enter into an agreement with the Board to cover their employees and their families under NHI.

(2) The premiums due from the employer would consist of community rated premiums estimated for the type of family of the enrollees.

(*b*) Costs and services to foreign visitors.

(1) The Federal government would be empowered to enter into agreements with foreign governments under which visitors, each to the other, would be covered under the plan of the national to which the visitor travels, if such an agreement seemed likely to produce acceptable results.

(2) The agreement would be premised on the assumption that benefits provided to foreigners in this country would be compensated for by services provided to NHI members outside the U.S., for which no reimbursement would be made. The services covered outside the U.S. would, in effect, constitute NHI benefits, paid for by providing services to foreigners in this country which the NHI program would pay for.

The program would not pay for services provided outside the country.

6. The Medicare portion of the social security tax.

(*a*) The tax would be retained at the level now provided for by law for each employer, employee, and self-employed.

	Percent
1979–80	1.10
1981–85	1.35
1986 and later	1.50

(*b*) The Medicare tax would be applied to all wages in the U.S., including those of Federal employees, all nonprofit organization employees, and under pain of deduction from grants of one and one-half times the tax as estimated by the Board, of state and local employees. Voluntary agreements with foreign governments would require a payment equivalent to this tax, as well as NHI premiums. (These funds, as well as Part B premiums and general revenue contributions to Medicare, would be handled separately from the rest of NHI through existing Trust Funds and the total would be sufficient to support the program.)

7. The Medicare Part B premium.

(*a*) The premium payment would be made compulsory for everyone age 65 or older, plus those disabled eligible for Part A coverage but would be paid by the Federal government in the case of SSI recipients.

(*b*) Membership of the Medicare group:

(1) People now eligible for Medicare (to include everyone over 65) plus

(2) People disabled six months to two years.

(*c*) The premium would be computed as in present Medicare law, rising no faster than social security benefits.

8. General revenues.

(*a*) Increased obligations including:

(1) SSI and increased payments for Federal institutional population, if any.

(2) Difference between Medicare tax plus premium and cost of services to the Medicare group. This difference results in part from the proposed added Medicare coverage and the fact that no increase in the social security tax rate is proposed.

(3) Premium payments due to private insurers uncollectible.

(4) Credits to impacted employers.

(5) Savings clause to State for Medicaid.

(6) Cost of administration of Board and State agencies.

(7) Increase, if any, in Federal employer payments on behalf of Federal employees and members of the armed forces. This increase possibility derives in part from the required percentage of premiums to be paid by employers.

(*b*) Offsets including:

(1) Elimination of individual income tax deduction for health insurance and the fact that deductions would not occur (or be allowed) for costs of services covered under NHI.

(2) Elimination of Federal grants-in-aid for Medicaid.

(3) Reduction of escalation in costs of covered services.

(4) Medicare health insurance payments from additional employers on behalf of new Medicare eligibles.

9. End of year round up.

(*a*) In the case of wage earners who have less than $2,000 in non-wage income, the wage related premium will constitute payment in full of the premium. Each

premium payer would be required to calculate his/her total annual premium obligation if he/she had non-wage income of over $2,000 (the exempt amount), as follows:

(1) Calculate the payer's non-wage income subject to the premium requirement. This income would equal the lesser of (a) the actual nonwage income in excess of $2,000 up to the maximum premium base or (b) the maximum premium base minus wages.

(2) The premium rate for non-wage income would be applied to the figure in (1) to determine his nonwage premium.

(3) Calculate the employee premium that was paid or could have been required by the employer to be paid by the employee on the basis of wage income, as reported on employer statements, up to the maximum.

(4) Compare the sum of (2) plus (3) with the State or area community rate for the family type of the individual. The lesser is the annual premium obligation unless the person had income of the sort on which minimum tax payments are due. In the latter case, the individual is assumed to have received the maximum in unearned income.

(5) Compare the result of (4) with payment withheld from wage, paid on the basis of estimated non-wage income, or paid to Medicare. If more was paid than the obligation, a refund would be paid. If less than the obligation was paid, the individual would be required to make a final payment and possibly pay a penalty, unless the delay in payment was excusable under the rules of the Board. Refunds would be paid by the consortia from the premium payments already made to them. In the case of a person covered by more than one consortium in a year, the refunds would be apportioned among consortia according to rules they establish, approved by the Board.

C. Enforcement of the premium payment

1. In the event an individual is determined to have failed to pay premiums due, the Federal government would be obliged to make the payment.

2. When the Federal government pays a premium on behalf of an individual, because of failure of that individual to pay, the payment would be a debt owned by the individual to the government and would be collectable by the government. If unpaid, the debt would be collected in accordance with the terms of the Federal Claims Collection Act of 1966.

D. Effective dates

1. The income related premiums would first become payable with the quarter before the effective date of payment of benefits.

2. The premiums paid monthly would first become payable one month before benefits become payable.

E. Residual Medicaid

1. Savings Clause.

(*a*) For the first three years after NHI benefits first become payable, each State would be guaranteed that its costs for benefits—for residual medicaid and premium payments for AFDC recipients—provided after NHI's effective date would be no larger than they were in the year preceding that date, with an increase per year equal to the overall program rate of increase. This guarantee would apply only to costs of those Medicaid benefits that were in effect in a State at least two years prior to the effective date of benefits under this Act.

(*b*) The savings clause would apply to a State only if it does not cut back on the medicaid benefits it provided before NHI becomes effective, and only if it pays the group rated premiums required for AFDC cash benefit recipients and the institutionalized population for whom premiums would not be paid under other provisions.

(*c*) The Federal grants-in-aid for medicaid benefits would be eliminated, but 90% of the reasonable administrative costs of the residual Medicaid program (see below), as determined in the budget process, would be paid if Federal Medicaid standards, including standards for budget reimbursement of nursing homes, were met.

2. Maintenance of effort—condition for Savings Clause, for Federal grants-in-aid for AFDC, and for grants toward administrative costs.

(*a*) Continuation of pre-enactment Medicaid benefits not provided by NHI.

(*b*) Payment of NHI group rated premiums for AFDC cash payment recipients.

(*c*) Meeting other Federal medicaid quality or other standards. The National

Board would establish the minimum scope of services required (in lieu of the requirements of Section 1902(a)(13) of the Social Security Act) as a condition of approval of a State plan under Title XIX.

(*d*) Payment of premiums for State institutional population.

F. National, state, and area premium determination process

1. The budget limit on expenses for NHI would be set by the National Board. The Act would provide that the budget increase in any year would not be permitted to increase at a rate greater than the average rate of increase in the GNP for the three preceding years.

2. The National Board, with the advice of the consortia, would perform the actuarial calculations required to translate the decision on expenses into a wage and non-wage income related premium and community rated premiums. An allowance would be made in the premiums for a contingency fund retained to cover variations from expected expenses and for net income (operating gain or loss and interest on revenues) in accordance with Board policy.

3. In the event the NHI income from the specified sources is found by the National Board to fall short for a given year of that required to pay insurers the community rated premiums negotiated for the year, taking into account contingency revenue funds that are available, an advance may be made from Federal funds to cover the shortfall temporarily, to be recovered from premiums in subsequent years established to provide for repayment.

4. The National Board would distribute the national budget among the states. In so doing, the health care operating cost increase allowed for a state would be greater than the national increase if the state's per capita expenditures, on a price adjusted basis to the degree feasible, are less than the national per capita expenditures. A similar variation would occur in the case of a state whose expenditures are greater than the national ones.

(*a*) The maximum variation above and below the national increase would be 20% each.

(*b*) The variation for a state with the average deviation of all states would be the lesser of its percentage deviation, or 10%, and the variation for other states would be proportional to that for an average deviation state.

(*c*) The limit could be adjusted upward for states (or areas) with severely underserved population, for whom special development programs have been approved in the Health Resources Distribution Plan.

(*d*) If a state actually budgeted less than the allowed NHI limit for the state, by applying effective restraints on cost increases, the state's income related premium rate would be adjusted downward accordingly.

5. The insurers' financial duties.

(*a*) Insurers would receive the premiums and make use of consortia in ways they determine to facilitate the process.

(*b*) Each insurer would determine the amount of community rated premiums it requires, adjusted by rules established within the consortium, to cover the risks enrolled and cost variations by area, so that no advantage would accrue from enrolling good risks or disadvantage from enrolling poor risks. The same premium would be paid by the consortium to each insurer for a given level of risk enrolled. An insurer other than an HMO with benefits costs over a period of time below those expected would be assumed to have had the superior results because of undetected selection advantages, unless it provided acceptable evidence that its superior results derived from cost effective provision of services, in which case the insurer would be permitted to retain the difference or to portion it out as added benefits or dividends to subscribers.

(*c*) The insurers would receive from the consortia payments from time to time during the year on a preliminary basis to provide the required cash flow and a final settlement with the consortia would be made at the close of the year, using schedules and procedures established by the consortia.

(*d*) Each insurer would set aside a reserve from premiums received from which a redistribution of funds among insurers may be made in the event income received were found, under procedures developed by the insurers and approved by the Board, not to be proportionate to the risks covered by the insurers.

(*e*) The Defense Department, acting for members of the armed forces and their dependents, would receive and retain all premium income paid by such persons and would receive additional appropriated funds to pay the costs of the covered services of these members. No funds received by the Defense De-

partment would be subject to redistribution to other consortia, and no funds received by other consortia could be redistributed to persons for whom the Defense Department acted as insurer.

G. Philanthropic contributions and State and local government supplemental payments

1. Such funds could be used to supplement financing provided by NHI, but no additional payments would be made by NHI to pay costs of services that might be added by the use of such funds, unless they were approved in the planning and budgeting processes.

2. Any capital investment or services changes made with such funds would be subject to planning approval.

VI. HEALTH CARE IMPROVEMENT

A. In consultation with the President's Commission on the Health of Americans, the National Board will establish national objectives for Health Care Improvement for guidance of the Health Care Improvement Planning process, the Annual NHI Budgeting process, and other activities under this Act

B. The Health Care Improvement Plan

1. The National Board will prepare and annually update a five year Health Care Improvement Plan describing

(*a*) The nation's needs with regard to the accessibility, quality, and costs of health care;

(*b*) The effect to date of the implementation of provisions of this Act on these needs;

(*c*) Strategies for meeting these needs in the future through provisions of this Act.

2. The plan would define such projected needs as:

(*a*) Shifts in geographic distribution of hospital, nursing home, and other facilities and services through closure, conversion, or expansion;

(*b*) Shifts in geographic and specialty distribution of professional providers;

(*c*) Growth in enrollment and number of cost effective alternative delivery systems;

(*d*) Reductions in use of outmoded or duplicative medical tests or procedures;

(*e*) Conformance of providers to certification requirements of the Program through budgeted reimbursement or grants from the HRD Fund;

(*f*) Other factors or special population emphases as the National Board may require.

3. The Plan will analyze past effects and project future effects on meeting national and state health care needs of the implementation of provisions of this Act, providing for:

(*a*) The Annual National Health Insurance Budget by category of service, with national and state limits on expenditures;

(*b*) Competitive marketing through HMOs and other innovative delivery systems of programs of enhanced benefits or premium rebates at the community rate;

(*c*) Negotiated prospective budgeting;

(*d*) Negotiated fee schedules;

(*e*) PSRO review of all health services covered by the Act;

(*f*) Health Care Resources Distribution Fund grants and contracts;

(*g*) Activities of state governments in preparing and implementing the Health Care Improvement Plan;

(*h*) Such other provisions of the Act as the National Board considers appropriate.

4. The plan would describe how standards and guidelines issued by the National Board (or proposed to be issued) implementing the provisions of this Act are designed to facilitate meeting the defined needs.

5. The national plan will be based on State Five Year Plans for Care Improvement which the National Board will request to be prepared and updated annually by the Governor of the State. This State Plan for Health Care Improvement will include the State health plan prepared under Title XV of the PHS Act, other state planning activities required by the PHS Act, and Community Mental Health Centers Act, and such additional state activities as the governor may determine.

6. The State Plans will describe the states' projected needs with regard to the accessibility, quality, and cost of care to the greatest degree of specificity possible, and what specific actions the state government plans to take to fill these needs.

7. The State Plan would be based on standards and guidelines (including projected overall budget constraints for each state) promulgated by the National Board, and all health related plans formerly submitted to the Secretary or Assistant Secretary for Health, DHEW, pursuant to the PHS and CMHC acts would henceforth be submitted to the State Board, along with the State Health Care Improvement Plan.

8. The State Board will make grants up to the level of the state's allocation from the Health Resources Distribution Fund, described in this part, with the guidance of this plan, and will deviate from the plan only after consultation with the Governor of the state and only upon review and approval of the National Board.

9. The State Board, in preparing its Annual NHI Budget for the state (as described above) will assume changes in resource availability and other factors proposed in the plan.

10. The State Board, in its negotiations with providers concerning budgets, fee schedules, and other reimbursement policies described in Part VII, will not approve:

(*a*) Provider budgets that include services, training, or accumulation of assets for capital expenditures that are inconsistent with the plan;

(*b*) Fee schedules that are inconsistent with the manpower redistribution goals of the state as described in the plan; issues of consistency would be subject to the review and decision of the National Board.

C. Health resources distribution

1. A national fund will be authorized from general revenues at a level of $500 million for the first year of benefits, and at commensurate levels for each of the next five years.

2. The national fund would include:

(*a*) Amounts requested by the National Board and appropriated by Congress to augment funding for such existing DHEW programs as are transferred into the jurisdiction of the National Health Board according to criteria in Part IV.

(*b*) An amount to be allocated for award by the National Board based on Health Care Improvement Plans and Annual NHI Budgets, and on the preparedness of States to use the funds to achieve the purposes of this Act—except that no state shall receive less than one-half a pro rata share, based on population.

3. The HRDF may be used by the National Board and the State Boards to award contracts and grants for purposes described in this Act, or the authorizing legislation for programs transferred to the National Health Agency from the PHS or other agencies, including:

(*a*) Conversion or closure of underutilized facilities;

(*b*) Start up of needed services in health manpower shortage areas;

(*c*) Renovations to enable providers to meet some specific requirements relating to safety or other factors judged critical by the National Board;

(*d*) Stimulation and support of HMOs and other cost effective delivery systems;

(*e*) Establishment or phasing out of health professional education programs according to projected needs for manpower in various specialties and professions.

(*f*) Start up programs of continuing educational and professional development through PSROs or other private agencies on state of the art in clinical practice and areas of possible improvement in current practice patterns;

(*g*) Such other purposes appropriate to improving the quality, accessibility, or other objectives for health care under this Act.

D. Health statistics, health services research, and technology evaluation

1. There would be established under the National Health Board a National Institutes of Health Care Research. These institutes would replace the existing DHEW Office of Health Technology, and include research institutes for Health Statistics, Health Services Research, and Technology Evaluation. These institutes would have the functions described in P.L. 96-623 for the existing DHEW programs in these areas, and would operate as independent research institutes under the Board.

2. In addition to functions established by Sec. 306 of the PHS Act and by P.L. 96-623, the National Center for Health Statistics would be given authority under the National Board for:

(*a*) Formulating data policy, regulations, and operational guidelines for establishment and operation of data gathering systems by the agency, that assure a systematic flow of information required for:

(1) Management of this national health insurance program by the national agency, such as for budget information;

(2) Assuring accountability of the program in terms of its impact on the cost, access, and quality of health care and on morbidity and mortality.

(*b*) Analysis of data gathered by the agency responsive to the needs for agency managers, consumers, and health care providers.

3. Data and information systems operated as defined by the Center under this Act and under Sec. 306 of the PHS Act should

(*a*) Be based on Uniform Minimum Data Sets established by the Center for Health Care Statistics;

(*b*) Include the entire U.S. population and all health services (not just those covered by this Act);

(*c*) Promote efficiency and effectiveness in the collection, processing, analysis, and dissemination of information;

(*d*) Establish and coordinate data gathering activities by consortia, state and local governments, and the national agency, to minimize duplication;

(*e*) Provide information as defined by the Board to consortia, employers, coinsurers, and providers of care, and other interested institutions affected by this act to inform their choices and facilitate their activities under the Act.

E. Health education

The State Board will carry out a program of education of all residents concerning health, self care, the effective use of the health care system, and their rights and privileges under this Act, including:

1. Health living habits and appropriate use of health resources.

(*a*) Development of material for distribution through media.

(*b*) Development of curricula suitable for classroom instruction at various levels.

(*c*) Training of professionals to pass on such information.

2. Appropriate patient participation in care.

(*a*) Preparation of training materials.

(*b*) Support for training sites related to serious but common impairments in which patient activities play an important role.

(*c*) Training of professionals.

F. Special studies and demonstrations

1. The Board shall make, on a continuing basis after the effective date of health benefits, a study and evaluation of the operation of this title in all its aspects, including study and evaluation of the adequacy and quality of services furnished under the title, analysis of the cost of each kind of service, and evaluation of the effectiveness of measures to restrain the costs, and to conduct any specific studies it may consider necessary or promising for the evaluation or improvement of the operation.

2. The Board, through the work of Commissions and other means, shall specifically study and evaluate the effects of this Act on residual medicaid programs in States, including the comprehensiveness, accessibility, and quality of services to medicaid eligibles in the states, study means for improving these residual state medicaid programs for the poor with respect to comprehensiveness, accessibility, and quality of services, and recommend legislation, guidelines for budgeting and for use of Health Resources Distribution Funds and use of regulations, and grant authority under this act to effect these improvements. The Board would submit to Congress no later than five years after enactment, its legislative recommendations in this regard, with special emphasis on how to meet the long-term care service needs.

3. Pursuant to these studies, the Board shall direct the Commissions as follows:

(*a*) The Commission on Benefits to study and recommend legislation or use of regulatory or granting authority under this Act to change covered benefits based on current clinical and other evidence of the cost and effectiveness of various health services for improving the health of the public. This Commission

would give early and continuing attention to defining or redefining preventive health, mental health, drugs, vision care, long term care, home health care, dental coverages, and other services for which limitations or exclusions exist under this Act.

(*b*) The Commission on Quality to study the quality of health care provided to the beneficiaries of this Act and recommend legislation or use of the regulatory or grant authority under this Act to improve quality. This Commission would give early and continuing attention to national standards for provider (including HMO) certification and recertification under this Act.

(*c*) The Commission on Access to study the level of services being utilized by various beneficiaries of this Act and recommend legislation, budgeting guidelines or requirements national or within states, and use of regulatory or grant authority under this Act to remove barriers to access and/or create needed resources for care. This Commission would give early and continuing attention to the problems of rural, elderly, migrant, American Indian, inner city, the disabled, and other special populations, including prisoners and other institutionalized individuals.

(*d*) The Commission on Health Care Organization to study the costs and effectiveness of the various ways of delivering health services are organized for beneficiaries under this Act, and recommend legislation or use of regulatory or grant authority under this Act to support and encourage the creation and expansion of more cost-effective systems by health care providers and insurers. This Commission would give early and continuing attention to the relative performance of HMOs and other innovative delivery systems.

4. The Board is authorized to develop, and to test and demonstrate through agreements with providers of services or otherwise, methods designed to achieve, through additional incentives or in any manner, improvement in the coordination of services furnished by providers, improvement in the adequacy, quality, or accessibility of services, or decrease in their cost; methods of peer review and peer control of the utilization of drugs, laboratory services, and other services, and methods of peer review of quality. Agreements with providers for tests or demonstrations may provide for alternative methods of reimbursement in lieu of methods prescribed in Part VII.

5. Programs of personal care services. The NHI Board would be required to carry out a substantial demonstration program in the organization, delivery, and financing of personal care services to the population at risk.

(*a*) The Board shall make grants from the Resource Distribution Fund to demonstrate and assist in the development of community programs for maintaining in their own home, by means of comprehensive health and personal care services, persons who, by reason of disability or other health-related causes, would, in the absence of such assistance, require inpatient institutional services or might be expected to require such institutional services in the near future. Initial funding would be at the $100 million level.

(*b*) A grant under this section would be made to communities to an eligible applicant which satisfies the Board that the applicant will be able (1) to develop, reasonably promptly, comprehensive services in accordance with this subpart, and (2) to develop non-Federal sources for the financing thereof to such extent as the Board finds appropriate in light of the economic resources of the community and resources otherwise available to it for this purpose.

(*c*) The Board is authorized to make grants, for the development and conduct of programs in accordance with this subpart, to participating public or other nonprofit hospitals or group practice organizations, or to other public or nonprofit agencies or organizations which the Board finds qualified to conduct such programs. Each program shall be designed to serve a substantial population, defined in the grant, in either an urban or a rural community.

(*d*) A grant under this section may be made to pay a part or all of the estimated cost of a program (including startup cost) for a period of not more than four years, payable in such installments as the Board may determine, and may provide for meeting a decreasing share of the cost over the period of the grant. A grant shall be irrevocable except for nonperformance by the grantee or violation of the terms of this subpart or of the grant, or for other causes which would justify the termination or rescission of a contract. If it appears during the period of the grant that the cost of the program will exceed the estimate, the Board may increase prospectively the amount of the grant.

(*e*) The services to be provided shall include, in addition to all covered health services (other than inpatient institutional services) which may be

provided by arrangement with participating providers, such groups or combinations of services as the Board deems necessary or appropriate to enable persons, found eligible for the services in accordance with subsection b., to continue to live in their own homes or other noninstitutional place of residence. The personal care services may include homemaker and home help services, home maintenance, laundry services, meals-on-wheels and other nutrition services, assistance with transportation and shopping, and such other services as may be appropriate in particular cases. The Board may prescribe different ranges of services in different programs.

(*f*) For each program the Board shall prescribe criteria for the approval of the application for assistance, and such criteria may be different in different programs, but all programs shall be required to assure adequate coordination with all agencies in the community furnishing health or personal care services to beneficiaries of the program. Each grant shall require the grantee to establish, or arrange for the services of, a committee to screen applications for assistance under the program, in accordance with the applicable criteria, and no assistance shall be given until an application has been approved by the committee. The committee shall also maintain a constant review of utilization of the services provided by the program, and assistsance to any person shall be terminated whenever the committee finds that he no longer meets the applicable criteria. The composition of the committee shall be subject to approval by the Board, and it shall include at least one physician, one professional nurse, one professional social worker, three representatives of the user of the services, and such other qualified persons as the Board may prescribe.

(g) Evaluation. Each grant shall require the grantee to establish procedures for the evaluation of the program, with respect both to the benefits accruing to persons receiving assistance and to the fiscal impact of the program on the health insurance system. The Board shall also make its own evaluation of each program, and shall include a summary thereof in its annual report to Congress.

6. The Board would include among the projects and demonstrations funded cases of applications of the hospice concept in order, as feasible, to test ways to apply this concept effectively.

7. Recommendations to the Congress. Before the end of the fifth calendar year after the enactment of this Act, the Board shall transmit to the Congress a comprehensive report on the operation of this subpart and the Boards' evaluation of such operation, and shall submit its recommendation of (a) methods for the development, as widely and rapidly as practicable of personal care services in communities lacking programs therefor, or lacking adequate programs, to the end that such services in lieu of institutional care be made generally available throughout the United States, and (b) methods for the continuing financial support of such services; together with the Board's recommendations with respect to the proper role of the program established by this Act in providing long-term institutional care and in providing personal care services in lieu thereof.

8. The Board will also examine the effects of current problems in malpractice insurance (based on existing studies and additional studies, if found necessary) on patients, practitioners of health care, and health care costs and will submit a report to the Congress within two years after enactment, including recommendations for changes in malpractice laws and changes in this program which will more effectively protect both providers of health services and their patients and contain costs of this program.

VII. PROVIDER REIMBURSEMENT

A. Type of reimbursement by type of provider

1. Prospective rate, based on approved budgets.

(*a*) Hospitals;

(*b*) Home health agencies;

(*c*) Community health centers and other forms of health centers;

(*d*) Skilled nursing facilities (see Part IV for NHI financing of reasonable administrative cost of determinations of budget based reimbursement of nursing-facilities under residual medicaid and NHI).

2. Fee schedules (subject to overall budget limits).

(*a*) Physicians;

(*b*) Podiatrists;

(*c*) Laboratory services and durable medical equipments (subject to limits based on lowest costs for widely available services).

3. Other providers as in Medicare.

4. Capitation for HMOs based on rates determined to be reasonable community wide for all persons (except those under Medicare) covered by NHI with appropriate adjustments for risks enrolled and area costs. The capitation rate for Medicare would be based on Medicare experience for all those under that program, adjusted for the type of risks who are enrolled in the HMO and who are entitled to Medicare. Developing HMOs would be paid approved budgeted costs in excess of normal capitation as part of support for such development. (See also Part VI). The payment in excess of capitation would be from grants from the Health Resources Distribution Fund. Hospitals used by HMOs would be subject to budget approval.

5. Salary or fee-for-time. For professionals eligible for fee schedule reimbursement, if the salary or fee-for-time alternative is not higher, as determined by the Board, in cost than the fee schedule.

6. Cost of goods provided plus professional fee for drugs and audiological services, with cost defined as the reasonable cost necessary to obtain an adequate product.

7. Special. Authority will be given to the Board to allow, experimentally or otherwise, other methods of payment if use of the other method is determined to advance program objectives. Such departures may be made for groups, including one or more entire States, that request authority to depart, if the Board determines these departures meet the objectives.

B. State budgeting process

1. Sum of total funds to be allowable in a State for all covered health services would be determined by the formula described in Part V.

2. The State approved budget would distribute funds among various health service components with such leeway for redistribution by the State as the Board may establish.

3. The State fund distribution shall set aside a contingency allowance that the State may use, after provider budgets and estimated payments on the basis of fee schedules and other methods are established, for contingencies unforeseen when the budget's fee schedules and other parameters of payment were approved.

C. Reimbursement by prospective rate based on approved budgets

1. Each budget reimbursed provider would submit to the State Agency its proposed budget at such time, providing such data, in such form, as the Board shall determine.

(*a*) The data shall include historical data, a full budget for the year to be approved, and a two and five year capital and service charge budget plan.

(*b*) The reports shall cover the total operation of the provider, as well as identifying the portion proposed to be reimbursed through NHI and how non-NHI reimbursable costs are to be recovered.

(*c*) The reports shall show data distributed in at least the following categories.

(1) Operating costs and capital costs.

(2) Inpatient and outpatient services.

(3) Costs of nursing services by and under the supervision of a registered nurse.

(4) Costs of continuing services and cost effects of discontinued and added services.

(5) Cost effects of expected productivity and utilization changes.

(6) Revenues by source, type, and service including nursing service.

(7) Volumes of services.

(8) Patient characteristics.

2. The State Board would review the proposed budget.

(*a*) Within the leeway provided by Board established policy and procedure, the State Board would negotiate with providers (including representatives of those employed to provide health services) its budget review plan and procedures. Representatives of patients and payers would be parties to this negotiation and the advice of representatives of consortia would be available in the process.

(*b*) In all cases, the review would be made to confirm conformity of the two and five year capital and service change budgets with the current approved plan of the Health Systems Agency for the area.

(*c*) The State Board would use screens to determine which budgets may be approved without further detailed individual review, as well as what elements

within a budget may require particular review. Parameters used in screening shall be set in accordance with National Board policy. Screens may be of various forms, such as—

(1) Rate of increase year-to-year: (a) Total budget; (b) Average inpatient cost per admission; (c) Average inpatient cost per day.

(2) Absolute levels of costs by type of hospital: (a) Average inpatient cost per admission; (b) Average inpatient cost per day; (c) Average cost per outpatient visit; (d) Educational cost per student by type of student.

(3) Cost ratios by type of hospital (generally expected to be used to help develop specifics of review, rather than whether a review should be conducted): (a) Administrative costs to total; (b) Cost of various services—nursing services by and under the supervision of a registered nurse, drugs, meals, etc.—to total and costs of the services per day, per admission, or other unit as appropriate.

(*d*) The State Board would conduct, in accordance with Board policy and procedures, detailed review of some or all aspects of the budgets of hospitals which fail one or more of the screens or that fall into a random sample quality control check of all budgets that would provide assurance that defects undetected by the screens were not occurring.

(1) This function may be delegated in whole or in part to another body with the approval of the Board.

(2) Quality and access issues shall be taken into account in this review, as well as effectiveness of the use of services; PSRO and JCAH findings would be considered.

(*e*) Where a particular function is found to have costs that do not appear to be approvable, the provider would be informed and given oportunity for comment. Budget reductions made that would cover costs only if methods of operations were modified would be scheduled in accordance with the time the State Board finds reasonable for the provider to take corrective action.

(*f*) The State Board would have the final authority (subject to reconsideration, appeal, and court review) for approval of the provider budgets.

(1) The budget approval would establish the total amount reimbursable to the provider under NHI, subject to adjustment for variations in use from predicted levels and may establish maximum levels for subparts of the budget subject ot transfers, within specified limits, by the hospital among the subparts.

(2) The State agency would receive a recommendation for the provider budget arrived at by negotiation between a committee of consumers with the provider who may be assisted by an association of providers or others. The interests of persons employed by the provider would be represented by persons nominated by organizations of such workers. State agency and consortia representatives would be available as technical advisers in the course of the negotiations. In the event that no recommendation is received timely, the State Board would proceed on its own.

(3) The approval would take account of: (a) Budget limits imposed by Congress and the Board; (b) The HSA plan for the area; (c) Demographic factors; (d) Expected rate of inflation of costs; (e) Effect of approved capital and service modification plans; (f) Effects of acceptable wage increases; (g) Efficiency objectives for the hospital based on inter-hospital comparisons, taking account, as feasible, of patient mis, as well as other pertinent factors.

6. The hospital would submit a reconciliation of experience during the year with approved budgets for the year and differences would be reflected in the budget for the subsequent year to the degree appropriate. Expenditures for purposes that were not previously approved may not be reimbursed unless and to the degree approved after the fact.

7. Definition of costs includable in budget. Reasonable costs of services generally provided by hospitals. Specific provisions include:

(*a*) Payments to physicians under contract with a hospital or other provider involved, and to all radiologists and pathologists providing service to hospital patients and all physicians serving patients of a mental hospital would be included in the hospital budget. Payments to other specialists may be added to hospital (or other provider) budgets by the determination of the Board that a large enough portion of such work is done under hospital (or other provider) contracts to merit such inclusion. Payments for the services of such physicians would be required to be reasonable in relation to the costs of employing such serv-

ices on a salaried basis and above that which would be paid on a fee-for-service basis.

(*b*) The budget and/or contingency fund payment would allow in full the cost of total wage and fringe benefit payments for non-supervisory employees, unless the Secretary of Labor finds, after a hearing in accordance with regulation adopted by the Secretary, that such wages and fringe benefit rates are substantially at variance with those rates which prevail, as determined by the Secretary, for services of comparable hospital employees in the locality.

Where a collective-bargaining agreement or other negotiations process covers any such hospital employees, such budget and contingency fund payments shall be in accordance with the rates for such employees provided for in such agreement or process, including prospective wage increases provided for in such agreement as a result of arm's-length negotiations.

In no case shall wages be lower than the minimum wage specified under Section 206(a)(1) of Title 2a of the U.S. Code.

(*c*) The term "supervisor" means an individual having authority in the interest of an employer to hire, direct, assign, promote, reward, transfer, furlough, layoff, recall, suspend, discipline or remove employees; to adjust employee grievances or to recommend such action if the authority is not merely routine or clerical in nature. The term "supervisor" applies only to individuals who devote a major portion of their employment time to exercising such authority.

(*d*) Cost of services provided to persons not covered by NHI for whom no reimbursement is obtainable by the provider from those persons are includable in budgeted costs reimbursable through NHI.

(*e*) Depreciation costs would not be includable in the budget but principal payments on debts incurred before NHI was enacted and costs of small capital items would be includable, as would costs of new major capital expenditures in a lump sum or in the form of amortization payments for debts, but only to the extent approved through the planning process. The costs of institutional closings and cutbacks, including the reasonable costs of easing personnel dislocations arising from such closings and cutbacks, would be includable as covered costs.

(*f*) Profit payable to investor-owned inpatient facilities would be allowed as under Medicare. Budgets would also allow for maintaining working capital and reasonable reserves for contingencies in other inpatient facilities. Profit for other than inpatient facilities reimbursed on a budget basis would follow the policy in the Medicare renal dialysis facility provisions which provide for incentive reimbursement methods.

8. The capital elements of the budget and the operating costs that would follow from capital and service changes would be reviewed and approved in coordination with planning program approvals, subject to limits on totals established in the NHI national budget limits and distributions of these totals made by the Congress or the Board.

(*a*) The limits for capital expenditures would be permitted to be exceeded in the case of hospitals which expended less than the budget allowed for operating expenses. The hospital could retain one-half the difference and allowed to use this difference for capital expenditures approved by the planning program.

(*b*) Planning approvals for purposes of the provider budget would take account of:

(1) The needs of the area.

(2) The cost effectiveness of the proposed change.

(3) The change in costs that would result in both the long and short term, with long term increases planned to be held in line with the past three year average GNP growth rates.

(4) The comparative results of making the proposed change at alternative sites and in alternative ways.

(5) Policy restrictions on the diffusion of the services involved.

(6) Recommendations and advice provided by the HSA's.

9. The National Board would establish uniform data reporting requirements to underlie the provider budget approval process. Data obtained through these requirements would be disclosable to the public, and Board would issue released to inform the public of its findings of their contents.

10. Payment would be made by insurers on the basis of estimates of the proportion of resources used, on an interim monthly or more frequent basis throughout the year, with final settlement after the year closes. The basis of apportion-

ment of provider costs by insurer would be established by the National Board. Whatever method is used would be designed to produce the budgeted revenues for the provider, with a limited amount of data furnished by the hospital on a patient-by-patient basis in order to minimize individual billing and the resultant administrative costs, but distributed reasonably among insurers in accordance with the services rendered to the insured persons. The National Board may establish a single method of apportionment for a class of providers or may provide two or more methods that may be used for a class. The choices that may be made by the State Board as the methods of apportionment would consist of:

(*a*) Prices or lump sum payments to be made for classes, or treatment for specific conditions/diagnoses, with such prices, payments, and classes or treatments determined by the State Boards under methods conforming to requirements of the National Board.

(*b*) Relative values of services used as estimated by indices established by the National Board.

(*c*) Admissions, patient days, diagnoses, and other factors found pertinent by the National Board. The apportionment (or payment rate) may be adjusted during the year to conform to the budget and differences from the budget may be reflected in adjustments to ensuing years.

(*d*) Such other method or methods as the National Board may determine.

11. The National Board would have the authority to allow States to depart from the normal budget reimbursement process if the Board finds that an experiment with an alternative approach would be in the interest of the NHI program.

12. Before the first year benefits were payable, the entire process would go through as complete a dry run and as soon as is feasible, with budget decisions from the dry run serving as guidelines to planners and reimbursers.

C. Physician fee schedules

1. Long term provision.

(*a*) Physician participation would be required for NHI reimbursment.

(1) The participating physician would not be permitted to charge any more than the NHI reimbursable amount.

(2) A nonparticipating physician's service would not be reimbursable by NHI.

(3) A physician could undertake to participate at any time, and once agreeing could not terminate participation until he had participated for at least one year.

(*b*) The fee schedule levels would be designed to provide payment levels consistent with those provided for in the budget. (Since the budget for physicians' services includes both fees and utilization, fee schedules would be negotiated under estimates of utilization consistent with the budget.) Insurers and State Boards would be directed to report to the National Board when payments appeared to depart from this intent. State or National Boards would investigate such occurrences and take any necessary corrective actions negotiated with those involved.

(*c*) The original fee schedules would be rationalized over time.

(1) A national relative value scale would be developed to serve as a guideline for modifying schedules. The criteria for use by the Board in establishing the relative value for a service would include: (a) Time and effort; (b) Difficulty of performance; (c) Cost of the provider; (d) Social desirability of its provision.

(2) A policy on the variation in fee levels to be permitted among areas, taking into account: (a) Variations in cost of practice; (b) Variations in non-physician earnings; (c) Reasonableness of rate of change from period to period, avoiding rollbacks in fees.

(3) The fee established where two or more categories of personnel—primary care physician and specialist, or physician and non-physician, for example—may provide a given service of essentially the same quality would be a the level reasonable for the lesser cost personnel.

(4) Services would be included or excluded on the list of those reimbursable on the basis of a determination of the Board with the advice of a commission on reimbursable medical procedures. New services would be added as approved.

(5) Reimbursement for services in ways that improve health care: (a) Based on the advice of the Commissions on Benefits and Quality, the NHI Board would:

i. Encourage use of or prohibit reimbursement for specified medical and other procedures based on developments in clinical science and practice.

ii. Establish a list of high risk, high cost, elective, or overutilized services which can be reimbursed only when the provider meets one or more of the following criteria: (aa) Board-certified in the relevant medical specialty; (bb) Supported in his diagnosis and treatment by a second opinion or by specific objective findings; (cc) An institution adequately equipped and staffed according to the regulations by the NHI Board to provide the service; (dd) A specialist or institution providing care to a patient referred to him by a primary care physician or through triage; (ee) Demonstrated through statistical evidence as providing properly used high quality services.

(b) State Boards would be authorized to encourage, and award HRDF funds to finance, programs of continuing educational and professional development through PSROs or other private agencies on state-of-the-art in clinical practice and areas of possible improvement in current practice patterns in the State or area, as indicated by reimbursement data.

(c) Based on the recommendation of a PSRO, an insurer would eliminate or reduce payments on a pro rata basis for specified services to providers found to abuse or misuse the services, after notice that a finding of misapplication has been made.

(6) Every five years, or earlier upon call of the Board or by petition of one-fourth of participating physicians, negotiations would be reopened on the relative values and fee schedules. If the negotiation fails to arrive at a consensus, the schedules would continue without change, subject to the normal updating process. Strong evidence for reexamination at the call of the Board would be considered to exist when the rate of growth in total payments to physicians is found to exceed the rate of growth in the GNP.

(7) The rationalization steps would be taken after opportunity for negotiation between payers for care and physicians. The specialists and primary physicians taking part in the negotiation would be nominated by physicians in the category of physicians involved in the negotiation. (For negotiation process and composition of negotiating group see Part IV.)

(d) A formula for establishing year to year changes would be developed by the Board that takes into account:

(1) Increases that have occurred in an index of non-physician earnings and of office costs;

(2) Limiting increases in line with Board policy on physician reimbursement, taking account of, among other things, demographic changes and other demand factors;

(3) The negotiations.

(e) A provision would be made for awards for physicians to recognize unusual merit among physicians who participate in the program.

2. Initial provision, effective during period before benefits become payable.

(a) The Board would establish State or area fee schedules based upon the average level of charges to Medicare for the year of enactment, after applying the limits imposed by the Medicare index on allowable year-to-year increases. The schedule would be applied to:

(1) Medicare and medicaid;

(2) Private insurers, who would be required to pay them as a condition of ellgibility to participate in NHI.

(b) Less than the fee schedule amount would be paid to physicians whose customary charge or billed charge was below the schedule.

(c) More than the fee schedule amount would be paid to a physician if a charge higher than that amount was paid to him by Medicare prior to the date the schedule became effective. His payment would be the prior reimbursement charge or the fee schedule amount, whichever was higher, but this payment would not be increased under the indexing provisions in 1.d. above until the fee schedule amount rose to that level.

D. A provider of health care services which provides service to an eligible individual who has not yet enrolled and does not have a health insurance card would be paid for the services by the insurer with which the individual later enrolls with the insurer guaranteed reimbursement for back premiums to the last opportunity for enrollment for the individual. E. Reimbursement for services not specifically described in subparts B and C would be reasonable in relation to that specified in B and C in amount, policy, and procedure

VIII. MISCELLANEOUS AMENDMENTS

A. Changes in Title XI, Part B, of the Social Security Act dealing with the Professional Standards Review Organization (PSRO) Program

1. Remove from the Social Security Act and incorporate in the National Health Policy Act, thus applying the provisions to benefits covered under the new law.
2. Have the program apply to Title XVIII and Title XIX of the Social Security Act, as well as to the National Health Policy Act.
3. Substitute "Board" for "Secretary" throughout.
4. Previously decided policy and actions taken would stand until changed by the Board.
5. Remove hearings function.
6. Provide that the source of funds will be general revenues—modify sec. 1168.

B. Section 1122 of the Social Security Act would be changed to conform to changes (elsewhere in the bill) to health facilities planning legislation

C. Railroad Retirement Act—make conforming changes to take into account changes in the medicare program

D. Premium payment credits

1. Existing law which provides for an income tax deduction equal to one-half of health insurance premiums up to a maximum of $150 would be repealed.
2. Existing law which permits the amount of health care insurance premiums (not claimed under the $150 rule) to count toward medical expenses for deduction purposes would be repealed.

E. Limitation on liability of beneficiary

A provision comparable to Sec. 1879 of Medicare, which limits the liability of beneficiaries for payment for noncovered services when they accepted the services on the assumption they were covered.

F. Existing employer-employee health benefit plans

1. No provision of this Act other than this section shall affect or alter any contractual or other nonstatutory obligation of an employer to pay for or provide health services to his present and former employees and their dependents and survivors, or to any of such persons, or the amount of any obligation for payment (including any amount payable by an employer for insurance premiums or into a fund to provide for any such payment) toward all or any part of the costs of such services if the effect or alteration shifts the obligation in any part to such persons.

2. Any contractual or other nonstatutory obligation of the employer to pay all or part of the cost of the health services referred to in subsection (1) shall continue, and shall apply as an obligation to pay the premiums imposed on his employees by this Act, but the per capita monthly amount involved in the payment of such premiums by the employer on behalf of his employees shall not exceed the greater of (a) the per capita monthly amount of the cost to the employer of providing or paying for health services (either through insurance premiums or into a fund) on behalf of persons referred to in subsection (1), for the month prior to the effective date of NHI premium payment, or (b) the per capita monthly amount of the cost the employer would have incurred had this Act not been enacted.

3. At least for the duration of any contractual or other nonstatutory obligation of an employer referred to in subsection (1), an employer shall arrange to pay to eligible employees, former employees, and survivors referred to in subsection (1) such amounts of money by which the per capita monthly costs to the employer of providing or paying for health services referred to in subsection (1) in the month immediately preceding the effective date of NHI premium payment exceed the sum of the per capita monthly costs to the employer of the premiums, the employer's liability referred to in subsection (1) of this section, and any other employer contributions for health insurance premiums or health benefits or services provided by the employer after the effective date of health security benefits. By agreement between the employer and his employees or their representatives, an employer may provide other benefits of an equivalent monetary value in lieu of such payments.

4. For purposes of subsections (2) and (3), the per capita amounts and per capita costs for an employer shall be determined by dividing the aggregate amounts and the aggregate costs by the number of eligible employees, former employees, and survivors on the date as of which the determination is made.

G. Various additional conforming and technical changes in statutes affected by the plan would be made. (No changes in any veterans legislation would be made.)

Detailed Explanation of "Health Care for All Americans" Plan

PART I—STATEMENT OF PURPOSE

Part I lists briefly the basic purposes of the legislation: making comprehensive health benefits available by applying social insurance principles to a private health insurance system; providing comprehensive benefits to all without consideration of means; containing health care cost increases to the rise in the GNP; distributing health care costs equitably, with the share borne by Federal and State governments and by employees and others kept at moderate levels; improving the organization and methods of health care delivery and enhancing the distribution and quality of care; encouraging preventive medicine and protecting against catastrophic costs; providing reasonable compensation to health care providers; and assuring full public accountability of the plan and its operation, as well as consumer participation in its development and administration.

PART II—RIGHTS AND ELIGIBILITY PROVISIONS

This part contains a statement of rights, and eligibility and enrollment provisions.

A. Statement of rights

The statement of rights describes the rights of patients, health care providers, and eligible insurers.

Patients would be guaranteed the right:

(*a*) To obtain covered benefits from the approved provider they choose;

(*b*) To confidentially with regard to information collected about them;

(c) To prompt and accurate handling of program decisions about their status;

(*d*) To be heard on grievances related to care or to insurance under the program.

Health care providers in general would have the right to decide whether or not to participate in the program, to prompt and accurate payment for services rendered, and to make their views known (and have them considered) on all program actions affecting them. Physicians would have the right to choose both mode and place of practice.

Eligible insurers would have the right to decide whether or not to participate in the program, to engage in business supplementing health care services covered under the program, and to make their views known, and considered, on program actions affecting them.

B. Universal eligibility

Program eligibility would be extended to every U.S. citizen and permanent resident alien; to legal nonpermanent aliens employed by a foreign embassy or international organization if the employer entered into a participation agreement; and to a foreign visitor admitted for short periods, under the terms of a treaty or other agreement between the U.S. and the visitor's nation.

Eligibility would continue whether or not premiums were paid, and whether or not the individual enrolled.

All eligible people would be entitled: to have payments for covered health care paid on their behalf; to enroll with approved insurers, including those which offer financial or benefit advantages for enrollment; to change enrollment when such a choice was available, during the annual enrollment period; and to a national health insurance card identifying their eligibility but not indicating any sources of funds paid to the program with respect to them.

C. Enrollment

All employers would be required to offer, during the program's first general enrollment period, to each employee (except to Medicare beneficiaries) a choice

of health insurance plan or plans, at least one from the insurer members of the non-HMO consortia and one from the members of the HMO consortia offering such plans in the employees' areas. The employer could offer supplemental benefits. The employee would choose a plan to be in effect at least until the next enrollment period. A family could choose only one plan, even if individuals within the family were offered a choice of plans from more than one employer. Dependents covered under the plan would be spouse and children (under 22) as defined for income tax exemption purposes.

For members of the armed services and their dependents, the Defense Department would act as both employer and consortium, retaining premiums paid and issuing identification card. Enrollment choices would be offered as the Defense Department found consistent with its policy requiring use of Department facilities. The Department would pay for covered care furnished outside its facilities and recover appropriate costs on the basis of NHI cards for services not reimbursable under the Defense Department plan.

Everyone who attained age 65, or was entitled to disability insurance benefits for a month, or had end-stage renal disease would be entitled to benefits under both Parts A and B of Medicare and all insured status requirements for the aged would be deleted. Coverage under Parts A and B would be mandatory. The premium would equal the present Part B premium, and be paid in the same amount as under present law. Those eligible for Medicare and for SSI would have their Part B premiums paid by the Federal government.

All other eligible people would have the same choices as employees to enroll in a plan and would have premiums paid on their behalf as follows:

(*a*) SSI recipients under age 65 not eligible for Medicare would receive enrollment information from Social Security district offices and would enroll directly with insurers. The Federal government would pay the premiums for this group. Information about income status of individuals would not be furnished to insurers or consortia. Premiums paid on behalf of SSI beneficiaries would not be considered as income in determining SSI cash benefit eligibility.

(*b*) For welfare recipients, States would be required to pay the premiums on behalf of all recipients of AFDC (and AFDC-U) and to furnish enrollment information. Individual eligibility information would not be furnished to insurers or consortia.

(*c*) For those enrolling individually, the State Boards would be responsible for furnishing enrollment information. Those enrolling individually in the first general enrollment period would compute and pay their premiums at the same time they computed and made their estimated tax payments. For those not enrolling during the first period, the State Agency would establish procedures for enrollment to take place when the individual first sought health care but did not have a health insurance card from a qualified insurer or when they filed an annual income tax return without showing health insurance enrollment. Premiums would be paid to the insurer chosen by the individual to cover the current enrollment year. Health care providers or insurers would notify the State Agency of all unenrolled individuals who sought care.

D. Open Enrollment Period

Enrollment periods would be organized as follows: a first general enrollment period during June through November of the year before basic benefits become effective; a general enrollment period from September through November of each year to be effective the following January 1.

First enrollment (after the first period) could occur when an individual reached age 22 or entered the country and became eligible. Disenrollment from private insurance would occur when persons become eligible for Medicare.

Changes in enrollment would be allowed if an individual of family changed areas or if a new employer did not offer their current insurance plan.

Upon enrollment, the insurer would issue enrollees NHI cards so that providers would know whom to bill.

E. Definitions

The definition of wages would be identical to that used for personal income tax withholding purposes.

The definitions of employer and employee would be identical to those used for purposes of determining who must withhold personal income tax payment, but would not include those eligible for Medicare.

PART III—HEALTH CARE SERVICES COVERED

A. Required benefits

Coverage of the following services would be required under the program:

1. Unlimited inpatient and outpatient hospital services as defined under Medicare, except that the services of hospital-based physicians would be incorporated in the definition. Inpatient hospital psychiatric services would be limited to 45 consecutive days of active treatment beginning with the first day of hospitalization beginning more than 60 days after the most recent such period. Physician services provided by physicians under contract with hospital to psychiatric hospital inpatients would be included without limit as a hosiptal service. Services of physician consultants could, as determined appropriate, be covered as physician services.

2. Unlimited physician services, as defined in Medicare, except for those provided for a mental condition and excluding the services of chiropractors other than under Medicare. Physician services for mental conditions would be limited to 20 visits (as defined by the Board) per year.

3. Home health services (as defined under Medicare) for 100 visits per year.

4. Skilled nursing facility services (as defined under Medicare) for 100 days following a hospitalization of three days or more.

5. Preventive services including at least basic immunizations, pre- and postnatal maternal care, and well baby care. The NHI Board could, upon advice of a panel of experts, authorize additional preventive services based on evidence that such would be cost effective and would not exceed $500 million in the first year (adjusted in line with program costs for succeeding years). If costs exceeded the limit, appropriate reduction in covered services would be required. The Board would also be authorized to establish conditions under which preventive services would be covered.

6. Medical and other health services (as defined under Medicare): services and supplies incident to physician's professional service in his office; hospital services incident to physicians' services rendered to outpatients; diagnostic services furnished in outpatient departments; outpatient physical therapy services; diagnostic X-ray tests, laboratory tests, and other diagnostic tests; X-ray and related therapy; surgical dressings and splints, casts, and other devices for treating fractures; durable medical equipment used outside an institution; ambulance services; prosthetic devices (other than dental) which replace an internal organ, including lens after cataract surgery; and leg, arm, and neck braces, and artificial legs, arms, and eyes, including necessary replacements.

7. Rural health clinic services as defined under Medicare, and services of other clinics if such clinics meet Board-set standards.

8. Out patient drug benefits for Medicare eligibles, but only for chronic illness. The Board would establish a list of diseases and conditions found to be chronic and the drugs to be covered for each such disease and condition. Only prescription drugs, including insulin, listed in a Broad-developed formulary would be covered. Generic prescriptions would be required whenever generic equivalents were available. Dispensing pharmacies would be reimbursed on the basis of the drug supplied or the lowest cost generic equivalent generally available plus a professional dispensing fee. HMOs or other insurers could use the Board formulary, or their own provided that the Board approved it. The Board would also have the authority to set maximums and minimums for the amount of a drug prescribed.

9. Mental health day care services are provided at a rate of two days a year for each day of inpatient psychiatric benefits not used. Electroshock therapy would be covered only in cases of severe depression and where prior approval was obtained through arrangements established by the area PSRO.

10. Outpatient physical and speech therapy services as defined under Medicare, plus short-term occupational therapy where the promise of improvement was substantial.

11. Audiological examinations and hearing aid coverage limited to one examination a year and one hearing aid every three years. Cost of hearing aids would be covered only up to the amount of those on a list of hearing aids whose costs were found reasonable by the Board.

12. Outpatient services provided by a community mental health center. The total amount payable during a year for a patient would be determined on a

salary equivalent basis for the type of personnel employed and could not exceed the equivalent of a negotiated fee for a psychiatric visit for that year times 20.

B. Exclusions

The following exclusions would apply to the basic benefits:

1. Services and items, other than preventive services, not reasonable or necessary for diagnosis or treatment of illness or injury or to improve functioning of a malformed body member.
2. Services or items not provided within the U.S. (defined as including States, commonwealth and territories), with the exception of current Medicare provisions for Medicare beneficiaries relating to closest convenient hospital and travel between parts of the U.S.
3. Services and items constituting personal comfort items.
4. Orthopedic shoes or other supportive devices for the feet, other than for Medicare eligibles.
5. Custodial care.
6. Cosmetic surgery except for prompt repair of trauma-induced injury or for improvement of functioning of a malformed body member.
7. Services or items furnished by immediate relatives or members of the patient's household.
8. Treatment of flat foot conditions, and prescriptions of supporting devices, treatment of subluxation of the foot or routine foot care, including cutting or removal of corns or calluses, trimming of nails, and other routine hygienic care, unless precribed by a physician other than a podiatrist or surgical chiropodist as seriously handicapping or a danger to general health for a patient with diabetes mellitus.
9. Services provided by practitioners excluded from Medicare because they have been found to have abused the program or have been convicted of crimes (under sections 1862(d) and (e)).

C. Medicare changes

The bill would make the following changes in the Medicare program:

1. Make the payroll tax applicable to all employment.
2. Remove limitations on days of hospital coverage and retain spell of illness provision for post-hospital extended care services only.
3. Remove deductible and coinsurance requirements for inpatient hospital services and post hospital extended care services, including the three-pint blood deductible.
4. Remove section 1814(g) related to payment for services in a teaching setting to a fund. This would be handled by normal budget reimbursement considerations under hospital reimbursement.
5. Extend automatic eligibility to all persons age 65 and over.
6. Delete the Part B deductible and 80 percent coinsurance requirements (except for that relating to treatment of mental conditions) and remove the three-pint blood deductible.
7. Mandate Part B enrollment. Where deduction for premiums from Federal benefits is currently authorized, it would be made mandatory. The Federal government would pay the premium on behalf of SSI beneficiaries. Where there was no Federal benefit payable to the individual from which the premium could be deducted, the individual would be subject to a charge of 115 percent of the amount due, unless he paid the premium out of pocket. All provisions for late enrollment in the future would be removed.
8. Repeal section 1843 related to State agreements for coverage under Medicare of persons eligible for medical assistance (the "buy-in" provision).
9. Add drug benefits to list of covered services.
10. Amend section 226 of the Social Security Act to provide Medicare entitlement in the same month as disability insurance entitlement, rather than 24 months later.
11. Repeal section 1867 authorizing the Health Insurance Benefits Advisory Council.
12. Modify section 1874 and other references throughout Title XVIII to change references to the Secretary to the National Health Board.

D. Effective dates

Basic benefits for the non-Medicare population would go into effect on January 1 of the third year following the year of enactment.

E. Incentive payments

Any person who chooses a plan offering more benefits at no cost or a cash rebate payment would be eligible for the benefits or payment without having it affect any credits due under provisions establishing a maximum on premiums. Insurers could limit services covered to those offered by selected providers offering services at reduced prices or under special arrangements; however, all NHI benefits would have to be provided or covered by the insurers.

Enrollment incentive payments could be in the form of increased benefits (if so, the insurer would have to stipulate actuarial value) or in the form of cash payments (cash payments would be nontaxable and would not off-set welfare payments). The full amount of such incentive payments would be rebated to enrollees. However, a portion could be allocated to employers in return for their services in arranging for availability of cost-effective HMO plans if the portion was negotiated in accordance with the dual choice provision of section 1310 of the PHS Act (regarding "Employers Health Benefits Plan" and the role of employers and employee representatives regarding HMO arrangements).

PART IV—ADMINISTRATION

A. Specification of responsibilities

The program would be administered primarily by certified private insurers and HMOs operating within regulations and negotiated agreements established and administered by National Health and State Health Boards with the involvement of State government, private health agencies, providers of care, employers, and individuals.

Certified private insurers and HMOs would be responsible for—

1. negotiating community-rated premiums on a national, State, and area basis with the National Board for insuring all services covered by this plan;
2. marketing insurance or HMO programs to all eligible people for all covered services, at negotiated premium community rates;
3. participating in negotiations of the State Board with providers and purchasers of care to establish budgets and fee schedules;
4. enrolling and issuing health care cards to all eligibles;
5. underwriting the costs of insuring all covered services in exchange for the community-rated premium;
6. arranging for the payment of health care providers for covered services at rates equal to or less than those negotiated by the State Board; and
7. establishing national consortia which perform certain specified administrative and fiscal functions.

Under the program, the newly established *National Health Board* would be responsible for—

1. establishing national policy guidelines and standards to implement the program, and overseeing the program's implementation;
2. computing national and State annual NHI Budgets, negotiating national and State premiums with insurers and HMOs, assuring payment of established income-related and other mandated premiums necessary to finance the program, establishing one or more systems for apportioning among insurers the costs of payment to providers reimbursed on a budget basis, and negotiating the establishment of provider budgets and fee schedules and payment mechanisms with providers;
3. establishing and administering a national Health Resources Distribution Plan;
4. certifying and performing other required functions with regard to insurers, HMOs, and their consortia;
5. extending fiscal relief to impacted employers;
6. collecting data required for the planning, budgeting, monitoring, and evaluating activities required under the program;
7. administering the amended Medicare program; and
8. contracting with the State Health Boards established by the states.

Under contract with the National Board, the *State Health Board* would be responsible for—

1. submitting State Annual NHI Budgets (within the overall budget allocated to the State) to the National Board and implement Budgets as approved by the National Board;

2. negotiating prospective budgets and fee schedules for the payment of providers within the approved budget and State Health Resource Distribution Plan;

3. administering grants from the States' allocations of the Health Resources Distribution Fund approved by the governor;

4. reviewing State administration of its residual Medicaid programs for conformity with Federal standards for Federal assumption of the administrative costs of the program;

5. facilitating enrollment by employers and individuals and guaranteeing payment to providers for covered services;

6. certifying providers of care and performing other provider-related functions; and

7. performing other functions delegated by the National Board.

State governments would be responsible for—

1. Nominating members of the State Board;

2. proposing to the State Board Five-Year Plans for Health Resources Distribution;

3. Implementing certificate-of-need and similar programs;

4. participating in negotiations of provider budgets and fee schedules;

5. paying group-rated premiums for AFDC eligibles; and

6. administering a residual medicaid program.

Two private agencies—the Joint Commission on Accreditation of Hospitals (JCAH) and Professional Standard Review Organizations (PSROs)—would continue to function under the program. The JCAH (and other comparable private agencies) would continue its present Medicare role of certifying provider compliance with requirements of the program. PSROs would be expanded to review all covered health services by all providers, including the establishment of norms and criteria for medical practice. They would also perform all other functions now assigned to them.

Providers of health care would be invited to offer services on a participating basis in the program, and to send elected representatives to national and state negotiations to establish budgeting procedures and fee schedule.

Employers would be assigned the responsibility of—

1. Negotiating with insurers and HMOs and offering a choice of insurance and HMO arrangements to their employees;

2. Facilitating enrollment of the employee and his/her dependents in the plan of his/her choice;

3. Making wage-related premium payments, including any employee share withheld (based on labor-management negotiations in organized companies) on behalf of the employee;

4. Issuing a statement at the end of the year to the employee of employee premiums paid;

5. Applying to the National Board for financial relief from excessive economic impact of mandated premiums, if any;

6. Participating, through representatives, in the negotiation of provider budgets and fee schedules for their state or area; and

7. Participating, through representatives, as members of the State Board.

Individuals (except those who are members of the armed forces, Medicare eligibles, or in Federal or State institutions) would—

1. Enroll themselves and their dependents in one of the insurance or HMO plans available to them through their employer, or if they are self-employed or non-employed, any of the plans available to residents of their State;

2. If an employee, pay a wage-related premium (subject to labor-management negotiations) through their employers and an income-related premium to their HMO or insurer if they had substantial non-wage income and did not reach the maximum payment on the basis of premiums related to wages;

3. Present their Health Card to all providers of care for covered services;

4. Participate, through representative groups, in the negotiations of provider budgets and fee schedules for their State or area; and

5. Participate, through representative groups, as members of the State Board.

B. *Conditions for Certification of Insurers and HMO's*

Any insurer or HMO could be certified (and recertified) to insure services under the program if it—

1. Meets applicable legal standards required by the State(s) in which it operated;

2. Makes available at the negotiated community rate a program of insurance or benefits covering all services specified by the program;

3. Accepts for enrollment all employee groups or eligible individuals at the negotiated rate, within the resource capacity of the HMO or similar arrangement and within limits appropriate for plans negotiated or arranged between employers and employees that are self-insured;

4. Provides the same added benefit to the required program of insurance, or the same premium rebate, to all enrollees (except that a portion of this rebate could be allocated to employers in return for services in arranging for the availability of a cost-effective insuring plan);

5. Complies with all regulations of the National Board regarding advertising, customer service, standard claims forms and procedures, rights of privacy of enrollees and providers, and other areas authorized by the program.

6. Is a member of a consortium and complies with all rules and procedures of the consortium considered reasonable by the National Board;

7. Makes no departure from those methods of marketing, or paying for health services without special approval.

C. *Consortia*

The National Board would certify four national corporations or "consortia," with State and area subsidiaries as follows: one consortium would be formed from Blue Cross and Blue Shield Plans, one from commercial insurance carriers, one from Prepaid Group Practice HMOs (as defined in title XIII of the PHS Act) and one from Independent Practice HMOs (as defined in title XIII of the PHS Act).

Each consortium would—

1. Represent its member plans in activities of the National Board;

2. Represent its members on a negotiating committee established by the State Board for the reimbursement of participating providers;

3. Collect and place in a fund all premiums due from employers, individuals, and State and Federal governments on a monthly, quarterly, or annual basis;

4. Notify the National Board of employers or individuals who are in default on premium payments;

5. Pay community-rated premiums from the consortium fund to the member plans on behalf of each plan's enrollees;

6. Establish an arrangement for transferring mandated premiums and other payments among consortia to adjust for differences to risks insured;

7. Make payments to participating providers of care on behalf of their member plans;

8. Monitor payments to providers of care;

9. Conduct claims review program and collect data as required by the National Board;

10. Facilitate smooth transfer of enrollment and premium collection in the same or different geographic areas, or between consortia.

In order to be certified:

1. The consortium of Blue Cross and Blue Shield plans and the consortium of commercial insurers would have to have member plans in all States and major areas;

2. Each consortia would be required to accept into membership any insurance or HMO plan certified by the National Board applying for membership; and

3. The consortia would have to possess resources and present a plan of operations to the National Board which demonstrates intent and capacity to carry out all the functions specified above.

D. *Structure and Administrative Functions of the National Health Board*

The National Health Board would be an independent agency of the Federal government, reporting directly to the President. It would be managed by a five-member National Health Board (hereafter called the National Board) appointed by the President and confirmed by the Senate. The Chairman would be appointed by the President; members would have staggered five-year terms. No more than three members could be from the same political party.

The National Board would be responsible for all policies under the program. It would appoint a chief administrator and organize bureaus and other staff and operating units within the National Health Board. The National Board's jurisdiction would include the current Health Care Financing Administration and other DHEW programs or elements of other current DHEW agencies. In addi-

tion, the National Board would administer the Health Resources Distribution Fund.

The National Board would include a Board of Appeals to which providers, insurers, individuals, or others could make final administrative appeal after opportunities for appeal at the State Board or, as appropriate, the consortium level had been exhausted.

The National Board would be served directly by staff offices of the Ombudsman, the Advocate, and the Inspector General. The Ombudsman would investigate and report to the Board on complaints about the operation of the program and recommend changes in regulations or practices.

The Advocate would assist consumers in defining, protecting, and asserting their rights and would focus on the needs of minorities, the elderly, the disabled, other disadvantaged groups, and women.

The Inspector General would perform functions with respect to health similar to those now performed by the HEW Inspector General. The Inspector General would conduct investigations into fraud and abuse, and acting through the State Board, would contract with State fraud and control units established under Sec. 1903 of the Social Security Act to conduct the activities defined in this section with respect to all health services covered and all health care providers reimbursed under the program.

E. Commissions on Benefits, Quality, Access, and Health Care Organization

The National Board would establish standing Commissions on Benefits, Quality, Access, and Health Care Organization in order to continually review and advise the Board on ways to improve the program and to attain program objectives. More than half the members of each Commission would represent consumers. Each Commission would be furnished full-time staff, with staff resources specifically assigned to consumer members. The Commissions would also include representatives of the various health care professions and provider institutions and their employees, and insurers, as the National Board considered warranted for the purposes of the Commissions.

F. Structure and Administrative Functions of the State Health Board

The State Health Board would be a State-chartered public corporation (hereinafter called the State Board), established by the governor at the request of the National Board to carry out specific functions under the program. The State Board would have five members appointed by the governor subject to the approval of the National Board. Representatives of major purchasers of health insurance (employer groups and labor unions) would have two seats on the board, and at least one other would have to be a consumer. Members would have staggered five-year terms and no more than three members could be from the same political party.

The State Board would appoint a full-time chief administrator, organize bureaus and other staff and operating units in the Agency, and oversee the activities of the Agency.

The State Board would appoint an ombudsman and advocate who would report directly to the Board and who would perform for the State the same functions described above for the National Board. In addition, the State Board would include a Bureau of Appeals to which providers, insurers, individuals, or others could make formal appeal and obtain a hearing on grounds established by the National Board. The State would be authorized to appoint such standing commissions or short-term commissions as were approved for funding under their agreement with the National Board.

H. The Annual NHI Budget

Annually the National Board would prepare a comprehensive budget establishing (1) all public and private expenditures for covered health services and for the administration of the program and (2) all revenues from mandated premiums and other sources for financing these expenditures. This Budget would limit the total annual increase of health care expenditures over the preceding year to a maximum of the average rate of increase in the GNP over the last three years.

The Annual Budget would be presented to the President and Congress, and to the State governments, in adequate time for funds to be appropriated to cover the premiums and other government payments mandated by the program, including funds for the Health Resources Distribution Fund. The Congressional

Budget Office would submit an analysis to relevant committees of Congress each year of all aspects of the Annual Budget. The Annual Budget would:

1. Balance all revenues to be paid to insurers with all expenditures to be made by insurers. (It would also balance projected revenues and expenditures of the Medicare program);

2. Establish expenditures for each State or area:

3. Establish premiums required to be paid to insurers to finance the negotiated national community rated premiums for all enrollees, showing variations in rates achieved in each State and present analyses of economic impact on employers and employment of the premiums, as well as on Federal and State budgets;

4. Include the amount to be requested of Congress for the Health Resources Distribution Fund;

5. Reflect annual budgets of the States and the advice of the National Board Commissions.

The national budget would be based on agreements with providers negotiated by the State Boards and approved by the National Board and agreements with consortia on national community-rated premiums. The State budgets submitted to the National Board would reflect the advice of State Board Commissions, representatives of the consortia, and providers in the State, and the Health Resources Distribution Plan for the State.

6. Be implemented by the State Boards, with the State Boards renegotiating provider budgets and fees if necessary in order to stay within the revenues approved; (Negotiated national community-rated premiums in the approved Budget would provide limits on revenues to consortia for payment for covered services under the program and could be increased only by a subsequent act of the National Board. State expenditures approved would be the basis for the negotiation (or renegotiation) of prospeceive budgets, annual adjustments of physician fee schedules as necessary, and other provider reimbursements.);

7. Be accompanied by projections of the Annual Budget for five years, showing the effect of the Health Resources Distribution Fund and the limits on increases in expenditures nationally and by State and area.

I. Negotiations with providers

For purposes of establishing prospective budgets, fee schedules, and other payment mechanisms (as described in Part VII), providers would be invited to send elected representatives to negotiate with committees convened by the National and State Boards.

State Negotiating Groups.—The National Board would establish categories of providers from which representatives to the negotiating group with the State Board would be elected. There would be two negotiating groups:

1. The State negotiating group regarding prospective budgets would include classes of hospitals, HMOs, hospital-based physicians, hospital employees of various professions and occupations, community health centers, community mental health centers, and other providers reimbursable on a prospective budget basis.

2. The negotiating group regarding fee schedules and other payment mechanisms would include medical and osteopathic specialties by geographic area of practice (e.g., rural, urban) and style of practice (e.g., solo, group, institution-based) as well as representatives of non-physicians reimbursed on other than budget basis. The National Board would also establish general guidelines for the election process of representatives to the various negotiating groups in each State. Among other factors, these guidelines would provide for proportional representation of categories of provides on negotiating groups in terms of their numbers in the State and the percentage their services represent of the total amounts reimbursed under the program. Terms of office would be three years with eligibility for re-election.

National Negotiating Groups.—The National Board would conduct an election among the State negotiating groups to elect representatives from the State groups to the national negotiating groups. In addition, the National Board could, in consultation with provider associations and institutions, appoint up to five additional non-voting members to each group to represent provider interests that were not represented on State groups. Categories of providers would be represented on the national negotiating groups (except for the additional non-voting members appointed by the Board) proportional to their numbers on State negotiating groups. The terms of elected and appointed members would be three years. Both the elec-

tions of negotiating groups and all negotiating sessions would be matters of public record.

J. Negotiations with insurers and HMO's

Insurers and HMO's would be invited to send representatives to negotiate on their behalf with the National Board regarding the community-rated premiums. The manner of selection of these representatives would be established by the insurers and HMO's through their consortia, but should provide for representatives of such categories of insurers as the Board might require. The number of representatives to the negotiating groups from each consortia would be proportional to the total number of enrollees of each consortium, with no consortium represented by fewer than two.

K. Apportionment of the costs of a provider's budget among insurers

The National Board would establish rules for apportionment of the costs of a provider's budget among the insurers after consultation with insurers. Payment amounts by insurers would be established initially on an interim basis paid at such time as may be determined, adjusted from time to time, and settled after the close of the year.

L. Start-up of administrative structure and processes

Upon enactment of the program and prior to the effective date of benefits, the National Board would establish and test administrative structures and processes needed to implement the program on the effective date of benefits. The Board would be required to report to Congress on its progress 18 months after enactment and on any technical changes or authorizations of temporary administrative structures or procedures that would facilitate implementation. The General Accounting Office would review the progress of the Board in initiating these administrative structures and processes and report to Congress 18 months after enactment.

M. Federal back-up for State and insurer functions

If a State failed to establish State Board or if insurers failed to establish consortia or acceptable plans for their operation, or if there were States or areas in which no insurers qualified for certification, the National Board would perform the functions of those agencies.

N. President's Commission on the Health of Americans

The President would appoint a group of nine distinguished citizens to review the health status of the nation, the opportunities for improvement, and the cost for doing so. This Commission would coordinate its activities with those of the National Board and report on its findings and recommendations.

PART V—PROGRAM FINANCING

A. Sources of revenues

Financing for the program would be from seven primary sources: wage-related premiums; premiums on substantial amounts of non-wage income; State payments in behalf of AFDC and State institutional populations; Federal payments in behalf of SSI beneficiaries and Federal institutional population; voluntary payments in behalf of U.S. residents who are employees of foreign governments or international organizations; Medicare taxes and premiums; and general revenues.

Premiums would be calculated as a percentage of income. The full percentage would be applied to wages and one-half would be applied to non-wage income up to the maximum premiums payable by the individual. The percentage would be computed so that the costs of NHI benefits for the entire population (except the Medicare, SSI, and AFDC groups) would be fully covered by total premiums paid. The prospective percentage rate would vary by State in accordance with actual budgeted cost increases in each State. If sufficient information were not available to establish variable rates in initial years, either State-by-State estimates or a single national rate could be employed.

The maximum on premium payable would apply with respect to premiums withheld from employee's wages or paid by recipients of non-wage income; however, employers would be assessed on their total payrolls. The premium maximum would be calculated by family type and no individual would pay more than the average community rated premium for the individual's family type.

The income to be derived from each of the seven revenue sources would be determined as follows:

1. Wage-Related Premiums

Employers would be responsible for the entire payment but would be authorized to require that employees pay 25–35 percent of the premium amount. Employee payments would be subject to labor-management negotiations. An employer who is severely impacted by the program (had a substantial increase in premiums which reduced net earnings) would be eligible for a tax credit (or a payment if not subject to tax). States and localities would be required to contribute as other employees—if they did not, an amount equal to 150 percent of the amounts due would be deducted from grants otherwise payable.

Wage-related premiums would not be paid by Medicare beneficiaries, nor would their employers have to pay wage related premiums on their behalf.

2. Non-wage Income Premium

A premium payment, equal to one-half of the rate applied to wages, would be paid by recipients of self-employment and unearned income. Premium payments (made quarterly) would be required on annual non-wage income in excess of $2,000 per individual or $4,000 per couple. Late payments would be subject to a penalty unless exempted by the National Board. For persons under 65 years of age receiving pensions, non-wage premiums could be paid by withholding and part or all could be paid by prior employers. Medicare beneficiaries would not be subject to the non-wage premiums.

3. Federal Payments on Behalf of SSI Recipients and Federal Institutional Population

Group-rated premiums would be paid monthly to insurers (or their consortia) selected by the insurer on behalf of these individuals. A deduction could be made for other premium payments made by or in behalf of SSI recipients.

4. State Payments on Behalf of AFDC Recipients and State Institutional Population

Group-rated premiums would be paid monthly to insurers (or their consortia) selected by the individual on behalf of these individuals. A deduction could be made for other premium payments made by or in behalf of AFDC recipients. Federal matching for AFDC payments would be contingent on payment of premiums.

5. Voluntary Participants

Foreign governments or international organizations could enter into agreements with the Board for coverage of their employees and families who are long-term U.S. residents.

The Federal government would be empowered to enter into reciprocal agreements with other countries under which health services would be provided to their residents visiting this country in exchange for provision of similar services to U.S. residents visiting their countries.

6. Medicare

The Hospital Insurance tax, at the same rate specified in current law, would be applied to all U.S. wages including those of Federal employees, all nonprofit organization employees, and, under pain of deduction from grants (equal to one and one-half time the estimated tax), state and local employees Voluntary agreements with foreign governments would require payments equal to this tax. The Medicare Part B premium, computed on the basis specified in existing law, would be made mandatory for all persons eligible for Part A (all persons currently eligible, all persons over age 65, and the disabled after they have been disabled for five months) The Federal government would pay the Part B premium, computed on the basis specified in existing law, would be made mandatory for all persons eligible for Part A (all persons currently eligible, all persons over age 65, and the disabled after they have been disabled for five months). The Federal government would pay the Part B premiums on behalf of SSI recipients.

7. General Revenues

Increased general revenue obligations would be incurred on account of: (a) Payments for SSI population and increased payments, if any, for Federal institutional population; (b) difference between Medicare tax plus premiums and cost of services to Medicare group; (c) uncollectable premium payments due to private insurers; (d) payments to impacted non-taxpaying employers; (e) savings clause to States for Medicaid; (f) administrative costs; and (g) an increase, if any, in Federal employer payments in behalf of Federal civilian and military personnel.

Offsets to current general revenue obligations would occur as a result of: (a) elimination of individual tax deductions for health insurance premiums and services covered under NHI; (b) deduction of Federal payments for Medicaid; (c) reduction in escalation of the costs of covered services; and (d) an increase in Medicare HI contributions by those presently not participating.

B. Year-end adjustments

The wage-related premium would constitute full premium payment for wage earners with less than $2,000 in non-wage income.

Each premium payer with non-wage income over $2,000 would be required to calculate his/her total premium obligation. The non-wage income subject to premium payments would be the amount of such income (over the $2,000 exemption) except that the total of premiums paid on the basis of wage and non-wage income could not exceed the maximum premium. The premium payment for non-wage income would be half that applied to wage income. If, at the end of the year, any individual paid (or his/her employer paid amounts that could have been assessed to him/her) more than the community rated premium for his/her family type, he/she would receive a refund.

C. Enforcement

The Federal government would make a premium payment in behalf of any individual who failed to pay the required amount. The payment would become a debt owed to and collectable by the government from such individual.

D. Effective dates

Income-related premium would first become payable the calendar quarter before provision of benefits while monthly premiums would first become payable in the month before provision of benefits.

E. Residual medicaid

During the first three years the NHI program was in operation, States would pay no more for premiums for AFDC recipients and residual Medicaid than they paid in the base year except for an annual adjustment equal to the overall program rate of increase. This savings clause would only apply to States which: (1) had the Medicaid benefits in effect for two or more years prior to the effective date, (2) continued pre-enactment Medicaid benefits not covered by NHI, (3) paid required premiums in behalf of AFDC recipients and State institutionalized population; and (4) met requisite Federal standards. In such cases, the Federal government would pay 90 percent of the administrative costs of the residual Medicaid program.

F. National, State, and area premium determination

The National Board would set the limit on NHI expenses. Budget expenses in any year could increase at a rate no greater than the average rate of increase in the GNP in the preceding three years.

The National Board, with the advice of the consortia, would perform the actuarial calculations for determining premiums (which would include an allowance for contingency reserves). In the event the NHI Board found a shortfall in income, a temporary advance could be made from general revenues. This amount would be recovered from premium income in subsequent years.

The National Board would distribute the national budget among the States. The health care operating cost increase allowed for a State could be greater than the national average if the state's per capita expenditures were less than the national figures and less than the national average if the State's per capita expenditures were greater. The maximum variation in the increase permitted would be 20 percent below to 20 percent above the average increase. The limit determined for a State (or area) could be adjusted upward if it had several underserved populations for whom special development programs had been approved

in the Health Resources Distribution plan. If a state budgeted less than the limit allowed, the state's income related premiums would be adjusted downward accordingly.

G. Insurer financial duties

Insurers would:

1. receive the premiums, making use of consorted as they decide in handling the funds;

2. determine the premiums required to cover the risks they cover taking into account the costs in the areas they serve so that no advantage would occur from enrolling good risks or disadvantage from enrolling poor risks. The insurers would gain from demonstrated cost-effective delivery of services;

3. set aside a reserve for redistribution of funds among insurers to assure income proportionate to risks covered;

Consortia, if used to distribute risks premiums, would pay insurers from time-to-time with final settlement after the end of the year. The Defense Department would act as insurer and consortium for members of the armed forces and their dependents, would operate independently from other insurers, and would receive other funds than the normal premiums as appropriated.

H. Philanthropic contributions and State and local government supplement payments

Philanthropic funds and additional State and local funds could be used to supplement NHI financing but could not be directed toward expansion of the benefit package. Any capital investment or services changes made with such funds would be subject to planning approval.

PART VI—HEALTH CARE IMPROVEMENT

A. National objectives

The bill requires the National Board, consulting with the President's Commission on the Health of Americans, to establish national objectives for health care improvement to guide the planning process, the annual budgeting process, and other activities under the Act.

B. The health care improvement plan

The National Board would prepare and update annually a five-year plan describing the nation's needs regarding health care accessibility, quality, and costs; the effect of implementation of the Act on these needs; and strategies for meeting the needs in the future. The National Plan would:

1. define such projected needs as: shifts in geographic distribution of health care facilities and geographic and specialty distribution of professional providers; growth in enrollment and in numbers of cost effective alternative delivery systems; reductions in use of outmoded or duplicative tests or procedures; provider conformance to certification requirements through budget reimbursement or grants from the HRD fund; and other factors or special population emphasis as the National Board may require;

2. analyze the impact of the Act's provisions that provide for: the annual budget by category of service, with national and state expenditure limits; competitive marketing through HMO's and other innovative systems; negotiated prospective budgeting and fee schedules; PSRO review of all covered services; Health Care Resources Distribution Fund grants and contracts; state government activities in preparing and implementing the Plan; and such other provisions as the National Board considered appropriate; and

3. describe how standards and guidelines issued or proposed by the National Board to implement the Act met defined needs.

The National plan, based on State five-year plans prepared and annually updated by Governors at the National Board's request, would also include the State health plan prepared under title XV of the PHS Act, other state planning activities required by the PHS Act and the Community Mental Health Centers Act, and such additional state activities as the Governor may determine.

The State five-year plans would describe projected needs regarding accessibility, quality, and cost of care as specifically as possible, and specific actions the State government planned to fill them. The State plans would be based on standards and guidelines (including projected budget limitations for each State) promulgated by the National Board. All health related plans formerly submitted to the Department of Health, Education, and Welfare under the PHS and CMHC Acts will be submitted to the State Board, along with the State Plan. The State

Board would make grants up to the state's allocation level from the HRD fund, with the guidance of this plan, deviating from the plan only after consulting the Governor and upon review and approval of the National Board.

The State Board, in preparing its annual state NHI budget, would assure resource availability and other changes proposed in the plan.

The State Board, negotiating with providers on budgets, fee schedules, and other reimbursement policies would not approve: provider budgets with services, training, or accumulation or assets for capital expenditures inconsistent with the plan; or fee schedules inconsistent with State manpower redistribution goals. Issues of consistency would be subject to review and decision of the National Board.

C. Health resources distribution

The bill would authorize a national fund from general revenues at a level of $500 million for the first year of benefits and for each of the next five years. The fund would include: amounts requested by the National Board and appropriated by Congress to augment funding for existing DHEW programs transferred to the Board's jurisdiction; an amount to be allocated by the National Board for award to states based on plans, annual NHI budgets, and the preparedness of states to use the funds effectively—except that no state would receive less than one-half of a pro rata share based on population.

The HRD Funds could be used by the National Board and State Boards to award grants and contracts for purposes described either in the Act or in the legislation authorizing programs transferred to the National Health Board from the PHS or other agencies, including: conversion or closure of underutilized facilities; start-up of needed services in critically unde, served areas; renovations enabling providers to meet specific requirements relating to safety accessibility, or other critical factors; stimulation and support of HMOs and other cost effective delivery systems; establishment of phasing out of health professional education programs according to projected manpower needs in specialties and professions; start-up programs of continuing educational and professional development through PSROs or other private agencies on clinical practice state of the art and improvement areas in current practice patterns; and other purposes appropriate to improving quality, accessibility, or other objectives for health care under the Act.

D. Health statistics, health services research, and technology evaluation

The bill would establish under the National Board a National Institute of Health Care Research, to replace the existing DHEW Office of Health Technology, and include research institutes for health statistics, health services research, and technology evaluation. The new institutes would have functions described P.L. 95-623 for DHEW programs in these areas and would operate as independent research institutes under the Board.

The National Center for Health Statistics would be given the following new functions: formulating data policy, regulations, and operational guidelines for establishment and operation of data-gathering systems by the agency; assuring a flow of information required for both management of the NHI program by the national agency, such as for budget information; assuring program accountability regarding its impact on cost, access, and quality of care and on morbidity and mortality; and analysis of data gathered to meet needs of agency managers, consumers, and providers.

Data and information systems operated as defined by the Center under this Act and under Sec. 306 of the PHS Act should: be based on Uniform Minimum Data Sets established by the Center for Health Statistics; include the entire U.S. population and all health services; promote efficiency and effectiveness in collecting, processing, analyzing, and disseminating information; establish and coordinate data gathering activities by consortia, state and local agenices, and the national agency, to minimize duplication; and provide information to consortia, employers, coinsurers, and providers, and other interested institutions affected by the Act to inform their choices and facilitate activities under the Act.

E. Health education

The State Board would be directed to carry out a program to educate all residents on health, self-care, effective use of the health care system, and their rights and privileges under the Act.

Information on health living habits and appropriate use of resources would be furnished through development of both materials for distribution through

media and curricula suitable for classroom instruction at various levels, as well as through training of professionals.

Appropriate patient participation in care would be dealt with through preparation of training materials, support for training sites related to serious but common impairments in which patient activities play an important role, and training of professionals.

F. Special studies and demonstrations

The National Board would be required to continuously study and evaluate the operation of all aspects of the program, including study and evaluation of the adequacy and quality of services furnished under the program, analysis of the cost of each kind of service, and evaluation of the effectiveness of measures to restrain costs.

The National Board, through the work of Commissions and other means, would specifically study and evaluate the effects of the program on residual Medicaid programs in States, including the comprehensiveness, accessibility, and quality of services to Medicaid beneficiaries, and would recommend legislation and guidelines for effecting improvements in the various Medicaid programs. The Board would submit to Congress no later than five years after enactment, its legislative recommendations in this regard, with special emphasis on how to meet the long-term care service needs of Medicaid eligibles.

With regard to these various special studies, the National Board would direct the Commissions as follows:

1. The Commission on Benefits would study and recommend changes in covered benefits based on current evidence of the cost and effectiveness of various health services including preventive health, mental health, drugs, vision care, long term care, home health care, dental coverage, and other services for which limitations or exclusions exist under the program.

2. The Commission on Quality would study and recommend legislation or regulations to improve the quality of health care services.

3. The Commission on Access would study the level of services utilized by various beneficiaries and would recommend legislation, guidelines, or regulations to remove barriers to access and/or create needed resources for care.

4. The Commission on Health Care Organization would study the costs and effectiveness of the various methods of delivering health services and would recommend legislation or regulations to support and encourage the creation and expansion of more cost-effective systems of health care.

Programs of personal care services.—The National Health Board would be required to carry out a substantial demonstration program in the organization delivery, and financing of personal care services to the elderly and chronically disabled including the hospice concept. Initial funding authorization would be at the $100 million level. The Board would make grants from the Resource Distribution Fund to demonstrate and assist in the development of community programs which seek to maintain in their homes people who, in the absence of comprehensive health and personal care services, would require inpatient institutional services. The hospice concept would be among those demonstrated and evaluated.

PART VII—PROVIDER REIMBURSEMENT

A. Types of reimbursement

The bill specifies the types of reimbursement by class of provider as follows:

1. Prospective rates based on approved budgets for hospitals, homes health agencies, neighborhood health and other health centers, and skilled nursing facilities;

2. Fee schedules (subject to overall budget limits) for physicians, podiatrists, and laboratory services and durable medical equipment (subject to limits based on lowest costs for widely available services);

3. Existing Medicare determinations for other providers;

4. Capitation payments for HMOs. Payment rates would be community-rated (with appropriate adjustments) for non-Medicare enrollees and experience-rated (with appropriate adjustments) for Medicare enrollees. Developing HMOs would be paid approved budget costs in excess of capitation payments from grants from the Health Resources Distribution Fund;

5. Salary or fee-for-time payments permitted in lieu of fee schedule payments if this alternative did not result in higher costs; and

6. Acquisition costs plus professional fees for drugs and audiological services.

The Board could allow, on an experimental or other basis, the use of other payment methods if it determined such use would advance program objectives.

B. State budgeting process

The State approved budget would distribute total allowable funds (as determined under Part V) among various health service components with leeway for redistribution and provision for contingencies.

C. Prospective reimbursement

Hospitals and other institutional providers would be reimbursed on the basis of negotiated budgets applied prospectively.

1. Submission of Proposed Budget

Each provider would submit its proposed budget to the State Board at such time, in such form, and providing such data as the Board required. Required data would include historical data, full year budget for the year subject to approval and a two and five year capital and service change budget plan. The reports would cover total provider operation and include data on operating and capital costs, inpatient and outpatient services, costs of continued services and cost effects of discontinued and added services, cost effects of expected productivity and utilization changes, revenues by source and type, volume of services, and patient characteristics.

2. Review by State Board

The State Board would review the proposed Budget and negotiate with providers within the parameters established by the National Board. Representatives of patients and payors would be party to the negotiations; the advice of consortia representatives would be available. In all cases, the review would confirm conformity of the two and five year capital and service change budgets with the approved HSA plan for the area.

The State Board would use screens to determine which budgets could be approved without further detailed review and what elements within a budget might require such review. Screening parameters would be set in accordance with National Board policy and could take various forms including: (a) annual rates of increase in total budgets, average inpatient costs per admission, or average inpatient costs per day; (b) absolute cost levels, by type of hospital, for average per admission inpatient cost, average per diem inpatient costs, average outpatient visit cost, or educational costs; and (c) cost ratios, by type of hospital for administrative costs or various service costs.

The State Board would conduct (or delegate the conduct of) detailed reviews of budgets which fail one or more screens or fall into a random quality control check. Reviews would include consideration of quality and access issues, effective use of services, and PSRO and JCAH findings.

Providers would be given an opportunity to comment on costs the State Board found were not approvable. Budget reductions based on modifications in operation would be scheduled.

3. Approval by State Board

The State Board would receive a recommendation for the provider budget arrived at by a negotiation between consumer and the provider (who may be assisted by an association of providers). Employees of the provider would be represented by persons nominated by their unions. The consortia would participate in this process. State Board representatives would be available as technical advisors. In the event no timely recommendation was received, the State Board would proceed on its own.

The State Board would have the final authority (subject to reconsideration, appeal, and court review) for approval of provider budgets. The approval would take account the budget limits imposed by Congress and the National Board, HSA area plans, demographic factors, expected cost inflation, effect of approved capital and service modification plans, effects of acceptable wage increases, and efficiency objectives for the institution.

The budget approval would establish, subject to adjustments, total amount reimbursable to the provider under NHI and could establish maximum levels for subparts of the budget subject to transfers among the subparts within specified limits.

4. Reconciliation of Accounts

The hospital would be required to submit a reconciliation of accounts at the end of the year. Differences would be recognized in subsequent budgets to the

extent appropriate. Expenditures for non-approved purposes could not be reimbursed unless subsequently approved.

5. Definition of Includable Costs

Costs included in provider budgets would be reasonable costs of services generally provided by hospitals. Specific provision is made for certain elements as follows:

(*a*) Payments to physicians under contract with the provider, payment to all radiologists and patnologists providing services in a hospital, and payments to physicians service patients in a mental hospital would be included in the provider budget. Payments to other specialists could be added to provider budgets where deemed appropriate by the Board.

(*b*) Wage increases for non-supervisory employees would be approved to the extent the Secretary determined such increases were reasonable.

(*c*) Payments for services rendered to non-covered individuals would be included in the Budget.

(*d*) Depreciation costs would be excluded. Principle payments on debts incurred before enactment of NHI and costs of small capital expenditures would be included. Costs for new major capital expenditures would be included in a lump sum payment or in the form of amortization payments for debts to the extent approved in the planning process. Covered costs would also include costs associated with institutional closings and cutbacks.

(*e*) Profit for investor owned facilities would be allowable to the extend currently provided under Medicare.

6. Capital Expenditures

The capital elements of a provider's budget and operating costs stemming from capital and service changes would be reviewed in coordination with the planning process, subject to NHI limits. Approved capital expenditure limits could be exceeded by an amount equal to one-half of the amount that operating expenditures were below the operating expense limit. Planning approvals for purposes of provider budgets would take into account area needs, cost effectiveness, projected cost changes, alternative means of making the proposed changes, and HSA recommendations.

7. Uniform Data Reporting Requirements

The National Board would establish uniform data reporting requirements for the provider budget. Data obtained would be disclosable to the public.

8. Basis of Payment

Interim payments would be made by insurers on the basis of estimates of the proportion of resources used by persons covered by the insurer with adjustments made at the end of the year. The basis of apportionment of provider costs by insurer would be set by the National Board; such basis would be designed to produce budgeted revenues without requiring a large amount of patient-by-patient data. The National Board could establish a single method of apportionment or more than one for a class of providers. The State Board could be given a number of specified choices as to methods of apportionment. The National Board could permit States to experiment with alternative approaches.

D. Physician fee schedules

1. Long-term Provisions

The bill would require participation of a physician as a condition for NHI reimbursement. Participating physicians would be required to accept program payment as payment in full for covered services.

Participating physicians would be paid on the basis of fee schedules designed to provide payment levels consistent with the budget. Insurers and State Boards would be required to report to the National Board when deviations occurred, and State or National Boards would be required to take necessary corrective action.

The National Board would develop a national relative value scale for services based on time and effort involved, difficulty of performances, cost to provider, and social desirability of the service. The RVS would serve as a guide for modifying fee schedules. The Board would develop a policy for variations permitted

in fee schedules taking into account variations in costs, variations in non-physician earnings, and reasonableness of rates of change (avoiding rollbacks in fees). The established fee for a given service which could be provided at essentially the same level of quality by two or more categories of personnel (primary care physician and specialist, or physician and nonphysician) would be at the level reasonable for the lesser cost personnel. The National Board, with the advice of a Commission on Reimbursable Medical Procedures, would determine those services which would be included or excluded from the list of reimbursable services. New services would be added as approved.

The National Board, based on the advice of the Commissions on Benefits and Quality, would encourage or prohibit reimbursement for specified procedures based on developments in clinical science and practice and would establish a list of high cost, elective or overutilized services which could only be reimbursed under specified conditions.

The State Board would be authorized to encourage and award HRDF funds to finance programs of continuing education and professional development through PSROs or other private agencies. Based on the recommendations of a PSRO, an insurer would eliminate or reduce payments on a pro rata basis for specified services for providers found to abuse or misuse the services.

Every five years (or earlier upon the call of the National Board or petition of 25 percent of participating physicians) negotiations would be reopened on relative values and fee schedules. If the negotiation failed to arrive at a concensus, the schedules would continue unchanged except for the normal updating process. Strong evidence for re-examination would be considered to exist when the rate of growth in total payments to physicians exceeded the rate of growth in the GNP. Modification in fee schedules would be made after an opportunity had been provided for negotiation between payors and physicians. Physician representatives would be nominated by peers in the category of physicians involved in the negotiations.

The National Board would develop a formula for establishing year-to-year changes in fee schedules taking into account increases in non-physician earnings, office costs, limitations on increases in line with Board policy, and the results of negotiations.

An award system would be established to recognize unusual merit among participating physicians.

2. Initial Provision (effective before payment of benefits)

The Board would set State (or area) fee schedules based on average medicare levels in the year or enactment after application of the Medicare index.

If a physicians' customary or billed charge was less than the schedule that is the amount which would be paid. If a physician's Medicare approved charge was higher than the fee schedule he would be paid at that rate, but this rate would not increase until the fee schedule catches up to it through the indexing provisions described above. Medicare, Medicaid, and all private insurers intending to participate in the program would reimburse physicians under these rules.

3. Services provided to a person not then enrolled with an insurer would be paid for by the insurers with which he later enrolls.

PART VIII—MISCELLANEOUS AMENDMENTS

This part would make appropriate changes in the Social Security Act to extend PSRO requirements to all services and all providers under NHI. PSRO activities would be funded through general revenues. This title would also modify Section 1122 of the Act (limitation on Federal participation for capital expenditures) to conform to other provisions in the bill relating to health facilities planning. A provision comparable to Section 1879 of the Act (limiting the liability of the beneficiary to pay the costs of certain non-covered services received where the beneficiary believes services are covered) would be incorporated under NHI.

The Railroad Retirement Act would be modified to take into account changes in the Medicare program. Other statutes would also be modified to conform to NHI except no changes would be made in any veterans legislation.

The IRS Code would be amended by repealing the deductions allowed for health insurance premiums for covered services.

This part also specifies the effect of NHI on existing employer-employee health benefit plans. NHI would not affect or alter any contractual or other nonstatutory

obligation of employers to pay toward any or all of the cost of services if the affect or alteration would shift the obligation to pay the costs in any part to employees, dependents or survivors. The obligation would continue and apply as an obligation to pay the employee premiums under NHI. The per capita monthly amount required to be paid by the employer under this provision would not exceed the greater of either: (1) the per capita monthly employer cost of providing or paying for health services in the month prior to implementation of NHI, or (2) the per capita monthly employer cost which would have been incurred in the absence of NHI. If the employers per capita monthly obligation was greater in the month prior to implementation of NHI than under the new program, the excess would be used to provide other benefits or rebated to employees at least for duration of the contract or other obligation.

SUMMARY OF COST ESTIMATES, FISCAL YEAR 1983[1]

[In billions of 1980 dollars]

	Present law	Kennedy plan	Difference
I. Total spending for services covered by the plan	$171.4	$211.4	$40.0
II. Total on-budget Federal cost	51.0	79.6	+28.6
III. Total non-Federal cost	120.4	131.8	+11.4

[1] All estimates prepared by Gordon Trapnell of Actuarial Research Corp.

Note: Actuary estimates an employer/employee premium of 7 to 8 percent, depending upon the success of cost containment programs.

Crossover Point[1]

The crossover point is the year in which, under this plan, the Nation spends less on health care than if it enacts no legislation.

Crossover—four years after passage.

In 1988, for example, the Nation would spend $38 billion less than if no law is enacted.

NATIONAL SPENDING UNDER PRESENT LAW IN FISCAL YEAR 1983 FOR SERVICES THAT WILL BE COVERED BY KENNEDY PLAN*—TOTAL POPULATION

[In billions of 1980 dollars]

	Part A[1]	Part B[2]	Mental[3]	Prevention[4]	Drugs[5]	Administration	Total
Total	81.2	66.5	5.2	0.7	5.0	12.8	171.4
Private payments	40.9	45.2	2.5	.6	4.1	9.7	103.0
Paid out of pocket	7.0	21.6	1.1	.4	3.7		33.8
Private insurance	33.0	22.7	1.2	.2	.4	9.2	66.7
Other private payments	.9	.9	.2	(*)	(*)	.5	2.5
Government required insurance	1.7	4.6	(*)	0	(*)	1.3	7.6
Medicare		2.5				.2	2.7
Workmen's compensation	1.7	2.1	(*)		(*)	1.1	4.9
Federal taxpayers	34.5	13.3	1.0	.1	.6	1.5	51.0
Medicare	26.3	7.6	.2			1.0	35.1
Medicaid/SSI beneficiary costs	4.2	3.3	.4	.1	.4	.4	8.8
Federal facilities and grants	4.0	2.4	.4	(*)	.2	.1	7.1
State and local taxpayers	4.1	3.4	1.7	(*)	.3	.3	9.8
Medicaid/AFDC recipient costs	3.3	2.6	.3	(*)	.3	.3	6.8
State or local facilities and grants	.8	.8	1.4	(*)	(*)	(*)	3.0
Bad debts and unbilled services[6]	2.9	5.9	.3	(*)	.1		9.2

[1] Includes services covered by part A of medicare and hospital based physician services, except those provided by psychiatric facilities.
[2] Includes services covered by part B of medicare, except hospital based physician and psychiatric facility services.
[3] Includes services in psychiatric facilities that are covered by proposal.
[4] Services for children only.
[5] Limited to a formulary for chronic conditions.
[6] Bad debts are services for which a valid bill is presented to a patient but is not paid, unbilled services are those for which a provider normally charges but are not billed for some patients.

*Assumes passage during 1979 of administration hospital cost control proposal.

[1] Figures prepared by Professor Isidore Falk, Professor Emeritus, Yale School of Medicine.

NATIONAL SPENDING UNDER KENNEDY PLAN IN FISCAL YEAR 1983 FOR SERVICES COVERED BY BILL*—TOTAL POPULATION

[In billions of 1980 dollars]

	Part A[1]	Part B[2]	Mental[3]	Prevention[4]	Drugs[5]	Administration	Total
Total	85.2	95.5	6.9	2.2	6.8	14.8	211.4
Government required insurance	39.7	65.9	4.2	1.9	2.2	11.1	125.0
Medicare		2.6				.2	2.8
National health plan	38.0	61.3	4.2	1.9	2.2	9.8	117.4
Workmens compensation	1.7	2.0	(*)		(*)	1.1	4.8
Federal taxpayers	42.2	27.0	2.4	.3	4.3	3.4	79.6
Medicare	36.8	21.5	1.8		3.8	2.0	65.9
Medicaid/SSI beneficiary costs	.6	1.1	.2	.2	.4	.2	2.7
Employment subsidies[6]	2.5	3.8	.3	.1	.1	.7	7.5
Federal facilities and grants	2.3	.6	.1			.5	3.5
State and local taxpayers	3.3	2.6	.3	(*)	.3	.3	6.8
Medicaid/AFDC recipient costs	3.3	2.6	.3	(*)	.3	.3	6.8

*Assumes passage during 1979 of administration hospital cost control proposal.

[1] Includes services covered by part A of medicare and hospital based physician services, except those provided by psychiatric facilities.
[2] Includes services covered by part B of medicare, except hospital based physician and psychiatric facility services.
[3] Includes services in psychiatric facilities that are covered by proposal.
[4] Services for children only.
[5] Limited to a formulary for chronic conditions.
[6] Assumes larger employment subsidy than specified in bill.

NATIONAL SPENDING UNDER PRESENT LAW IN FISCAL YEAR 1983 FOR SERVICES THAT WILL BE COVERED BY KENNEDY PLAN*—AGED AND D.I. BENEFICIARIES

[In billions of 1980 dollars]

	Part A[1]	Part B[2]	Mental[3]	Prevention[4]	Drugs[5]	Administration	Total
Total	36.1	19.1	1.2	0	2.8	4.1	63.3
Private payments	5.9	6.9	.5		2.3	2.5	18.1
Paid out of pocket	2.2	3.7	.3		2.0		8.2
Private insurance	3.4	3.0	.2		.3	2.4	9.3
Other private payments	.3	.2			(*)	.1	.6
Government required insurance	.4	2.7	(*)		(*)	.4	3.5
Medicare	(*)	2.5				.2	2.7
Work ens co pensation	.4	.2	(*)		(*)	.2	.8
Federal taxpayers	28.6	8.7	.3		.3	1.1	39.0
Medicare	26.3	7.6	.2			1.0	35.1
Medicaid/SSI beneficiary costs	1.3	.9	.1		.3	.1	2.7
Federal facilities and grants	1.0	.2			(*)	(*)	1.2
State and local taxpayers	1.2	.8	.4		.2	.1	2.7
Medicaid/AFDC recipient costs	1.0	.7	.1		.2	.1	2.1
State or local facilities	.2	.1	.3		(*)	(*)	.6
Bad debts and unbilled services[6]	1.7	1.3	.1		.1		3.2

[1] Includes services covered by part A of medicare and hospital based physician services, except those provided by psychiatric facilities.
[2] Includes services covered by part B of medicare, except hospital based physician and psychiatric facility services.
[3] Includes services in psychiatric facilities that are covered by proposal.
[4] Services for children only.
[5] Limited to a for ulary for chronic conditions.
[6] Bad debts are services for which a valid bill is presented to a patient but is not paid, unbilled services are those for which a provider normally charges but are not billed for some patients.
* Assumes passage during 1979 of administration hospital cost control proposal.

NATIONAL SPENDING UNDER KENNEDY PLAN IN FISCAL YEAR 1983 FOR SERVICES COVERED BY BILL*—AGE AND D.I. BENEFICIARIES

[In billions of 1980 dollars]

	Part A[1]	Part B[2]	Mental[3]	Prevention[4]	Drugs[5]	Administration	Total
Total	37.5	24.4	1.8		3.8	2.4	69.9
Government required insurance	.4	2.8				.4	3.6
Medicare		2.6				.2	2.8
Workmens compensation	.4	.2	(*)		(*)	.2	.8
Federal taxpayers	37.1	21.6	1.8		3.8	2.0	66.3
Medicare	36.8	21.5	1.8		3.8	2.0	65.9
Federal facilities and grants	.3	.1					.4

[1] Includes services covered by part A of medicare and hospital based physican services, except those provided by psychiatric facilities.
[2] Includes services covered by part B of medicare, except hospital based physican and psychiatric facility services.
[3] Includes services in psychiatric facilities that are covered by proposal.
[4] Services for children only.
[5] Limited to a formulary for chronic conditions.

* Assumes passage during 1979 of administration hospital cost control proposal.

NATIONAL SPENDING UNDER PRESENT LAW IN FISCAL YEAR 1983 FOR SERVICES THAT WILL BE COVERED BY KENNEDY PLAN*—AFDC/SSI BENEFICIARIES

[In billions of 1980 dollars]

	Part A[1]	Part B[2]	Mental[3]	Prevention[4]	Drugs[5]	Administration	Total
Total	3.6	2.9	0.3	0.1	0.5	0.5	7.8
Private payments	.5	.3	(*)	(*)	.3	.2	1.3
Paid out of pocket	.2	.2	(*)	(*)	.3		.7
Private insurance	.3	.1	(*)			.2	.6
Other private payments	(*)	(*)				(*)	(*)
Government required insurance	(*)	.1				(*)	.1
Workmen's compensation	(*)	.1				(*)	.1
Federal taxpayers	1.7	1.3	.1	.1	.1	.2	3.5
Medicaid/SSI beneficiary costs	1.7	1.3	.1	.1	.1	.2	3.5
Federal facilities and grants	(*)	(*)		(*)	(*)	(*)	(*)
State and local taxpayers	1.4	1.1	.2		.1	.1	2.9
Medicaid/AFDC recipient costs	1.4	1.1	.1		.1	.1	2.8
State or local facilities and grants	*	*	.1			(*)	.1
Bad debts and unbilled services[6]	.1	.1	(*)	(*)	(*)		.2

[1] Includes services covered by part A of medicare and hospital based physician services, except those provided by psychiatric facilities
[2] Includes services covered by part B of medicare, except hospital based physician and psychiatric facility services
[3] Includes services in psychiatric facilities that are covered by proposal.
[4] Services for children only.
[5] Limited to a formulary for chronic conditions.
[6] Bad debts are services for which a valid bill is presented to a patient but is not paid, unbilled services are those for which a provider normally charges but are not billed for some patients.

* Assumes passage during 1979 of administration hospital cost control proposal.

NATIONAL SPENDING UNDER KENNEDY PLAN IN FISCAL YEAR 1983 FOR SERVICES COVERED BY BILL*—AFDC/SS BENEFICIARIES

[In billions of 1980 dollars]

	Part A[1]	Part B[2]	Mental[3]	Prevention[4]	Drugs[5]	Administration	Total
Total	3.9	3.7	0.5	0.2	0.7	0.6	9.6
Federal taxpayers	.6	1.1	.2	.2	.4	.3	2.8
Medicaid/SSI beneficiary costs	.6	1.1	.2	.2	.4	.2	2.7
Federal facilities and grants	*					.1	.1
State and local taxpayers	3.3	2.6	.3	*	.3	.3	6.8
Medicaid/AFDC recipient costs	3.3	2.6	.3	*	.3	.3	6.8

[1] Includes services covered by part A of medicare and hospital based physician services, except those provided by psychiatric facilities.
[2] Includes services covered by part B of medicare, except hospital based physician and psychiatric facility services.
[3] Includes services in psychiatric facilities that are covered by proposal.
[4] Services for children only.
[5] Limited to a formulary for chronic conditions.

* Assumes passage during 1979 administration hospital cost control proposal.

NATIONAL SPENDING UNDER PRESENT LAW IN FISCAL YEAR 1983 FOR SERVICES THAT WILL BE COVERED BY KENNEDY PLAN *—OTHER POPULATION

[In billions of 1980 dollars]

	Part A[1]	Part B[2]	Mental[3]	Prevention[4]	Drugs[5]	Administration	Total
Total	41.5	44.6	3.7	0.6	1.7	8.2	100.3
Private payments	34.5	38.0	2.0	.6	1.5	7.0	83.6
Paid out of pocket	4.6	17.7	.8	.4	1.4	----	24.9
Private insurance	29.3	19.6	1.0	.2	.1	6.6	56.8
Other private payments	.6	.7	.2	----	----	.5	1.9
Government required insurance	1.3	1.8	----	----	----	.9	4.0
Workmens compensation	1.3	1.8	----	----	----	.9	4.0
Federal taxpayers	4.2	3.3	.6	(*)	.2	.2	8.5
Medicaid/SSI beneficiary costs	1.2	1.1	.2	----	----	.1	2.6
Federal facilities and grants	3.0	2.2	.4	(*)	.2	.1	5.9
State and local taxpayers	1.5	1.5	1.1	(*)	----	.1	4.2
Medicaid/AFDC recipient costs	.9	.8	.1	(*)	----	.1	1.9
State or local facilities and grants	.6	.7	1.0	(*)	----	----	2.3
Bad debts and unbilled services[6]	1.1	4.5	.2	----	----	----	5.8

[1] Includes services covered by part A of medicare and hospital based physician services, except those provided by psychiatric facilities.
[2] Includes services covered by part B of medicare, except hospital based physician and psychiatric facility services.
[3] Includes services in psychiatric facilities that are covered by proposal.
[4] Services for children only.
[5] Limited to a formulary for chronic conditions.
[6] Bad debts are services for which a valid bill is presented to a patient but is not paid, unbilled services are those for which a provider normally charges but are not billed for some patients.

* Assumes passage during 1979 of administration hospital cost control proposal.

NATIONAL SPENDING UNDER KENNEDY PLAN IN FISCAL YEAR 1983 FOR SERVICES COVERED BY BILL*—OTHER POPULATION

[In billions of 1980 dollars]

	Part A[1]	Part B[2]	Mental[3]	Prevention[4]	Drugs[5]	Administration	Total
Total	43.8	67.4	4.6	2.0	2.3	11.8	131.9
Government required insurance	39.3	63.1	4.2	1.9	2.2	10.7	121.4
National health plan	38.0	61.3	4.2	1.9	2.2	9.8	117.4
Workmens compensation	1.3	1.8	(*)	----	----	.9	4.0
Federal taxpayers	4.5	4.3	.4	.1	.1	1.1	10.5
Employment subsidies[6]	2.5	3.8	.3	.1	.1	.7	7.5
Federal facilities and grants	2.0	.5	.1	----	----	.4	3.0

[1] Includes services covered by part A of medicare and hospital based physician services, except those provided by psychiatric facilities.
[2] Includes services covered by part B of medicare, except hospital based physician and psychiatric facility services.
[3] Includes services in psychiatric facilities that are covered by proposal.
[4] Services for children only.
[5] Limited to a formulary for chronic conditions.
[6] Assumes larger employment subsidy than specified in bill.

*Assumes passage during 1979 of administration hospital cost control proposal.

Major Features of Health Care for All Americans Act

Every American—
Is automatically eligible.
Is covered for broad health services.
Pays premiums related to income.
Enrolls with HMO or other insurer of his choice.

Every American Automatically Eligible

Covers American citizens and resident legal aliens.[1]
Extends medicare to all aged and all social security disabled.

[1] Special Provisions for Other Aliens in United States.

COVERAGE FOR BROAD HEALTH SERVICES

Unlimited services: hospital care; physician's services; laboratory services; X-rays; ambulance services; and medical equipment.
Includes preventive services.
No cost sharing.
Limited services: Drugs (For medicare only); home health; nursing home; and mental health care. Thus prevents financial catastrophe.

PREMIUMS RELATED TO INCOME

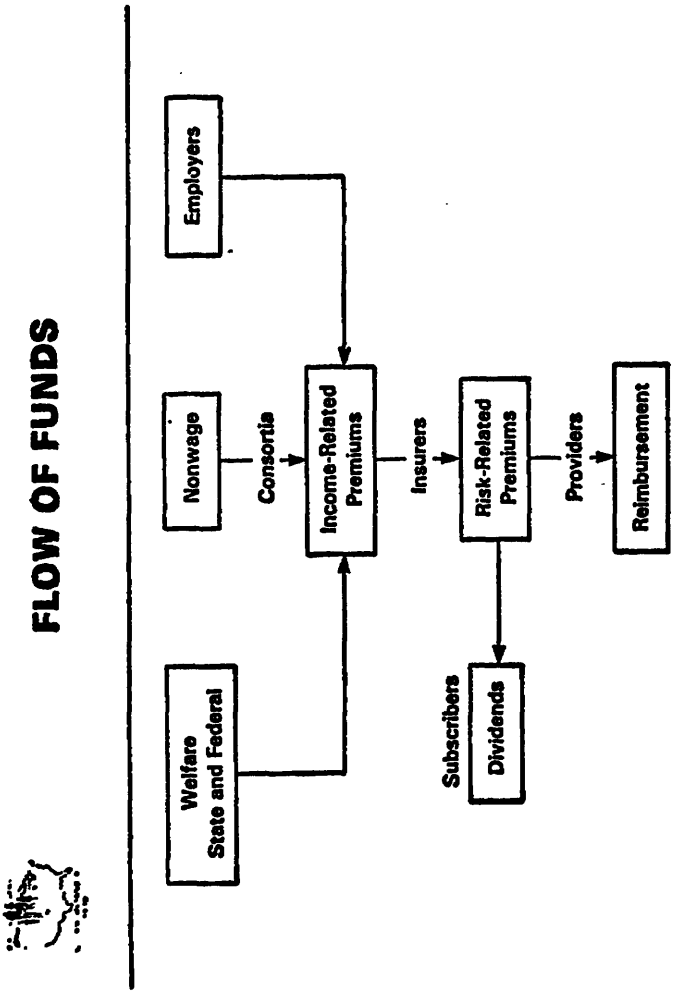
A. Wage related premiums paid by employers—employee shares up to 35 percent.
B. Income related premiums—half employer rate paid by individuals with non-earned income above $2,000.
No individual pays more than value of his protection.

PREMIUMS TOTALLY SUPPORT NON-MEDICARE, NON-WELFARE POPULATION

C. Premiums for SSI recipients from Federal Government equal to costs.
D. Premiums for AFDC recipients from State governments equal to costs.

ENROLLMENT WITH HMO OR INSURER

Everyone eligible for choice of HMO or other insurer: Non-medicare—HMO or private insurer; or medicare—HMO or normal medicare.
Open enrollment period available every year.
Additional benefits or cash rebate for enrollees of efficient insurer.



TRANSLATION OF INCOME-RELATED TO RISK-RELATED INSURANCE PREMIUMS

Income related and experience rated (for needy) premiums paid to fund.
Insurers determine nature of risks insured: personal characteristics and area costs.
Agents of insurers (Consortia) distribute income related premiums to insurers as risk-related premiums.

HEALTH SYSTEM FEATURES

Sets strong cost controls and incentives.
Builds on existing private and government systems.
Improves access to and quality of care.

COST CONTROLS AND INCENTIVES

Competition among insurers and providers—incentives to enrollees to join HMO's and other effective arrangements.
Budgeting—overall increase rate limited by formula to GNP increases; State budget increase allocation by formula; more to low cost States, less to high cost States; State cost control incentives; AFDC premium rate based on cost; State premium varies with over or under cost.
Negotiated rates between providers and—employers and employees; insurers; State agency.
Reformed reimbursement and benefit structure—fee schedules; approved hospital budgets; exclusion of unproven and non-essential services.

INCENTIVES IN THE PLAN

For individual employees—to choose plan which has rebate or better benefits.
For labor and management—to influence provider negotiation and State budgets to keep premium rates down.
For Insurers—to incur costs less than premium by efficient operations, special reimbursement or provider arrangements.
For Providers—to come in under budgeted amount, or discount to do business.

BUILDS ON EXISTING PROGRAMS

Operates primarily through reformed private insurance: underwriting—determining insurance company premiums; marketing; claims processing—Paying Providers; follows government policies on benefits, marketing, and reimbursement.
Reforms and expands medicare.
Gives States functions: rate setting—monitoring fee negotiations; planning; provider qualifications; and manage residual medicaid.

IMPROVED ACCESS AND QUALITY OF CARE

Budget allocations address maldistributions of resources.
Health resources distribution fund helps finance capital redistribution.
Existing resource support programs merged and coordinated.
PSRO program applied to all care.

The CHAIRMAN. Senator, we started on the early bird rule, and we should continue.

Senator Talmadge was the first man here, but he left and lost his place. I guess I am now the early bird. I will claim my privilege.

As I see it, Senator, we have two problems. How much cost controls is the majority of this Congress willing to support, and let me say the way costs are going, I am on the high side. I will be voting for more cost controls than the majority on this committee, and I suspect I will be voting for more cost controls, or at least as much, as the majority of the Senators willing to vote.

Then we have a second question: How much additional medical care is the majority of the Congress willing to support?

Now, again, let me say as far as I am concerned, maybe I am not going as far as the Senator from Massachusetts, but my guess is I will be voting for more than the majority of the Senate is going to vote to support, and I suspect more likely more than the majority of the committee is willing to support.

As one who has been around here for a very long time now—I do not feel like it has been all that long, and perhaps I am just beginning to approach my greatest usefulness to the country—my impression is

that it is a mistake for us to fail to pass a good bill just because it is not perfect. About all I can say for any bill we have passed is that it is a good bill as far as it goes.

Now, can the Senator tell me why must we decline to do a lot of good for great numbers of people who are suffering today merely because we are not able to do as much as some of us would like to be able to do?

Senator KENNEDY. The second point, I think, should not be an issue. The administration's cost, you see, about the cost of the phase, is $24 billion.

I dare say the first phase of our program would be closer to $10 billion.

I think, in the public's mind, the issue has been whoever has the most expensive program has the comprehensive program. They are over on one side of the argument, and the people who are cutting back and have the most modest program are on the other.

I do not think that is where the argument lies.

I would hope that the point that we would make is that any addition, even if it be a modest addition, as a first phase, should also have the elements of the systems change and cost controls.

Now, if you do not do that, even if it looks like it is a modest kind of increase, and trying to relieve the pressures on elderly people, the benefits you are providing today are going to be less in relationship to tomorrow. I would ask Bill Hutton to make a brief comment on that.

The administration has put cost controls on negotiated fees in the public sector, those that they are going to deal with in the public sector. My sense is that that exacerbates the issue of the dual standard of health care. You are going to have one set of fees for the poor and another for middle income, or for the rich.

The doctors themselves are not going to take a financial bath, and you are going to find the squeeze on the poor from a negotiated fee schedule, and you are going to find they are going to make it up by raising the costs for middle income people. And it seems that the only way that you are really going to deal with that particular issue of negotiated fees is if it is going to be applicable across the board.

I do not know how else you can reach that, Mr. Chairman.

I think you raise a legitimate question about whether it is better to provide for the elderly where the needs are greater, or to the youth who are the most vulnerable. Anyone's choice on that is certainly as good as mine on it.

The central thrust, and the point that I think our coalition feels so strongly about, is whatever we do in terms of the additional kinds of benefits, unless it is tied to system reform and cost containment, those that will receive the benefits today are going to lose them tomorrow.

That is a longer answer than I would like.

I would like to ask Bill Hutton just to make a comment, since so much of this is related to catastrophic illness and to the elderly.

I would finally just refer to a recent New England Journal of Medicine's article on how they think the money will be used under a catastrophic plan.

[The material referred to follows:]

[From the New England Journal of Medicine, June 7, 1979]

Frequency and Clinical Description of High-Cost Patients in 17 Acute-Care Hospitals

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Abstract To assess the potential impact of national "catastrophic" health insurance on the medical-care system, the frequency and clinical characteristics of high-cost patients were surveyed at 17 acute-care hospitals in the San Francisco Bay Area. The percentage of patients whose yearly hospital charges exceeded $4,000 in 1976 ranged from 4 at a community hospital to 24 at a referral hospital. Hospital costs charged to these patients ranged from 20 to 68 percent of total billings, with the highest percentages generally occurring at large referral hospitals. Forty-seven per cent of adult high-cost patients had chronic medical conditions, and only one in six suffered from an acute medical "catastrophe." In addition, more than 13 per cent of high-cost patients died in the hospital.

National catastrophic health insurance is likely to pay for much chronic illness and terminal care and divert resources toward acute-care hospitals. (N Engl J Med 300:1306–1309, 1979)

Legislative proposals for national health insurance range from comprehensive schemes to more limited proposals that would pay for only certain categories of health expenses. It is sometimes assumed that expenditures under a categoric program would be fairly easy to predict and that the health-care system would not change fundamentally as a result of categoric funding. Comprehensive schemes are often criticized on the basis of their potential inflationary impact. In contrast, categoric programs are politically attractive since they have a much lower perceived price tag and can be directed to needy groups. Moreover, there is substantial precedent for enacting categoric programs. Major federal health-care-funding programs introduced in the past two decades have been of a categoric nature: Medicare (in general, limited to the aged), Medicaid (limited to the poor) and the 1972 end-stage-renal-disease amendments to Medicare. These amendments, in particular, were enacted in response to effective lobbying by concerned health professionals and lay persons. However, predictions of the actual costs of these amendments were gross underestimates.[1]

As a result of the continuing rise in medical-care costs, and the increasing public perception that a single unexpected illness can cause financial ruin, a politically attractive categoric system for national health insurance has been proposed in the form of national "catastrophic" health insurance. This type of insurance would pay for health expenses above a certain dollar amount (e.g., $5000), or portion of income (e.g., 15 percent), per person or family per year. Almost all proposals for national catastrophic health insurance have an economic, rather than medical, definition of catastrophic illness. Although it is possible to conceive of disease-specific definitions, as was the case with the end-stage-renal-disease amendments, the political push for this type of health insurance is clearly economic in nature.

Despite the political attractiveness of national health insurance, little or no data exist on which to base an estimate of the potential effects of various plans on the care received by patients or on the medical-care system itself. The analyses performed by McClure,[2] Mitchell and Schwartz,[3] Enthoven,[4] Falk,[5]

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[1] Rettig RA: End-stage renal disease and the "cost" of medical technology. Presented at the Sun Valley Forum on National Health. August 1–5, 1977.

[2] McClure, W: The medical care system under national health insurance: four models. J Health Politics Policy Law 1:22–68, 1976.

[3] Mitchell BM, Schwartz WB: Strategies for financing national health insurance: who wins and who loses. N Engl J Med 295:866–871, 1976.

[4] Enthoven AC: Consumer choice health plan. N Engl J Med 298:650–658; 709–720, 1978.

[5] Falk IS: Proposals for national health insurance in the USA: origins and evolution, and some perceptions for the future. Milbank Mem Fund Q 55:161–191, 1977.

and Newhouse et al.[6] have highlighted the fundamental issues involved. Falk, in particular, expresses concern about the effects of national catastrophic health insurance on the medical-care system but presents no data to support his concern. Trapnell and McFadden,[7] Birnbaum[8] and the Congressional Budget Office[9] have studied high-cost illness, primarily from an economic standpoint. Birnbaum reports that patients in institutions for long-term care account for more than half of those in this country's high-cost category; however, his data do not allow an assessment of the conditions that result in high costs.

Other investigators have looked more specifically at medical-care resources as used in acute-care hospitals. Cullen and his associates reported on 226 critically ill patients admitted to the recovery-room and acute-care unit of the Massachusetts General Hospital between July 1, 1972, and June 30, 1973. Charges for these patients averaged $14,300—with full recovery occurring in only 12 per cent of the sample.[10] Hiatt[11] and Griner[12] have pointed out the difficulties involved in conserving resources in the face of overwhelming clinical pressures in acute-care hospitals.

All these studies answer certain economic questions and hint at the reasons for high costs. However, none have provided data on the current experience of acute-care hospitals with high-cost patients and on what types of patients incur high charges in this setting. Our study was undertaken in an attempt to assess the effects of national catastrophic health insurance on the medical-care system by asking the medical, rather than economic, question: "If national catastrophic health insurance had been in effect in 1976 and included a $5000 deductible, what types of medical care would it have paid for in the acute-care hospital?" Data were collected to determine the experience of acute-care hospitals within a defined geographic region—the San Francisco Bay Area—compare differences among hospitals and describe the clinical characteristics of high-cost patients.

METHODS

Study site and hospital selection

The study was conducted in California's health service areas 4 and 5, which include San Francisco and nearby communities. Data were collected at 17 hospitals selected at a cross section of the 50 acute-care hospitals within the two health service areas. Omitted were federal and health-maintenance-organization hospitals. Although slightly larger than average, the study hospitals appear to constitute a fairly representative sample within the two health service areas. In 1976, the 17 study hospitals accounted for about 41 per cent of the beds, 42 per cent of the patient-days and 39 per cent of the discharges of the 50 acute-care hospitals in health service areas 4 and 5.

Hospitals are categorized for descriptive purposes as: community, county, adult referral and pediatric referral. The distinction between community hospitals and the other three groups is based on teaching program: community hospitals have few or no teaching programs, whereas the other hospitals have full medical-student and graduate-house-staff teaching programs. The number of house staff at the community hospitals ranged from zero to five, and at the teaching hospitals from 50 to more than 200.

Five thousand dollars is commonly considered a potential deductible level for catastrophic health insurance. Hospital financial data generally do not include the fees of the attending physician and surgeon; therefore, to provide a better estimate of expenditures for hospital care, we defined "high costs" as total* yearly charges of $4000 and above. These data underestimate total yearly charges since they exclude the costs of ambulatory care, admissions to other acute-care, psychiatric and long-term hospitals and doctors' fees.

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[6] Newhouse JP, Phelps CE, Schwartz WB: Policy options and the impact of national health insurance. N Engl J Med 290:1345–1359, 1974.

[7] Trapnell GR, McFadden F: The Rising Cost of Catastrophic Illness. Falls Church, Virginia, Actuarial Research, 1977.

[8] Birnbaum H: The Cost of Catastrophic Illness. Toronto, Lexington Books, 1978.

[9] Congressional Budget Office, Congress of the United States: Catastrophic Health Insurance, Budget Issue Paper. Washington, DC, Government Printing Office, 1977.

[10] Cullen DJ, Ferrara LC, Briggs BA, et al: Survival, hospitalization charges and follow-up results in critically ill patients. N Engl J Med 294:982–987, 1976.

[11] Hiatt HH: Protecting the medical commons: who is responsible? N Engl J Med 293: 235–240, 1975.

[12] Griner PF: Treatment of acute pulmonary edema: conventional or intensive care? Ann Intern Med 77:501–506, 1972.

*In this report, we use the word "cost" interchangeably with "charge."

Data Collection

Data on yearly charges per patient were collected at all 17 hospitals from patients' financial records. All admissions for one patient during the year studied (either fiscal or calendar 1976) were combined; thus, patients, not admissions, were the units of analysis. The sampling process was random among patients. Patients with several admissions had the same likelihood of selection as those with single admissions.

Data on yearly charges were used to estimate the proportion of patients who incurred charges equal to or greater than $4000 or $10,000 and the proportion of total hospital revenues derived from these two groups. (Note that the second group is included in the first group.) At 10 hospitals, additional information was collected from the medical records of 933 patients who had yearly charges of $4000 or more (Table 1).

Three physicians involved in this project made several diagnostic classifications according to the clinical data that we obtained. First of all, the condition for which the patient was hospitalized was judged to be either acute or chronic. A condition was considered chronic if the clinical records showed that it had existed for one year or longer. This figure is a conservative measure of chronicity when compared to the definitions used by others, such as the National Center for Health Statistics.[13] This variable provides an estimate of the long-term predictability of the need for medical care. Secondly, the reason for admission was classified according to one of four categories: palliation or custodial, restore to normal (unimpaired) function, improve to a previously impaired condition or diagnostic. Thirdly, the principal investigator classified the principal diagnosis according to the International Classification of Diseases, Adapted.[14] For patients with several admissions, all classifications were based on the first of the high-cost series of admissions.

RESULTS

The estimated proportion of patients with yearly charges greater than $4000 ranged from 4 to 24 per cent; the proportion with charges over $10,000 ranged from less than 1 to 6 per cent (Table 1). The proportion of total hospital billings charged to patients whose costs exceeded $4000 ranged from 20 to 68 per cent, and the proportion charged to patients with costs greater than $10,000 from 3 to 51 per cent. Pearson correlations of the charge-distribution variables with measures of hospital size (number of beds and inpatient revenues) are uniformly high and positive.

TABLE 1.—ESTIMATED DISTRIBUTION OF YEARLY PATIENT CHARGES AT 17 ACUTE-CARE HOSPITALS

[In percent]

Hospital classification[1]	Patients with charges more than $4,000	Hospital costs due to patients with charges more than $4,000	Patients with charges more than $10,000	Hospital costs due to patients with charges more than $10,000
Community:				
A	6	23	<1	6
B[2]	4	20	<1	4
C[2]	5	25	<1	3
D[2]	10	40	2	14
E[2]	16	52	3	18
F	9	40	2	16
G	13	44	2	16
H	16	48	2	16
I	18	59	5	34
J[2]	14	50	3	22
K	13	49	3	23
County:				
L[2]	11	46	2	20
M[2]	14	57	4	31
Adult referral:				
N	24	63	6	27
O[2]	19	59	6	32
P[2]	22	66	6	35
Pediatric referral: Q[2]	13	68	6	51

[1] Hospitals are listed in order within each class from smallest to largest according to inpatient gross revenue.
[2] Patient-specific clinical data were collected at these hospitals.

[13] Black ER: Estimates from the Health Interview Survey, United States, 1976 (DHEW Publication No. [PHS] 78-1547). Washington, DC, Government Printing Office, 1977.
[14] International Classification of Diseases: Adapted for use in the United States. Eighth revision. Vol. 1 (DHEW Publication No. [PHS] 1693). Washington, DC, Government Printing Office, 1967.

Demographic characteristics of patients who incurred high charges* differed among the four types of hospital (Table 2). Patients in community hospitals were the oldest group and were predominantly white. Those in county hospitals were the youngest adult group, were generally men, and approximately half were nonwhite. Adult-referral-hospital patients had a median age of 56, more than half were women, and most were white. Approximately half the pediatric-referral-hospital patients were newborn, and nearly half were nonwhite.

TABLE 2.—AGE, SEX AND ETHNIC-GROUP CHARACTERISTICS OF HIGH-COST PATIENTS ACCORDING TO HOSPITAL TYPE

	Hospital type			
	Community	County	Adult referral	Pediatric referral
Age:				
Median	66	52	56	<1
Adjusted mean [1,2]	62.8	48.2	53.7	2.6
Sex (percent of cases): [3]				
Male	46	69	44	61
Female	54	31	56	39
Ethnic group (percent of cases): [4]				
White	92	51	79	52
Nonwhite	8	49	21	48
Patients in sample	416	172	236	109

[1] Each hospital weighted equally.
[2] $P<0.001$. 1-way analysis of variance, with contrast for community versus county and adult-referral hospitals, omitting pediatric-referral hospital, separate variance estimate ($\eta=823$).
[3] $\chi^2=35.3$, with 3 degrees of freedom: $P<0.001$ ($\eta=923$).
[4] $\chi^2=152.9$, with 3 degrees of freedom; $P<0.001$ ($\eta=907$).

The means total cost to these patients also differed according to hospital type ($P<0.001$). Pediatric-referral-hospital patients had the highest mean charge ($14,384), followed by county ($9183), adult referral ($8812) and community ($7311) hospital patients. The mean number of hospital days was not significantly different among hospital types (27.7, 30.4, 29.3 and 29.1 days, respectively). Significantly more community-hospital patients had several admissions than did those from the other hospitals ($P<0.001$). The 933 patients in the sample accounted for a total of 1736 admissions during 1976 (mean number of admissions per patient, 1.86; median, 2).

Community and county-hospital patients tended to have acute conditions, whereas patients in the adult-referral hospitals tended to have chronic conditions, although this difference was not statistically significant (Table 3). Forty-seven per cent of the high-cost adult patients had chronic conditions. The reasons for admission were similar among the adult hospitals, with approximately 40 per cent of the patients hospitalized to improve to a previously impaired condition, 35 per cent for diagnostic reasons and 25 per cent to restore to normal (unimpaired) health.

More than 13 per cent of the high-cost patients died in the hospitals during the year studied. These patients accounted for 18 per cent of the charges to all high-cost patients. Patients who died incurred significantly higher charges than did those who did not ($P<0.01$). The proportion of deceased high-cost patients was similar across almost all hospital, diagnostic and demographic variables. For instance, the proportions of deceased high-cost patients according to age were: less than one year of age, 13 per cent; one to 18 years, 9 per cent; 19 to 64 years, 13 per cent; and 65 or older, 14 per cent.

An analysis of diagnostic categories (combined according to codes from the *International Classification of Diseases, Adapted*) revealed that, among categories in which there were more than 30 patients, those with neonatal (generally respiratory distress) disease showed by far the highest costs (mean charge, $21,441; 43 patients). Congenital illnesses (mean charge, $10,249; 33 patients) and neoplasms (mean charge, $8590; 151 patients) were next in order of cost. The most common diagnosis was circulatory problems (mean charge, $7375; 190 patients). Almost two thirds of the patients were accounted for by four diagnostic

*All data reported subsequently in this section are for high-cost patients only—that is, patients who had total yearly charges equal to or greater than $4000.

categories: circulatory diseases, neoplasms, accidents and violence, and digestive disorders.

Seven per cent of the patients were hospitalized because of falls or burns, 5 per cent because of involvement in a motor-vehicle accident and 3 per cent because of assault or child abuse. An additional 6 per cent were hospitalized as a direct result of alcohol abuse and 2 per cent as a direct result of drug abuse. Approximately 60 per cent of all assault victims, motor-vehicle-accident victims, and alcohol and drug abusers in the sample of high-cost patients were treated in the county hospitals. Trauma (assault, motor-vehicle-accident, and fall or burn victims) and alcohol and drug abusers accounted for 61 per cent of all high-cost patients at the two county hospitals, both of which have busy emergency rooms.

TABLE 3.—DIAGNOSTIC CHARACTERISTICS OF HIGH-COST PATIENTS ACCORDING TO HOSPITAL TYPE

[Percentage of cases]

Diagnostic characteristics	Hospital type			
	Community	County	Adult referral	Pediatric referral
Duration of condition: [1]				
Less than 1 yr (acute)	56	55	49	[2] NA
More than 1 yr (chronic)	44	45	51	NA
Reason for admission: [3]				
Palliation or custodial	2	1	4	0
Restore to normal health	19	28	21	60
Improve to previously impaired condition	44	43	45	14
Diagnostic	35	28	30	26

[1] $\chi^2=2.98$, with 2 degrees of freedom; P value was not significant ($n=787$).
[2] Not applicable.
[3] $\chi^2=5.49$, with 4 degrees of freedom. P value was not significant, omitting category "palliation or custodial" and pediatric-referral hospital ($n=788$).

DISCUSSION

High-cost patients appear to be common in, and to represent an important part of the business of, acute-care hospitals. For most hospitals in our sample, a large proportion of total revenues came from high-cost patients. There is a definiate tendency for large hospitals to have more high-cost patients, and a higher proportion of total billings are charged to these patients at large hospitals than at small hospitals. On the basis of our data, national catastrophic health insurance may pay a large portion of the total charges at all types of hospitals, but especially at tertiary-care facilities. It is unclear whether this type of health insurance would add new money to the health-care system or simply shift resources within it. However, given fixed resources, any differential subsidies for high-cost acute care could divert resources toward tertiary-care facilities and, in general, result in movement toward increased subsidization of acute-care hospitals.

Most discussions of, and arguments for, national catastrophic health insurance assume that high medical expenses result most often from unexpected, acute medical problems. Our findings do not support this assumption. In our sample of high-cst patients, fewer than 16 per cent were hospitalized because of trauma. Rather than an acute medical "catastrophe," the typical high-cost adult patient in our sample suffered from chronic heart disease or cancer and had been receiving treatment for some time. Almost half the patients admitted to the adult hospitals in our sample had pre-existing conditions of at least one year's duration; thus, even in an acute-care setting, a substantial amount of high-cost chronic illness is treated. These chronically ill patients were usually admitted to improve their condition to a previously impaired level of functioning.

The possible contributions of high-cost technology to the rising costs of medical care have attracted much attention recently.[15] High-cost medical technologies (such as coronary-artery bypass grafts or total hip replacements) can obviously

[15] Medical Technologies: The culprit behind health care costs?: proceedings of the 1977 Sun Valley Forum on National Health (DHEW Publication No. [PHS] 79-3216). Edited by SH Altman, R Blendon. Washington, DC, Government Printing Office (in press).

contribute to the cost of individual treatment, but it is less clear how much they contribute to national medical-care costs. Although neonatal intensive care was the highest priced treatment for our patients, high-cost medical treatments were infrequent among our sample of high-cost patients. In fact, less than 1 per cent of the adult high-cost patients received a coronary-artery by-pass graft, less than 2 per cent received a total hip replacement, and about 2 per cent had end-stage renal disease (kidney transplant or dialysis, or both). Although we did not collect data on similar low-cost patients, it appears that the high-cost patients differed from their low-cost counterparts more in the amount than in the kind of care received.

Finally, almost one out of seven patients in our sample died in these hospitals. This figure undoubtedly underestimates the number who died during the year because it does not include dying patients who were transferred to nursing homes or patients who died at home or in other hospitals. The data indicate that use of resources for dying patients exceeds resource use for other high-cost patients. Although the use of large amounts of medical-care resources for dying patients is an issue with which society continues to struggle, these data indicate that without a formal social decision on this matter, a large portion of national-catastrophic-health-insurance resources will be devoted to persons who will die soon after receiving high-cost medical treatment.

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Mr. HUTTON. The fact is, Mr. Chairman, what is catastrophic to who, and what about for the older people in this country, for example? Less than 1 percent of those over 65 stay in a hospital for more than 60 days. So your catastrophic in this bill does not really affect them at that time. Actually, what is catastrophic to them is the payment of the co-insurance and deductibles for the first, second, third, fourth, and fifth days. That is catastrophic to most of them, certainly to the 5 million couples who I told you only have $5,000 a year coming in.

The CHAIRMAN. It seems to me, Mr. Hutton, the thing that is most catastrophic to these aged people is when all of their hospital days have run out. And may I say, when we passed medicare, I was on the committee at that time—not as chairman, but I was here—and I fought to amend that bill to say that we were going to take care of these dear old people until the good Lord called them home, even if it cost us $1 billion—that we would not put them out on the street because they were not going to get well.

Now, one of these days, we will get around to saying that we are going to do a great deal more for these elderly people, but I cannot recall Mr. Cruikshank, who headed your organization prior to you, taking that view when he came to ask me to vote for medicare. He took the attitude that comprehensive program is not going to happen any time soon. He took the view that we had better start somewhere. He thought the logical place to start was with these aged people because he thought that they, as a group, needed it a lot more than others.

Mr. HUTTON. Yes, sir. It was a good first step, first—13 years ago.

The CHAIRMAN. If we were here sitting taking the view that we were not going to do anything unless we can do the whole bit, then we would not have had medicare. We would not have medicaid. We would not have what we have now, which is close to $60 billion of Federal and State expenditures on health care, most of it for the poor and the disabled and the aged.

They are quarreling over what the overall soup to nuts program ought to be and for the life of me, I cannot understand why we have to postpone doing something to take care of suffering mankind that is not in a position to pay, merely because you would like to do more.

Mr. HUTTON. Mr. Chairman, there has been such a terrific erosion in the medicare benefits over the 13 years since you took the first step that it has become desperate now, and the inflation which has gone on in this country—older people are having to pay so much for so many things that they really cannot afford those first 2 or 3 days in the hospital.

You want to take care of them after their medicare has run out. What about the people 55 to 65 who do not have any medicare?

The CHAIRMAN. What little I have learned, Mr. Hutton, about helping people with Federal money is that you cannot do all of the things that you would like to do for people. You do not have that much money.

Mr. HUTTON. You do not have to spend it on those who do not need it.

The CHAIRMAN. What you tend to do is try to zero in on the cases where it makes the best sense, and where it claims the highest priority, where it is needed the worst.

Mr. HUTTON. I am with you there, Senator.

Senator KENNEDY. The point that I think is worth mentioning here, for the elderly people, the percent of their income that they are paying for health care is today higher than prior to the time of the passage of medicare.

Mr. HUTTON. Twice as much.

Senator KENNEDY. What was a humane concept today is costing billions and billions and billions of dollars, and the seniors are actually worse off now than they were prior to the passage of medicare.

You can say you had a different economic situation. We did not have the runaway inflation at the time of the passage of that particular program.

What I am saying today is that we should learn from the mistakes of the past. We have found that one of the principal problems that we are faced with today, and will be over certainly the next decade, is going to be inflation, and we will see those benefits erode away.

We have seen the same kind of lesson in the end stage renal disease program, same in medicaid.

OK. We cannot do all the things that Senator Long would do, or that I would do, or that President Carter would do. Let us say that we have learned the one lesson about runaway inflation in this area and the importance of cost control. Whatever we are going to do in terms of benefitting these people, must be put in the context of effective cost controls and budget limitations that really are going to stand.

The CHAIRMAN. Senator Durenberger?

Senator DURENBERGER. Senator, I am a believer in universal, comprehensive health care, but I have been at the policy business only about 3 months now, and you and the chairman have been at it for many, many years.

I have a sense from the hearings over the last couple of weeks, where he has come from, that my impression as just a plain citizen that you

have come a long way since you first started, in terms of your policy thinking.

I am curious to know whether I am correct, how you have changed, and why.

Senator KENNEDY. The first bill that we put in was public financed. It would have primarily been based on a progressive tax system. President Carter indicated to me several weeks after he was inaugurated that doing it as a budget item was unacceptable. If you are not going to have it in on budget, there are only two other places: through an employer, or out of your own individual pocket. Only three places where you can get the resources.

Then you draw a balance between the employer and the employee some mechanism, but you take it off-budget. That was a major factor.

But you also have other aspects that are less progressive in terms of the payment mechanism.

Second, the President wanted to build on the private sector. We had run 53 basically through an expanded medicare program.

But we have now gone to a private system. We build on the private sector through the private insurance companies, health maintenance organizations, or IPA's run by the doctors.

Third, we have tried to simplify the administration by working with the State and the private sector.

What we have not altered and changed was the first item I mentioned today. When an individual walks into the doctor, he will be treated and the doctor will get paid. We have separated the payment mechanism from the risk mechanism.

That is a very significant point. The same benefits will flow to the individuals as did in our earlier program.

It seems to me that that was a reasonable request. Obviously, I was disappointed that we were unable to hold our effort together in terms of achieving it.

Senator DURENBERGER. I am surprised by the influence that the administration has on you.

Senator KENNEDY. That was a few years ago.

Senator DURENBERGER. My concerns are for the things you started out with, which I believe is competition between health care providers, alternative health care system; competition between insurers, consumer choice, all that sort of things.

If you believe in all of that, and think that that is an important part of the system, tell me why we need the national cap, why we need State budgeting, why we need to negotiate fee schedules, hospital rates?

I heard one witness condemn this whole process as too much administrative regulations for this operation. Why do we need the cap when we have all of these other things going?

Senator KENNEDY. Well, effectively the current reimbursement mechanism encourages the addition of high cost technology.

Without at least putting some limitation on total budget expenditures, you are going to continue to see the escalation of high costs technology and reimbursement in high cost delivery settings. That was the point of the earlier New England Journal of Medicine article.

What we want to try to do is reverse the incentive and so we place an overall limitation or cap. Through competition, and by stimulat-

ing and supporting alternative delivery systems, these will be a downward pressure on cost. For example, through imaginative, new, innovative delivery systems such as HMO's, we can realize savings from 10 to 40 percent. In my own State of Massachusetts, it is 30 percent at the present time.

Perhaps Mr. Fine has a comment.

Mr. FINE. Yes.

Senator, we also believe that competition ought to be encouraged and strengthened. The problem is that competition alone leaves millions of people out, people with preexisting conditions, the people who cannot get health insurance, or where their conditions are waivered out.

Competition alone leave them out of the picture, and so you have to provide mechanisms whereby the carrier is not disadvantaged by enlisting people with preexisting conditions but, as a matter of fact, would have an incentive to sign up those people as well as the hearty young men in groups, and that is a very important consideration in the new plan that we have presented today.

Senator DURENBERGER. Thank you.

Senator RIBICOFF. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Senatory Kennedy, one question I have as I look at this is the financing mechanisms. As I understand it, you said approximately 7.5 percent; is that right?

Senator KENNEDY. Yes.

Senator BAUCUS. Is that income?

Senator KENNEDY. Wage.

Senator BAUCUS. Wage?

Senator KENNEDY. Wage-related premium, or a lesser premium on the self-employed and on unearned income.

Senator BAUCUS. To finance the entire system?

Senator KENNEDY. Yes.

Senator BAUCUS. That would be taxed to finance, all Americans, except for medicare and SSI recipients. Is that correct?

Senator KENNEDY. The Senator is correct.

7.5 percent of wages, of which 35 percent—no higher than that—could be paid by the employee.

Senator BAUCUS. 7.5 percent of wage-related income?

Senatory KENNEDY. 7.5 percent.

Senator BAUCUS. That is the target?

Senator KENNEDY. That would be.

Senator BAUCUS. The target rate, as you see it?

Senator KENNEDY. Yes.

Senator BAUCUS. Paging through the bill here, I take it that there would be a national board that would be set up, that would set up an annual budget and would have, I guess, some regulations that would prescribe benefits and then it would be up to, I suppose, the board to prescribe the rate or adjust the rate.

Would Congress adjust the rate?

Senator KENNEDY. The important thing is that the board would not be dealing with claims or any administrative aspects. That is left to the private sector. The percent of GNP spent on health would be decided by Congress.

The board would insure that States are in conformity with the national objective. Importantly, the State then is left to work out the negotiations process. But the negotiations are not between the State and the providers, but between the providers and the insurers.

Senator BAUCUS. As I understand it, still there would be an annual budget that would be presented to the Congress annually?

Senator KENNEDY. That is right. We would say that x percent of GNP will be spent on health. Canada has established 7.1 percent. We would not lock-in a particular percentage. It could change over a period of time. It would be a congressional statement.

I would suppose that we would start out where we were at the time that the plan was actually implemented, even though that is well above double the rate of inflation. I would suppose we would start at that, and then you would try to have it flow, hopefully from the downward pressures in this system. Gradually, that would move down, or at least be stabilized, which it has not been.

Senator BAUCUS. According to the President, the increase would be a 3-year average of GNP?

Senator KENNEDY. Yes.

Senator BAUCUS. Roughly what has been the rate of increase of GNP within the last 3 years.

Senator KENNEDY. We will be here 10.2 percent. In 1968, we were 6.3 percent; yesterday, 9.1 percent.

So it is both percent of GNP and the amount of money is just beyond belief. It is virtually out of control.

Getting back to the essential scheme we talked about, most health economists believe that just adding more benefits will be an additional inflator.

Senator BAUCUS. The board would prescribe benefits, is that correct?

Senator KENNEDY. The essential benefit package would be included in the legislation. Both the administration and our program includes essentially the same benefit package.

Senator BAUCUS. My concern here, in the last 2 hours, looking at all of this, is that as much as I think all of us are trying to find built-in incentives to encourage competition and get rid of a lot of the waste and the fat in the present health system, it strikes me that perhaps the system you outline would not be as competitive in the long run as we would all like it to be, because there may be pressure on the board and the Congress to increase the rate, which would take some of the pressure off the competition within the HMO's and other providers.

Is that a problem?

Senator KENNEDY. If the rate went up, it would mean that the ability to reimburse, if they can do it efficiently to the citizens, would increase. However, I think quite the opposite will happen. I suspect the rate will go down. Members of Congress will say, that competition is reducing costs back in my State, and citizens are getting premium dividends.

I think we will see entrepreneurs and others who would say we can do it and provide high quality services at reduced costs.

We reverse the impetus and get the downward pressure. That would certainly be the hope.

I do not know whether anybody would like to say another word on that.

Mr. FEIN. I agree with the Senator.

Congress would have to be resolute if the pressure developed the other way.

The alternative, however, is to rely on competition exclusively, and that is dangerous.

While I firmly believe that the market has its place, markets do tend to ration on the basis of price and income, so we are trying to blend the market and the competition where appropriate. At the same time, we are trying to insure that no one is barred from a particular market because he or she does not have the requisite income to pay the premium.

And it is that kind of a blend, then, that one will have to rely on the various political forces to be resolute in letting the thing escape from them.

Senator RIBICOFF. Senator Baucus, you have far exceeded your time. We are running late.

Senator Packwood?

Senator PACKWOOD. You indicated that your first bill, years ago, relied on the income tax, collected the money, and, by and large, paid the bulk of the bills from the Federal treasury. It that right?

Senator KENNEDY. That is right. 50 percent.

Senator PACKWOOD. You indicated the principal reason for change is that the President insists on an off-budget and he wanted to run it through the private sector.

Senator KENNEDY. That was one of the principal reasons for changing.

Senator PACKWOOD. It is a very practical reason for changing it.

Senator KENNEDY. The Senator is correct.

Senator PACKWOOD. Senator Durenberger was asking philosophically, if you had your druthers, would you stick with your present system, or go back to your original bill?

Senator KENNEDY. I do think that the other is more progressive in terms of the financing of it, but I am fully committed to this approach. I am fully committed to this approach.

Senator PACKWOOD. Let me phrase it this way. If no bill were to pass this Congress and after 1980 President Carter would not be President, would you still stick with this particular approach?

Senator KENNEDY. The answer is yes.

Senator PACKWOOD. Second, let me ask Kenny Young and Miss Jeffrey and Mr. Berry referred to it, the disappointment that this committee has not had hearings on a comprehensive plan and are rushing ahead on a catastrophic plan. Are you willing to hold fire and hold the line while this committee, or if this committee will have extensive hearings on a comprehensive plan and simply not move ahead with your plan at the moment.

Mr. YOUNG. If you mean are we willing to hold fire and hold comprehensive hearings, the answer is certainly yes. We think that makes a great deal of sense.

Senator PACKWOOD. Now, let me ask, lastly—and I guess I can ask this of anyone—the competition argument. Assuming you mandate a plan that guarantees coverage, so nobody can be excluded—and indeed, for those who cannot afford to pay, be they unemployed, under-

employed, or otherwise, the Government is paying the premi s, would the evidence that Dr. Enthoven gave today hold, and coul. n-deed competition alone contain costs, bearing in mind no one could be excluded?

I might ask Mr. Fein that.

Mr. FEIN. I did not have the privilege of hearing all of Alan Enthoven's testimony. I will have to answer the second part of your question—do I believe competition alone could hold down costs?

My answer to that is no.

Senator PACKWOOD. Why?

Mr. FEIN. We are dealing with a virtually unique sector, the sector where the role of the physician is very different than that of other suppliers of goods and services, the role of the physician vis-a-vis the patient, dominance of the physician, emotional relationships, ignorance of the patient, hope. It may be true that many things are upper respiratory infections and not of great consequence, but the image that we Americans have of the medical care system is one of technology and intersection with someone who is really going to help us, and in many cases, that is what happens.

The kind of relationship between seller and buyer, if you will—I doubt that I can rely on the force of competition, which assumes consumer knowledge, assumes mobility, assumes free entry, assumes a variety of things that I simply do not believe are present in this kind of a market on this kind of a service.

Senator PACKWOOD. Let me describe what Dr. Enthoven was talking about. Assuming we mandated coverage, and assuming that for whatever basic package we decide is fair and is passed, whether we all agree with it or not. Dr. Enthoven is then saying, in his experience, that Stanford—although he cited other examples—that where you, as an individual are given, if the package is $100 a month and you find you have two or three places to shop around, they cannot cut the benefits. That, indeed, has been the effect in the Palo Alto area, dramatically cutting costs, where a doctor is running his own clinic and he sees he can save money, or if the individual finds that shifting from the prepaid Palo Alto clinic, sort of an HMO to a durational insurance plan to get what they regard as better service, they do.

Why would that not work nationally?

Mr. FEIN. I think it will work across the country, but not 100 percent in any part of the country. We are a long way away from having prepaid group package, so that kind of competition so dominant that those who are not part of it are affected by it.

In due course, we may reach that point where even solo practitioners are aware of the important role that a prepaid group practice placed in their community will be affected by that prepaid group practice, but we are a very long way from spreading prepaid group practice, from abolishing collusion, if you will, and in that interim period, our costs, it seems to me, by relying exclusively on the competition that is not there yet, in that interim period until it is developed, we run into a great deal of difficulty.

Senator KENNEDY. If I could ask Max Fine?

Mr. FINE. We did have a demonstration of competition alone in terms of a health care delivery system in California a few years ago,

when the State encouraged groups which came to be known as prepaid health plans, PHP's, to go out and compete for the medical population, and in places like Watts, they ran loudspeaker trucks in the streets and promised free chicken dinners and they had people going from door to door and signing up people on the basis of a lower cost plan. A lot of people feared they would lose their Medi-Cal if they did not join, because the salesmen implied that.

I am not saying that that is the kind of system that Professor Enthoven has in mind, because I know he has a higher goal and motivation, but Senator Kennedy's plan provides the incentive to join a proven, lower-cost, high-quality plan, because the rebate provisions and the expanded benefit provisions that Senator Kennedy's plan provides for would encourage people to join health care delivery systems which do not impair the quality of the service, and only at that point would the provider and the employer and the employee benefit from having the individual and the family join a health care delivery system which has proven itself capable of delivering a given set of benefits at a lower cost without impairment of quality.

The PHP's, the problem that started in California, we began getting—and I know Senator Long received many complaints—because these PHP's promised to provide the total range of medical—which is the medicaid program out there—including hospitalization, and the people would arrive at the hospital and it would be closed at 5 p.m.

Competition alone for some of the reasons that Professor Fein has stated, in this unique marketplace, so far has not shown the capability of working.

The CHAIRMAN. Senator Boren?

Senator BOREN. Senator, I think all of us share your goal of providing more adequate health care when we talk about the needs of preventive medicine or health care for senior citizens who are unable to meet the deductible costs. We are all very sympathetic to that.

But also, I am glad to hear you put the emphasis on cost containment in the proposal you made. There is even a stronger feeling among the public today that we must get costs under control and that inflation is the ultimate robber of the people. I get far more letters from the members of organizations represented here today, be they Presbyterians, or rank and file union members, about spending and inflation and getting the budget closer to balance than I do—50 times as many as I do—on any other subject.

As I have listened today, one of the things that has concerned me is cost. The taxpayers have been burned again and again by embarking on new programs when they have been told, "if you spend so many billions, it will save us money in the long run." We have just about saved ourselves into bankruptcy on that proposal. It is kind of like going out to the sales and coming home with two new suits and a TV set and new furniture and say, "think of all the money I saved today," when you spent a couple of thousand dollars at the sales.

If we do not find ways of containing costs, if you peg health expenditures at 7.1 percent of gross national product and if gross national product is going up 10 percent but health costs are going up at 13 to 14 percent, we are going to find ourselves where we find ourselves

in the other social benefit programs. We will have benefits out there with which the gross national product will not keep up. Then you are in a position where we are going to cut back the benefits, or we are going to let inflation rob the recipients, just as we are now, with the effects on medicare.

Once the benefit is given, we all know you can never really cut it back. You can never take back a medical benefit once it is given to a citizen. If you do, you cut the cost at the rate of growth of gross national product, and with your 7.1-percent cap staying at a constant rate of gross national product, we are going to be in desperate trouble if the cost containment proposals do not work.

We will spend $60 billion 2 or 3 years from now, whatever it is, and put ourselves closer to bankruptcy and fuel the rate of inflation.

I think a lot of people would feel a lot better about taking the first step—I know I would—if we could put some of the cost saving steps into operation as phase I before we spend a nickel.

I wonder if you could comment on some of the cost savings steps, some elements of the competitiveness and the bonus payment, rebates. What are some of the things that this committee could do tomorrow, in essence, in terms—without having extra expenditures—of demonstrating the cost savings techniques of your system, then we could feel much better about moving ahead on the expenditures side.

Senator KENNEDY. Senator, I am in agreement with you that the system changes we have talked about and the cost of programs ought to be implemented immediately. That ought to be a part of any phased program.

I could not agree with you more.

I do not think that it is a false promise. I am mindful of some of the problems that Canada has had. In the course of our hearings we heard from a strong critic of the Canadian system, however, among the things he granted was that they had effective cost controls.

The other fact he granted to us was that they had strong consumer support. The last poll of the Canadian system was that 84 percent strongly supported the system. During the last Canadian election, the health care issue was never even raised. Even in the British election, it was not even raised about reducing benefits or changing or altering their system.

The Canadians have effectively capped their system at 7.1 percent annual growth from 1968 through 1978.

But they have been effective in terms of the cap on it.

That is why I would agree with you, Senator. I would strongly hope that we could have strong system changes and cost containment. There are ways of bringing competition through HMO's and other ways that are currently in effect. I think the administration added $57 million in terms of new HMO's.

We can implement the cost controls and we can put the budget limitations in place.

Those are very difficult, politically, because the basic institutions that would oppose it. Doctors will oppose negotiated fee. The fact of the matter is, however, if we meet the unmet needs of people in our society including the neediest that are outside the system, we are basically talking about $30 billion.

That was true under the AMA program, or the health insurance industry program, or our program. You can phase that in over a period of time.

The fact is that you are going to have strong political problems, in terms of doctors, in terms of hospitals, administrators, and in terms of the insurance industry itself.

I daresay that this is where the bullet has to really be bitten.

I could not agree with you more that putting the system changes into place initially should be the key and I would say here that we should not see the additional phases that this coalition supports unless it is going to meet standards that are establihed by this committee and the Senate in terms of meeting criteria.

Is there anyone else that wants to talk about the particular kinds of cost controls? Max?

Mr. FINE. I would mention an additional point. It does not cost any money to have a system where there are predetermined, through negotiation, fair and reasonable fees for physicians across the board. I would say when I go around the country and talk to senior groups, one of the greatest problems that is raised in every State, including recently in Ridgewood, N.J., Senator Bradley, is the fact that the doctors do not accept assignment.

Doctors have freedom of choice. The patient does not have it. Only the doctor can decide whether or not he or she will accept assignment. More than half of them do not.

It does not cost the Government, it does not cost the individual, it does not cost the premium payer more money to negotiate a fair and equitable payment to the doctor. It costs less money, and that is the kind of system change that Senator Kennedy is talking about.

The CHAIRMAN. Senator Bradley?

Senator BRADLEY. Thank you, Mr. Chairman.

Senator Kennedy, on your graph, "Cost Controls and Incentives," under budgeting, the second item, it says that State budget allocations would be increased by formula, with more moneys going to low cost States, less to high cost States.

Could you be specific in explaining the allocation formula and how it would affect, in particular, the high cost States?

Senator KENNEDY. There is an internal mechanism that permits a flexibility of up to 2 percent of the total amounts that would be allocated. That would be considered within the total health care system and could be adjusted in areas where there is a maldistribution of services. This maldistribution has generally been defined both by nature of population and by other region characteristics.

You may find, in urban areas, there is a maldistribution in terms of elderly people and not the needed kinds of services. In a rural area it may be maldistribution because they do not have medical personnel in those underserved areas.

Senator BRADLEY. Obviously, those of us from the high cost States would not like to get into a national health program that penalizes our best efforts in the past.

In Dr. Enthroven's testimony, he explained how his approach would really engage doctors in reducing their fees and how this would exert significant downward pressure on hospital charges as well.

Could you be very specific in your plan as to how you would get doctors involved in reducing their fees?

Senator KENNEDY. Well, essentially, you have a negotiated fee schedule with doctors within an overall limit. These fees are negotiated not by the insurance companies sitting down at the table with the hospitals and with the doctors. There wouldn't be any Federal or State interference on that.

But it has to be done within a level, and it seems to me that once you have established the limitation of costs, then you establish those particular fees.

Senator BRADLEY. Who would negotiate?

Senator KENNEDY. That would be the insurance companies and the employers negotiating with the doctors across the table about what they have to pay in terms of fees.

It does not do you much good to negotiate fee schedules unless you are going to have payment in full, and that is what we essentially insist on.

Max?

Mr. FINE. Yes.

Essentially, what we have now, and have had all of these years, Senator Bradley, is a system in which the doctors negotiate only with themselves how much they are going to be paid. It may be that a lot of us would negotiate only with ourselves. Maybe Senators would like to negotiate only with themselves. But we are talking about a countervailing force made up of purchasers, industry, and employees, through unions or otherwise, sitting across the table. And through that system, develop fee schedules and develop utilization patterns and get a handle on the physicians' charges.

Senator BRADLEY. Under your system, do you see that there would be a need for more doctors per thousand, or less doctors? If so, how many?

Senator KENNEDY. My own sense is that we have sufficient doctors. We have the AAMC—American Association of Medical Colleges—that is going to make a complete report on that. We have a maldistribution in some areas, a maldistribution of specialties, but we have attempted over time to move physicians from areas of specialization into primary care and into the family practice.

That is happening, to some extent, in the medical schools.

Because of the research dollars and because of the elitism which is surrounding many of the medical schools, most of the incentives encourage students toward specialization.

We do have a maldistribution. We have tried, through the mechanism of loan forgiveness and the national health service corps, to try to deal with these issues and to try to make it more attractive to go into underserved areas.

It is a complex issue and a difficult one, but the total number of doctors do not need to be increased.

I would hope that we could cost out the additional costs to our health care system for every doctor. They do that, for example, in Canada, so that the public knows and the Parliament knows, and the Congress would know, that for every new cardiologist what it is going to cost

the health care system over the next year and the next several years.

We add more and more doctors, as others have pointed out. It does not mean the lowering of costs, in many instances; it is raising it.

In what we call the manpower legislation, we will be making some recommendations. My own personal feeling is that we have sufficient manpower. It is not quite the right mix. We do have a serious maldistribution problem in the country today.

Senator BRADLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Ribicoff?

Senator RIBICOFF. Senator Kennedy, I think that you, and those with you, have put together a very interesting and ingenious plan. Philosophically, I think that if this plan had been projected before the Kennedy-Corman plan and all the energy that went into it, we might be somewhere today in health insurance.

Let us see if we can, at the present time, find a way to get a health insurance proposal. An examination of your proposal and the proposals made by President Carter and Senator Long and Senator Dole show a consensus developing on a number of key issues.

Let me list them.

All the plans agree that a national health insurance program must be implemented in phases. Your plan, however, contemplates enacting all the phases at one time.

All agree that medicaid is inadequate, that we need uniform standards and a more substantial Federal role.

All the plans would improve medicare by putting a cap on the medical expenses of the elderly.

All the plans rely on the private health insurance industry as a dominant mode of administering health insurance for the vast majority of our citizens.

All the plans agree that the cost to the Federal budget must be as limited as possible, yet they all agree that health care for the poor and the elderly is the responsibility of the Federal Government and must be paid for out of the Federal budget.

On the important issue of cost controls and systems reform, the thrust of your proposal and that of the President are similar, involving some budgeting, fee schedules, and capital controls.

Up until a day ago, I did not know where Senator Long stood on this, but he made a very provocative statement—I do not know if it was careless or thought out; his comments are usually thought out. What I heard him state for the first time was that, if we are going to have catastrophic and these people are in the hospital and doctors are visiting them constantly, the doctors cannot expect to get their same usual fees. They are going to have to do something about that, and their fees are going to have to be contracted or limited.

As far as I am concerned, I am taking it at face value that Senator Long is for cost controls, and he said today he would go further than many. I think that he would.

So we have the situation that a consensus has developed. The question is, are you and the group backing you willing to try to work out a health care measure where you are not going to get everything you want, and neither the President nor Senator Long nor Senator Dole

are going to get everything they want, but to put into place a system on which we can build? If there is one thing that I have learned from 40 years in government, it is that it is impossible to try to plan an overall social program affecting the whole country, being multibillion in cost, and think that in working it out and in having the thing in place that it will work in accordance with the blueprints that social reformers—and I use that in the best sense and not the worst sense—that social reformers think it will?

Now, you are dealing with human beings. Also, the incremental approach assures that we are going to act step by step with the feeling that we will not continue massive mistakes like we have made in medicare.

Now, I am saying to all of you gentlemen and ladies who are so deeply emotionally, philosophically, politically, socially, and economically committed to this program, are you ready to try to work out a health care program upon which this country can build?

Senator KENNEDY. I think that the answer, Senator Ribicoff, would be yes. There is a very keen desire to work with you, the chairman, the administration, with the President and Secretary Califano, Senator Dole, and with others. This issue has been before the country in one form or another almost since the turn of the century with Teddy Roosevelt. Earl Warren tried to do it in the State of California. So did Harry Truman.

So there is no provide of authorship, but there is a sense in recognizing that we cannot achieve all of the things that are essential. I think there is a sense, as you mentioned, that there has to be a feeling of one class of care so that we are not going to have a dual kind of class, one for the poor and elderly, and a different kind of class for everyone else. I think that there has to be a realization that as we make some progress toward the future, we be sure that the progress is not going to evaporate because of the continued growth of inflation. This will mean some systems changes.

There may be different ways and means of achieving that, of accomplishing that. We, quite frankly, have given a great deal of thought to that issue, and we have a plan which we think deals with the problem. There may be alternative approachs, and we would welcome the opportunity to work with you on how you insure that whatever benefits are going to reach the people are not evaporated.

I would just say finally, Mr. Chairman, and I think that this coalition and others can speak for it as well, they do not want to be in a situation where every 10 or 15 years they have to come back to Congress and refight the battle again on trying to achieve a comprehensive and universal health care system. We would certainly want to move forward. If we are able to get the kind of cost controls and systems reforms, then there is no reason why we should not see a continuation of that process to extend to benefits for those who are basically excluded from the system today. This would mean that the groups here would not have to come back and fight every 2, 3, 5 years against some of the interests which are entrenched and opposed to health insurance.

The answer to your question is yes; we want to work with you.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. Mr. Chairman, that was the question that we were waiting to have asked and that was the answer that we were waiting to hear, and it is almost superfluous for me to continue.

I would ask one question because it does go to a central concern of the coalition and of Senator Kennedy, and that is this question of one class of health care. It has to do with what seems to me to be a problem on a regional basis, as against social class hierarchy, which I think is what you were talking about.

One of the major disputes—you say this goes back to Theodore Roosevelt; it certainly goes back to Franklin Roosevelt—and when President Roosevelt set up his committee on social security with Mrs. Perkins as its chairman—there were three task forces—subcommittees, if you will. One was social security, and that produced the social security bill. One was unemployment insurance; that produced the unemployment insurance bill. And the third was health insurance, and we are still at it 50 years later.

One of the basic decisions that we made at that time, and it had to do somewhat with the politics of Congress, but much more with the state of public administration theory, was to set up a national program and let States administer it, particularly in things like welfare and unemployment insurance. Social security was different, but in the main the whole pattern of new directives was to have a national program run by the States and with standards varying from State to State, sometimes varying enormously.

And so, under medicaid today, you have a marvelous variation. You have Arizona, where medicaid benefits are zero; there is no medicaid in Arizona; and then you have my State and Senator Bradley's State and Senator Ribicoff's State, where they are very high indeed.

This has produced classes of citizenry—those who live in Arizona and those who live in New Jersey.

These variations, I would suppose, on many important matters are wider than any social class variations.

So I wondered at your inclusion of State governments and State contributions in this program. Is that going to perpetuate this 50-class problem, or do you see a way in which you are going to get one standard of health care for people regardless of where they live and what political jurisdictions do?

I do not have to tell you that an element of economic competition has entered into this. There are regions that keep their benefits to the poor very low for the purpose of attracting industry, and it works. It is an old problem. How do you feel you have handled it?

Senator KENNEDY. In the program, we have the benefit package which is effectively guaranteed to all citizens whether they live in Arizona or whether they live in New York, and that is established as outlined here. It is not greatly different from the HMO benefit package or the administration's benefit package.

The program would be comprehensive in terms of its benefits and universal in terms of application.

Then there is the budgeting aspect that we have reviewed today in the course of our hearing. This particular benefit package would fall within the national budget which is set as a percentage of GNP. The States would then conform to the overall count.

Within those budgets of those particular States, it is left up to the various consortia, the private sector, to negotiate what the fee schedules and other factors will be.

The worker in Tucson will know that an essential package is going to be available to him, and it will not exceed a certain rate in terms of what he is going to have to pay.

Now, if it is done more creatively, more imaginatively, as a result of competition in Arizona, he may get a rebate. Thus, it may be a great deal cheaper for him in Arizona because of this.

Senator MOYNIHAN. Your arrangement would not admit of this pattern of the last half century where some jurisdictions have deliberately kept their services low and others have kept them high?

Senator KENNEDY. It would avoid that. Would you like to add something to that?

Mr. FEIN. One of the difficulties with the purely national program, is that there is no variation permitted that a Governor of a State or some residents of the State may, in spite of the fact that we have a hospital ought to close, that it is empty, et cetera.

We have to pay the same tax, rather to have an empty hospital than no hospital at all.

We want to provide a modest incentive. Why modest? Because of the balancing of the problem you raised, so there is a balance here of offering some stimulus but not so much stimulus that in fact some States will rob their citizens of the medical care that the benefits say they ought to have.

Senator MOYNIHAN. Thank you.

The CHAIRMAN. Senator Ribicoff?

Senator RIBICOFF. One more question, Senator Kennedy, for you and the members of your group.

If we proceed in this committee with the first phase, whether we pass the entire future, or just one phase, the first phase, that is obvious, is catastrophic. The President's concept, Senator Long's concept—I think even you contemplate that the first phase would be catastrophic.

What cost controls and system reforms do those of you who have worked in this field believe are most important during such a first phase?

Senator KENNEDY. The administration's program has an element in terms of adjustment of the medicare program, but it also has an important youth component in terms of well baby care and prenatal care.

Max, do you want to take a minute?

Mr. FINE. Senator Ribicoff, of course it would depend upon the threshold. If you had a 60-day hospital deductible, you could begin negotiating the hospital budget after the 60th day. If you had a $2,500 medical deductible, you could hardly negotiate with the doctors below that amount.

It is very hard and our technical committee has spent literally hundreds of hours on this, and we have some of the best people in the country involved looking at it. We have been unable to figure out how you could get the cost controls or the system impetus where you would have enough leverage with the catastrophic only plan to begin the systems improvements or the type of cost controls that we so dearly believe in.

Senator MOYNIHAN. Did you say that you thought that it would not be easy to put cost controls on a system where you had catastrophic coverage—first a deductible, but no cost thereafter?

Mr. FINE. That is exactly what I said.

Senator MOYNIHAN. I was afraid that was what you said.

Senator RIBICOFF. I do not quite understand. Let's say you even have—first, you have got—let's say it is $2,500 so the patient is concerned that he is not being overcharged. If you have a fee schedule, that would apply to the first $2,500 as well as what follows after the $2,500.

Senator Kennedy pointed out his concern in the President's program that he was going to have a fee schedule for the public patients—medicare and medicaid—but no fee schedule for the employer mandated, and this concerned Senator Kennedy deeply.

I gather it concerns Senator Long, too. Can you not begin to put in some cost controls, if you took the Long approach or the Dole approach? Can you not put something in effect, some cost controls there?

Mr. FINE. I think that is exactly the reason why the administration under its proposal is saying that we will have cost controls on the physicians under the public side. But since we are not mandating basic benefits on the private side, we cannot find a mechanism to negotiate with the doctors on the private side.

Senator RIBICOFF. But the insurance companies will be the mechanism that you are using. They will enter into contracts.

What concerns Senator Kennedy, and what concerns Senator Long, are these long-term-care situations both in the hospital and doctors side. If there is some schedule of fees and compensation put into effect, I am at a loss to understand why that could not be done between the insurance companies and the doctors as to what the schedule will be.

Mr. FINE. You cannot order doctors to accept a certain fee. You can contract with doctors under programs that had been publicly legislated and mandated and under that system you can think of a variety of ways of negotiating fees with doctors, but when you are excluding the first $2,000 or $2,500, or whatever amount, you cannot negotiate below that amount. It is not a part of the program that you are providing for.

Senator RIBICOFF. It is part of the program because you are passing a health insurance program of whatever type you do and you are saying as a part of this program the first $2,500 or $2,000 or $3,000 or whatever it is will be paid by the individual and that the doctor, in order to be under the mandated employer part, I think you could ask the doctor to take the same schedule of fees for the first $2,500.

Senator Kennedy, as chairman of the Judiciary Committee, I do not think we are hurting anybody's constitutional rights, if he wants to come in under a system, that his fees would be on a schedule for the money he pays out of his own pocket as well as those paid by the employer and employee.

Do you think that there would be a restriction on that, Senator Kennedy?

Senator KENNEDY. First of all, with a catastrophic plan only, we have a couple of different items. One is the implementation of the cost aspects. The other is systems reform.

The cost is the negotiated fee aspect, which the administration accepted as to the public aspect, not the private, which would create the blueprint that I mentioned in my testimony.

The costs aspects are one aspect of putting a limitation on expenditures. How you are going to do it in terms of catastrophic? Do you use a progressive system in terms of a castastrophic definition such as a percentage of income, which might be an idea. Do you have negotiated fees, for certain doctors?

Do they just become applicable after the first $60 or not? You have the administrative aspects with regard to that issue, which would be complex and difficult.

But beyond that point, I would say there is another consideration that we would be skewing the system itself very heavily to one aspect of health care delivery, and that is to very in the expensive catastrophic hospital care.

I think that is the central theme which we believe would be inadvisable, and which the administration would believe is inadvisable. The justification for our position could not be more carefully illustrated than the article in the New England Journal of Medicine which spells out the move toward tertiary care technology at the cost of providing the kinds of health care needs for elements of the population with catastrophic insurance.

The effect of the implementation of our program includes the concept of catastrophic. The administration in its proposal, had different elements, had an aspect in terms of youth, in terms of the most vulnerable groups of our society, and a balance for the senior citizens.

They did not have the cost control aspects or the other kinds of system changes that we would support. But it seems to me that our approach would be a much fairer type of distribution in terms of where they were targeting.

We have our strong concerns that without those cost controls and systems reform, that we would run into the problems that Bill Hutton has mentioned earlier. That is basically our sense.

We would be glad to sit down with you, Senator Ribicoff and Mr. Chairman and the other interested members and go over this in more careful kind of detail.

Senator RIBICOFF. I think that is a point. My feeling is, personally, that this is not going to work, may I say, frankly, unless Senator Kennedy has a piece of the action.

Senator KENNEDY. There is another way of saying that.

Senator RIBICOFF. And I think it is not going to work unless Senator Long has a piece of the action, and I do not think it is going to work unless President Carter has a piece of the action, and Senator Dole.

But it is doable, and I think that it would be a tragedy when you have reached the stage where those people can make this thing work that we allow ourselves to get involved in personalities or political one upmanship to prevent it from working. I think everybody that is involved here has a great and grave obligation to try to work this out together.

The CHAIRMAN. I always tell the President, if it happens during his administration he is entitled to take credit for it, even though he might not have advocated it.

When a President signs a bill into law, he is entitled to claim credit for it if he wants to.

I usually share credit with my colleagues on the basis, if we can get together on something, it can be the Long bill in Louisiana and the

Ribicoff bill in Connecticut and the Kennedy bill in Massachusetts. We do not usually call each other a liar in another State.

I think, Senator, that you have made some very fine suggestions here, and I particularly think there is great merit to the idea of trying to put groups representing patients in a position of strength to negotiate with the medical fraternity to arrive at a contract that is fair to both sides.

And that has been missing in the past.

There have been some very good points made today about this matter. It seems to me that we ought to move in this area and pass the best bill that the majority in the House and the Senate can agree on. I think it was your brother, who said that the journey of a thousand miles begins with a single step. I think he found it from some old Chinese philosopher somewhere.

Let me just make this point to you, Senator, and to your supporters here. Sometime back we were unable to get the administration's position on health insurance. They thought about it and thought about it and were studying it and so we scheduled executive hearings to vote on this matter a month ago.

Our thought was if you tell the bureaucracy you're going to move ahead—it is like when you play cops and robbers. You count to 10 and say, "I'm coming, ready or not."

We told them we were going to go ahead and vote on a health care bill and would like their recommendations, but if we did not have them we would have to vote anyway.

It worked, they came up here and told us what they were ready to recommend.

As far as you and your supporters are concerned, my impression has been that you have always been ready to take your position. You are not the one who has been holding the matter up.

We will hold some further hearings, but the way that we are doing business at this point, we will vote for awhile and when we hit a snag and cannot find an answer, then we will hold some more hearings and see if we can find some more answers, or hold some more sessions to consult with people who can give us their best advice and information.

And we will go from there.

Let me say as the chairman speaking for the committee, that we welcome all the advice that members of this group and their associates can bring us, and I hope very much that some of your associates will continue to monitor these hearings and, as thing go along, if you agree with us, let us know. If you do not agree with us, let us know about that, too.

We will try to bring out a bill that we hope that the Senate will pass, in so far that we fail to meet the standards that you think should be in the bill, we certainly expect to hear from you on the floor.

I am sure we will.

Thank you very much.

Senator KENNEDY. You always take care of us on the floor.

Thank you very much.

[Whereupon, at 1:05 p.m., the committee recessed, to reconvene at the call of the Chair.]

[By direction of the chairman the following communications were made a part of the hearing record:]

NATIONAL COUNCIL OF SENIOR CITIZENS, INC.,
Washington, D.C., June 18, 1979.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee, U.S. Senate, Washington, D.C.

DEAR CHAIRMAN LONG: We appreciate the opportunity to comment on S. 748 and S. 760, introduced subsequent to S. 350 and S. 351 on which we have previously testified.

To begin with, NCSC's fundamental and longstanding opposition to the catastrophic health insurance concept is unchanged. Our position with regard to both S. 748 and S. 760 is little different from our position on S. 350 and S. 351 as presented before the Finance Committee earlier this year.

NCSC shares your desire to protect individuals and families from financial ruin which so often accompanies major illness. But we do not subscribe to the belief that adding another increment to existing layers of health insurance is the solution. In fact, NCSC submits that catastrophic health insurance may have precisely the opposite effect than the one intended.

By limiting coverage to only the most expensive form of treatment, catastrophic health insurance, with its high deductibles, will encourage high intensity medicine and discourage preventive care. This inflation in this section of the economy will continue to rise unabated and indeed be reinforced.

Similarly, high deductibles rather than acting as a limit to individual liability tend to be seen as a floor above which the provider of care is guaranteed payment. In this case, the incentive is to increase the price charged the patient in order to trigger-in coverage. Once catastrophic health insurance is triggered, all the physician has to do is write off as a loss any money the patient could not afford to pay out-of-pocket to the doctor.

But even more important, neither S. 748 nor S. 760 protects the average senior citizen from financial bankruptcy. Deductibles as high as $2,000 or $5,000 are well beyond the means of the average social security pensioner whose monthly check is on average $264.00.

Senator Long, NCSC submits that experience with Medicare, including Medicare's deductibles and coinsurance and other large gaps in its coverage, provides overwhelming evidence of the need for a universal comprehensive national health insurance program. Such a program should provide first dollar coverage and force the health care decison-makers, that is the physicians and administrators to work within a pre-determined negotiated budget. Only system-wide reform with strong built-in cost controls can possibly stave off bankruptcy not only for individuals but also for the nation as a whole. In short, we believe that enactment of a catastrophic health insurance program no matter what sweeteners are added by way of improving Medicare, would be penny-wise and pound-foolish.

Sincerely,

WILLIAM R. HUTTON,
Executive Director.

STATEMENT OF THE AMERICAN ACADEMY OF DERMATOLOGY REGARDING NATIONAL HEALTH INSURANCE

(Prepared at the Direction of the Council on the National Program for Dermatology by the Task Force on National Health Insurance)

[Asterisk (*) indicates those unable to attend meeting in New Orleans on Mar. 3–4]

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Peyton E. Weary, M.D., Chairman, Charlottesville, Va.
John T. Grupenhoff, Ph. D., Consultant, Washington, D.C.

PREAMBLE

It is clear that the American public believes that:

1. All Americans should have access to quality medical care regardless of income; and that

2. Catastrophic illness should not destroy the economic stability of individuals nor families; and that

3. Health care should be financed in such a manner that the individual members of society can afford the costs and the total economic burden should not disrupt the Nation's economy.

The American Academy of Dermatology, whose membership of 5,070 includes the majority of American dermatologists, endorses these concepts and shares the concern of the Congress about the rapid escalation of health care costs. The American Academy of Dermatology does not endorse any existing legislative proposal for national health insurance, nor does it specifically indicate that there is currently a need for national health insurance legislation. That, after all, is a political decision which the American public must make through its elected representatives, but only after being fully informed of the needs, the consequences and the true costs of such legislation. The academy believes that its recommendations, which are incorporated in the following document, will insure that our patients with skin disease will receive quality medical care on a cost-effective basis under any form of national health insurance the Congress may ultimately adopt.

1. BACKGROUND INFORMATION

A. Significance and scope of skin disease in the United States

1. Significant skin disease which is deserving of medical attention afflicts 31.2 percent of the population of the United States. The prevalence data for skin disease are derived from the Health and Nutrition Examination Survey of 1971–1974 (appendix A).

2. Skin disease accounts for an economic loss to society in excess of $2.05 billion. This information is derived from data in a report entitled "The Economic Cost of Illness Revisted" (appendix B) and is based on 1972 data.

3. Skin disease is second only to trauma as a cause for occupational disability and economic loss to industry. A recent estimate indicates that approximately 178,000 new cases of occupational skin disease are acquired annually and the economic loss to society of occupational skin disease was estimated by NIOSH in 1972 to exceed $250 million per year.

4. Skin disease is not only disabling but patients with disfiguring skin disease often have serious difficulty in securing appropriate employment because of their appearance. Furthermore, the psychological impact of many disfiguring skin diseases may seriously impair interpersonal interactions and create societal adjustment problems for many people.

5. The skin is the interface of man with his environment and is thus subject to many noxious environmental influences. This is particularly true with regard to skin cancer which accounts for over 20 percent of all cancers (the largest single group of cancers) and is clearly related to excessive sunlight exposure.

6 The skin is often an important indicator of the presence of serious internal diseases including internal cancer. Recognition of the significance of these outward manifestations of internal conditions is of great importance to early diagnosis and treatment of many internal diseases.

7. Many skin conditions can be prevented by good public education and improved personal hygiene. Improved public education programs, such as those promoted by the American Academy of Dermatology, will also improve early recognition of potentially serious problems thereby improving the outlook for treatments.

B. The role of the dermatologist in care of patients with skin disease

1. The dermatologist is a physician who specializes in the recognition, treatment and prevention of all aspects of skin diseases. Clinical and investigative dermatologists are trained to integrate their special diagnostic and therapeutic skills with total care of their patients where the skin disease has internal manifestations.

2. Dermatologists serve as the initial contact physician for a large segment of the population with skin disease on a self-referral basis. They also serve as consultants to other physicians for patients with complex or unusual dermatologic problems. It is understandable that the majority of patients seen by the average dermatologist are on a self-referral basis because the skin disease is readily visible to the patient. Thus those patients who are aware of the special

competence of dermatologists in recognition and treatment of skin disease often go directly to the specialist who can be expected to deliver the highest quality of care by virtue of training and experience. Self-referral tends to eliminate the possibility of multiple referral and reduce the potential for inappropriate or unnecessarily prolonged therapy by those less skilled in management of skin disease. Thus skin care by the dermatologist can be invisioned as a cost-effective type of care by reducing the need for referral and increasing the possibility of returning the patient to a productive status more rapidly.

3. Approximately 97 percent of the care delivered by dermatologists is currently provided on an ambulatory basis—a higher percentage than for any other specialty. As a group, therefore, dermatologists provide a less expensive type of medical care because they seldom have to admit their patients to a hospital.

4. Dermatologists can often diagnose their patients' problems without resorting to the use of expensive diagnostic equipment or laboratory technology. The substitution of visual expertise by a highly trained physician for expensive laboratory studies thus further enhances the cost-effectiveness of the dermatologist's management of many problems.

5. Dermatologists are trained to employ a wide range of therapeutic skills on an ambulatory basis. This is, in large measure, responsible for the reduced necessity for dermatologists to admit patients to hospitals for treatment.

6. Dermatologists have long been aware of the importance of providing geographic access for patients with skin disease to specialist-care and have been leaders in the field of health manpower analysis, specialist placement services and voluntary educational incentives to attract young dermatologists to underserved areas. Dermatologists currently are neither in oversupply, nor serious undersupply, although there are admittedly still some underserved areas of the country. Long-range projections of the need for dematologic manpower indicate that by reasonable criteria we are currently close to an optimal level of training new dermatologists.

7. Dematologic services are perhaps more subject than most other medical services to fluctuations in the state of the economy and would be most apt to experience a sharp increase in demand under a comprehensive, compulsory system of national health insurance. The potential effect of unrestrained demand upon the ambulatory care system has been carefully analyzed by Newhouse and his associates. Patient queing and physician shortages which might be created by increased demand for services by the abrupt imposition of comprehensive third-party payment mechanisms upon the ambulatory care system would be particularly acute for the specialty of dematology which is so heavily devoted to provision of ambulatory care. Such a system might be expected to result in substantial patient queing and inordinate delays for patients with serious problems.

II. GENERAL GUIDELINES

The following recommendations regarding national health insurance are in part a reflection of the perspective which is created by the type of problems unique to our patient population and the type of practice of the dermatologist as outlined in section I. They are also in part a reflection of our belief that a system of national health insurance should correct only the inequities in the present system but not create such severe disruptions in a reasonably efficient health care system as to subvert the superb quality of care which has characterized the American system of health care delivery. The American Academy of Dermatology does not currently endorse any of the existing proposals for national heatlh insurance but would propose that if the American public chooses to adopt a system of national health insurance the following guidelines be adhered to:

1. During the formative period, when various proposals are under discussion, the public should be fully informed about the overall costs of each proposal including, but not limited to, the overall administrative costs of each program. The cost analyses should not only include estimates of the direct out-of-pocket yearly expenses to the individual and/or family, but the hidden, indirect expenses in terms of increased costs of goods and services which would result from employer-manated provision of portions of the yearly premiums. These should be presented to the public in readily understandable terms. The information should specify precisely what fraction of the cost of selected items would reflect the cost of the insurance provisions to the manufacturers or other provider of goods and services. In addition, the increase in costs of these goods and services over current costs which would accure if the program is adopted should be docu-

mented. Furthermore, cost projections should be published which indicate estimated increases in costs over a period of at least 10 years.

2. Administrative costs of any program adopted should be compiled and published annually as an audit by the General Accounting Office and there should be dissemination of information about the impact of the program upon the economy.

3. All patients should have the right to seek the services of the physician of their choice regardless of specialty or type of health care delivery system. Furthermore, there should be no financial or other constraints imposed which would deter the patient from, or reward the patient for, selection of any special category of physician or ancillary health personnel.

4. To reduce unnecessary utilization of services and to enhance patient cooperation and compliance, graded co-payment should be required in all types of health care delivery systems for the provision of all medical services. The level of co-payment would vary according to the patient's economic status and the type of service provided and should not be of such magnitude as to preclude the provision of appropriate care for all patients.

5. Reimbursement mechanisms should not be so constructed as to favor hospital admission over ambulatory care.

6. Other than appropriate peer review, external judgments or financial constraints via reimbursement mechanisms should not be applied, either directly or indirectly, to influence medical decisions about the need for, or appropriateness of, the provision of services.

7. Purely cosmetic surgery should not be reimbursable and for this purpose a carefully constructed definition of cosmetic surgery should be adopted to provide general direction for the decisionmaking process. The American Academy of Dermatology would consider a slight modification of the definition of cosmetic surgery developed by the American Medical Association as noted below to be most appropriate:

Definition of cosmetic surgery

"Cosmetic surgery shall be defined as: That surgery which is done to revise or change the texture, configuration or relationship of contiguous structures of any feature of the human body which would be considered by the average prudent observer to be within the broad range of 'normal' and acceptable variation for age and ethnic origin; and in addition is performed for a condition which is judged by competent medical opinion to be without potential for jeopardy to physical or mental health. Removal of a skin lesion suspected of being a benign or malignant cutaneous neoplasm (new growth), whether congenital or acquired, is not cosmetic surgery."

8. There are many nonsurgical skin conditions, either of an inherited, congenital or acquired nature, which have a significant cosmetic component. Because these conditions are not normal for the average individual and because they may be either disabling or disfiguring, medical management of such conditions should be reimbursable.

9. The freedom of the physician to bill patients directly and to refuse assignment of benefits should be preserved.

10. The law should not require a physician or other medical personnel to participate in a program of national health insurance as a condition of the practice of the individual's chosen profession.

11. If there is to be an expansion or alteration of the financing of the health care delivery system in the United States, it should be added to and integrated with the existing third-party system. Federal funding should be provided to purchase appropriate insurance for those who cannot afford such coverage for usual care. All individuals, regardless of their economic status, should have adequate protection against catastrophic illness by one mechanism or another.

12. It is improbable that any single monolithic and rigid health care delivery system can adequately address all of the medical care needs of our complex society. Sufficient flexibility should be incorporated into any program to provide for innovative or alternative methods of health care delivery. Federal subsidies for health care delivery systems should not favor one system over another without clear evidence of quality assurance and economic superiority of the subsidized system. No financial or other constraints should be created to limit patient mobility from one type of health care delivery system to another.

13. Minimal standards for health insurance coverage should be established at a national level under any program of national health insurance for both public and private insurance policies.

APPENDIX

RESPONSES TO QUESTIONS SUBMITTED BY COMMITTEE MEMBERS BY DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The following material is supplied in response to questions asked during Finance Committee consideration of National Health Insurance.

Answers to question on page 14:

According to Department of Labor estimates, 5 million full-time employed workers out of a work force of 73 million full-time workers, are without health insurance.

The proportion of premiums paid by employers and employees varies considerably for those with coverage.

Industry:	*Percentage paid by employer*
Total	85.2
Manufacturing	88.2
Mining	86.9
Construction	97.7
Transportation	96.9
Communication and public utilities	95.9
Wholesale and retail trade	62.1
Finance, insurance, and real estate	71.5
Services	87.6

Source: These estimates are from a sample of 1,665 company health plans of private firms with more than 25 employees. The data were provided to the Department of Labor by plan administrators pursuant to the Welfare and Pension Plans Disclosure Act (WPPDA). Leo Fraser, "BLS Health Plan Computerized Data" preliminary report. Office of Health and Disability, ASPE, U.S. Department of Labor, January 1978.

Answer to question on page 35:

The Administration plan will have the following tax impact:

Individual out-of-pocket payments will be reduced, and itemized deductions under the personal income tax lowered. This will increase federal tax payments by $0.5 billion.

The personal income tax provisions for health insurance premiums and medical expenses will be changed. A deduction will be provided only to the extent that premium and medical expenses exceed 10 percent of adjusted gross income (rather than 3 percent as in current law). This will increase federal tax payments, and reduce the net deficit to be financed. Net Cost—$1.3 billion.

Employers will be required to spend $6.1 billion more under the employer guarantee plan than they would under current law. To the extent that employers substitute these premium payments for wage payments, taxable income of employees will be reduced (or, in practice, increased less than they otherwise would have increased). This will reduce federal tax payments, and increase the net deficit to be financed. Net Cost—$1.2 billion.

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