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RUSSELL B. LONG *Chairman*

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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% 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 along 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 Committee 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 Republican 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 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.

Secondly, 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 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 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 elimianting 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 $600 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% 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 believe 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 Secreatry 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 shoe 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 alos 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 monies and Title V monies, 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.

REMARKS OF SENATOR RUSSELL B. LONG ON HEALTH INSURANCE BEFORE THE COMMITTEE ON FINANCE

June 19, 1979

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 six 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 prolonged 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 Company 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 everyone 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 expansions 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 sufficent 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 consensus for action on catastrophic health insurance.

Again, I think that consensus should be translated into early action by this Committee and this 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 difficulty purchasing the coverage now.

I think, as always, common sense and a common sense of concern will prevail in the Finance Committee.

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.

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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-sharing 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 mandate, 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.

JUNE 12, 1979

President Carter's

NATIONAL HEALTH PLAN LEGISLATION:

CHARTS

1. National Health Plan: The Basic Approach
2. National Health Plan: Problems with the Current System
3. Phase I: Goals
4. Phase I: Structure
5. Phase I: Benefits for the Aged and Disabled
6. Phase I: Benefits for the Poor and the Near Poor
7. Phase I: Benefits for the Full-Time Employed
8. Phase I: Benefits for Others
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10. Phase I: HealthCare
11. Phase I: The Role for Private Insurance
12. Phase I: State Role and Fiscal Relief
13. Phase I: Payment to Providers
14. Phase I: System Reform
15. Phase I: Net New Costs
16. The National Health Plan: Steps Beyond Phase I

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 Majcr 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 Million 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

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

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

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

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

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

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.

- o 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 [illegible]) All employers will be required to provide [illegible] 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:

- o 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.
- o 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 indiviouals 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 cor inue 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.

- o 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.

   - o 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.
   - o Current Medicare benefits will be improved through providing unlimited days of hospital care and expanded benefits for mental health and alcoholism services
   - o 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.

- o 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.

- o 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.

- o 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.

- o 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)

- o 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.

o 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.

o 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 costs -- 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:

- 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.

- 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.

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.

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

   - 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.
   - 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:

   - 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.
   - 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.

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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:

   - 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.

   - 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.

   - 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:

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

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

   - Avoidance of adverse employment effects.

   - 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 insurers 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.

Testimony by Senator Gary Hart
Before the Finance Committee
National Health Insurance Hearing
Washington, D.C.
June 19, 1979

Before discussing my proposal in detail, let me first describe its key features.

1. 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.

2. It emphasizes preventive health care, and contains provisions to help hold down overall health care costs.

3. It relies on private health insurers and existing medical institutions, and it minimizes the role of the Federal government.

4. It is completely voluntary, and it has a sunset provision requiring review of the program and reauthorization after five years.

5. Finally, it is affordable in these belt-tightening times, and it should be relatively easy to administer.

The proposal's centerpiece is the inititation 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 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.

Children and pregnant women also offer the ideal group on which to implement preventive preactices and policies, a central component of a truly effective and cost-efficient national health care program.

Furthermore, 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.

It is important to note that in 1976 the per capita expenditure for children under 19 years was $249, compared to $547 for those aged 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 produceable, fairly predictable and, though not minimal in cost, has been demonstrated time and again to be tremendously valuable in imporving the health of newborn infants and reducing future illness.

Despite existing Federal programs, children--especially the poor--receive fewer health care benefits than any other group. Less than 50 percent of eligible children receive standard immunizations 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. One in five infants born premature will die within the first year of life and the others will be prone to serious and often irreparable ilnesses. 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, simultaneously with the standard fee-for-service system, or not at all. Patients could 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 "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 Boards would set capitation rates, administer the program, and review and improve it as needed. The Boards would also involve public officials, doctors, and insurers in the task of holding down the skyrocketing costs of medical care.

Finally, my plan has a sunset provision, so that after five years its continuation or expansion will require reauthorization by the 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.

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 my best estimate the cost of this legislation would be between $13 - $18 billion.

What will people get in return?

In many average families there will be one child under six. 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 $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 will have free insurance against catastrophic illness, protecting it from financial devastation by catastrophic illness or injury.

This payment plan is fair because every taxpayer will contribute to an imporved national health system--according to ability to pay. Also, larger families, which will benefit more, will contribute a slightly larger amount if they have more children under six years of age.

Some of the major differences between my plan 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 fee regulation. Theestimated cost of the plan would be about $60 billion annually.

My plan differs by offering a more limited approach. Specifically, it provides comprehensive care for children and pregnant women; uses capitation payments and the "market" approach to cost control rather than government-mandated fees; and uses income tax revenues for financing instead of the inherently inflationary employer-mandated insurance plans.

President Carter's proposal relies on passage of hospital cost containment legislation to control escalating costs and expands a porgram similar to the present Medicaid system to additional poor and nera-poor persons. The President's proposal also contians a catastrophic plan with a fixed $2,500 deductible for individuals and $1,250 per senior citizen deductible.

My plan 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 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. The deductible in my catastrophic plan is income-related because financial catastrophe is a relative thing. A fixed deductible of $2,500 per senior couple would be absolutely devastating to most seniors on a fixed, limited monthly income.

The Long proposals are varied, but the basic features of the major piece of legislation are similar in many respects to the President's. Senator Long's proposals would also create "classes" of beneficiaries for health care. At least two of the Long plans are financed by a 1 percent payroll tax. Finally, the LOng plans would institute a catastrophic plan with deductibles even more stringent than the President's.

I chose carefully not to use a mechanism like the payroll tax to finance my plan. Such a financing scheme, like the employer-mandated plans, are inflationary and somewhat discriminatory.

Finally, the Dole-Danforth-Domenici plan offers some needed reforms to the Medicare provisions of the Social Security Act and an employment-related catastrophic plan with an extremley high deductible.

Again, my plan differs from the Dole catastrophic plan on the issue of deductibles. A fixed deductible, especially a high one, will offer no assitance to the persons who most need protection against financial catastrophe brought about by serious illness.

While my plan does not--indeed no plan can--solve at once all the ills of the present system, it does represent a reasonable, fiscally responsible and administrable plan with which to begin.

It is time to resolve our differences and serve the public's best interest by improving our national health system. We at once have a duty to ensure their health at a time of crisis in their health care system as well as restore the health of their political order at a time of general disappointment in government. I believe the plan I have outlined here today is a sure step toward doing both. Thank you.

STATEMENT OF SENATOR EDWARD M. KENNEDY AT A PRESS CONFERENCE

INTRODUCING THE "HEALTH CARE FOR ALL AMERICANS ACT"

For release:
Monday, May 14, 1979
11:00 a.m.

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 to 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 budgeting 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 pre-negotiated 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 Resources 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

For Release: 11:00 a.m.
Monday, May 14, 1979

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 Psychological 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

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 the employees works. With respect to HMO plans, the employer shall offer any plan to any representative of the employees according to conditions 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 21) 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 corporation (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 all 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 set 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 filed an annual income tax return without showing 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 enrolment 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 benefits 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 inpatients 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 artifical 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 short-term Medicare, plus 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.

6. 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 pind 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% 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% 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.

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.

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;

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 budgeted 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 certificate-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, pay 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 HMOs

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 consistant 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 HHI 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 agreeable 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 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 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;

or

b. Providing direct services, a significant portion of which are covered services under this Act;

or

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 Inspector 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 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 called 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 their 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 fir. ing

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 analysis 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 for 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 basis 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 Resources 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 .ission on the Health of Americans.

1. The Pre .ent 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 nonwage 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 absolute 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 National 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 deducted 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

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 pertinent 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 SSI 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 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.

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 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 but 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 $2000 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 $2000 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 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 even 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 owed 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 annual 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 Department 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.

f. 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 HHI 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;

or

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 of 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 Resource Distribution Funds and use of regulations, and grantauthority 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 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 alternatives 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 homes, 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 cause 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 places 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 assistance 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 change 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) [illegible] productivity and [illegible]

(6) [illegible] and service [illegible]

(7) [illegible]

(8) [illegible]

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 consumers 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 opportunity 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 amount total/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 to 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 mix, 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 services 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 negotiation 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 29 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/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 apportionment 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 agreement 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 reimbursement.

(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 or performance;

(c) Cost to 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 at 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 Committee 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 payment 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 concensus, 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; and

(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 eligibility 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 reimbursable 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 services 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 unless 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 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 counted 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 nonsta-

tutory 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.

C. Various additional conforming and technical changes in statutes affected by the plan would be made. (No changes in any veterans legislation would be made.)

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 *

Extends Medicare to All Aged and All Social Security Disabled

* Special Provisions for Other Aliens in U.S.

COVERAGE FOR BROAD HEALTH SERVICES

- **Unlimited Services:**

Hospital Care	X-Rays
Physician's Services	Ambulance Services
Laboratory Services	Medical Equipment

- **Includes Preventive Services**
- **No Cost Sharing**

Limited Services

Drugs (For Medicare Only)	Nursing Home
Home Health	Mental Health Care

Thus

Prevents Financial Catastrophe

PREMIUMS RELATED TO INCOME

A. Wage Related Premiums Paid by Employers—
Employee Shares Up to 35%

B. Income Related Premiums—1/2 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

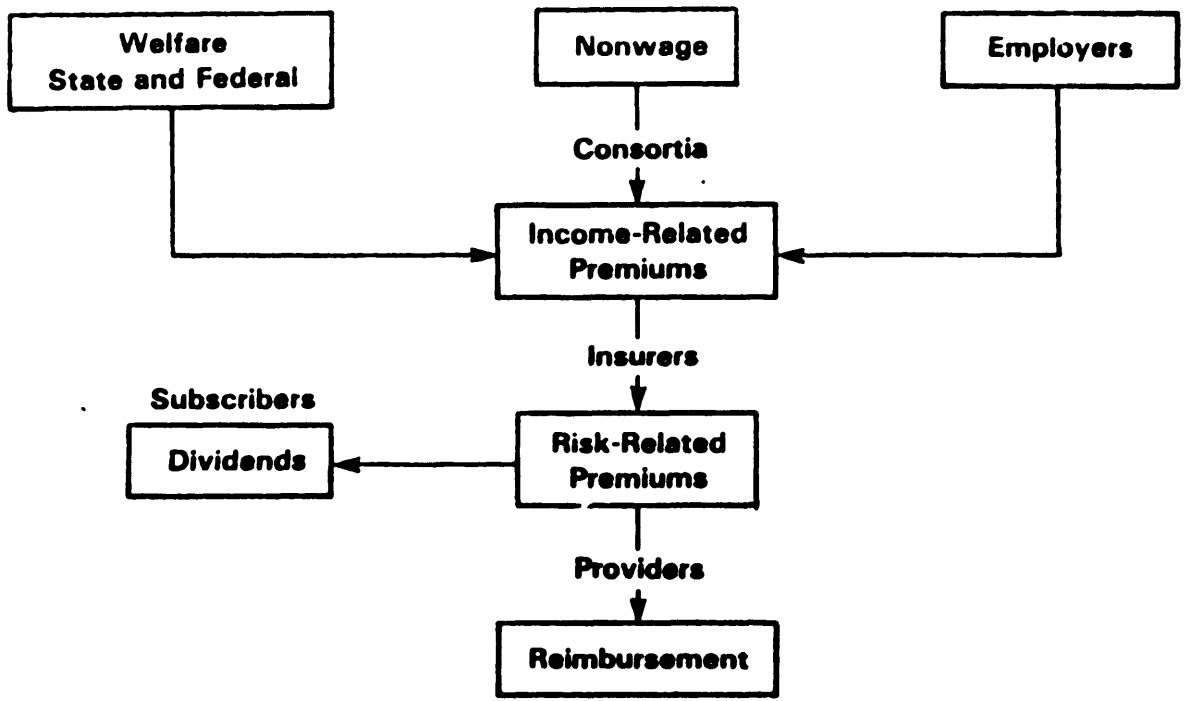
- **Everyone Eligible for Choice of HMO or Other Insurer**

  Non-Medicare—HMO or Private Insurer
  Medicare—HMO or Normal Medicare

- **Open Enrollment Period Available Every Year**

- **Additional Benefits or Cash Rebate for Enrollees of Efficient Insurer**

FLOW OF FUNDS



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
  - Area Costs
- **Agents of Insurers (Consortia) Distribute Income Related Premiums to Insurers As Risk-Related Premiums**

HEALTH SYSTEM FEATURES

- Sets Strong Cost Controls & Incentives
- Builds on Existing Private & 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
Labor and Management—	To Influence Provider Negotiation and State Budgets to Keep Premium Rates Down
Insurers—	To Incur Costs Less Than Premium by Efficient Operations, Special Reimbursement or Provider Arrangments
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
  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

SUMMARY OF COST ESTIMATES FY 1983*
(In billions of 1980 dollars)

I. Total spending for services covered by the plan:

Present Law	Kennedy Plan	Difference
$171.4	$211.4	$40.0

II. Total on budget federal cost:

Present Law	Kennedy Plan	Difference
$51.0	$79.6	+$28.6

III. Total non-federal cost:

Present Law	Kennedy Plan	Difference
$120.4	$131.8	+$11.4

Actuary estimates an employer/employee premium of 7.8%, depending upon the success of cost containment programs.

*All estimates prepared by Gordon Trapnell of Actuarial Research Corp.

CROSSOVER POINT**

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.

**Figures preapred by Professor Isidore Falk, Professor Emeritus, Yale School of Medicine.

NATIONAL SPENDING UNDER PRESENT LAW IN FY 1983 FOR SERVICES THAT WILL BE COVERED BY KENNEDY PLAN* - TOTAL POPULATION
(Billions of 1980 Dollars)

	Part A[1]	Part B[2]	Mental[3]	Prevent[4]	Drugs[5]	Admin.	Total
Total	81.2	66.5	5.2	.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
National Health Plan							
Workmens Compensation	1.7	2.1	•		•	1.1	4.5
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
Employment Subsidies							
Federal Facilities & 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 & Grants	.8	.8	1.4	•	•	•	3.0
Bad Debts and Unbilled Services[6]	2.9	5.9	.3	•	.1		9.2

* 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/ 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.

NATIONAL SPENDING UNDER PRESENT LAW IN FY 1983 FOR SERVICES THAT WILL BE COVERED BY KENNEDY PLAN* - AGED & D.I. BENEFICIARIES
(Billions of 1980 Dollars)

	Part A[1]	Part B[2]	Mental[3]	Payments[4]	Drugs[5]	Admin.	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
National Health Plan							
Workmens Compensation	.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
Employment Subsidies							
Federal Facilities & 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 & Grants	.2	.1	.3		•	•	.6
Bad Debts and Unbilled Services[6]	1.7	1.3	.1		.1		3.2

* 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/ 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.

NATIONAL SPENDING UNDER PRESENT LAW IN FY 1983 FOR SERVICES THAT WILL BE COVERED BY KENNEDY PLAN* - AGED & D.I. BENEFICIARIES
(Billions of 1980 Dollars)

	Part A[1]	Part B[2]	Mental[3]	Prevent[4]	Drugs[5]	Admin.	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
National Health Plan							
Workmens Compensation	.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
Employment Subsidies							
Federal Facilities & 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 & Grants	.2	.1	.3		•	•	.6
Bad Debts and Unbilled Services[6]	1.7	1.3	.1		.1		3.2

• 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/ 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.

NATIONAL SPENDING UNDER KENNEDY PLAN IN FY 1983 FOR SERVICES COVERED BY BILL* - AGED AND D. I. BENEFICIARIES
(Billions of 1980 Dollars)

	Part A 1/	Part B 2/	Mental 3/	Prevent 4/	Drugs 5/	Admin.	Total
Total	37.5	24.4	1.9		3.8	2.4	69.9
Private Payments							
Paid Out of Pocket							
Private Insurance							
Other Private Payments							
Government Required Insurance	.4	2.8				.4	3.6
Medicare		2.6				.2	2.8
National Health Plan							
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
Medicaid/SSI Beneficiary Costs							
Employment Subsidies							
Federal Facilities & Grants	.3	.1					.4
State and Local Taxpayers							
Medicaid/AFDC Recipient Costs							
State or Local Facilities & Grants							

* 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.

NATIONAL SPENDING UNDER PRESENT LAW IN FY 1983 FOR SERVICES THAT WILL BE COVERED BY [illegible] PLAN* - AFDC/SSI BENEFICIARIES
(Billions of 1980 Dollars)

	Part A[1]	Part B[2]	Dental[3]	Prevent[4]	Drugs[5]	Admin.	Total
Total	3.6	2.8	.2	.1	.5	.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
Medicare							
National Health Plan							
Workmens Compensation	•	.1				•	.1
Federal Taxpayers	1.7	1.3	.1	.1	.1	.2	3.5
Medicare							
Medicaid/SSI Beneficiary Costs	1.7	1.3	.1	.1	.1	.2	3.5
Employment Subsidies							
Federal Facilities & 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 & Grants	•	•	.1			•	.1
Bad Debts and Unbilled Services[6]	.1	.1	•	•	•		.2

* 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/ 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.

NATIONAL SPENDING UNDER NATIONAL PLAN IN FY 1983 FOR SERVICES COVERED BY BILL* - AFDC/SSI BENEFICIARIES

(Billions of 1980 Dollars)

	Part A 1/	Part B 2/	Mental 3/	P.Hymns 4/	Drugs 5/	Admin.	Total
Total	3.9	3.7	.5	.2	.7	.6	9.6
Private Payments							
Paid Out of Pocket							
Private Insurance							
Other Private Payments							
Government Required Insurance							
Medicare							
National Health Plan							
Workmens Compensation							
Federal Taxpayers	.6	1.1	.2	.2	.4	.3	2.8
Medicare							
Medicaid/SSI Beneficiary Costs	.6	1.1	.2	.2	.4	.2	2.7
Employment Subsidies							
Federal Facilities & 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
State or Local Facilities & Grants							

* 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.

NATIONAL SPENDING UNDER PRESENT LAW IN FY 1981 FOR SERVICES THAT WILL BE COVERED BY NATIONAL PLAN* - OTHER POPULATION
(Billions of 1980 Dollars)

	Part A[1]	Part B[2]	Mental[3]	Prescr.[4]	Dental[5]	Admin.	Total
Total	41.5	44.6	3.7	.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	.6	1.4		24.9
Private Insurance	29.3	19.6	1.0	.2	.1	6.6	56.8
Other Private Payments	.6	.7	.2			.4	1.9
Government Required Insurance	1.3	1.8				.9	4.0
Medicare							
National Health Plan							
Workmens Compensation	1.3	1.8				.9	4.0
Federal Taxpayers	4.2	3.3	.6	•	.2	.2	8.5
Medicare							
Medicaid/SSI Beneficiary Costs	1.2	1.1	.2			.1	2.6
Employment Subsidies							
Federal Facilities & 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 & Grants	.6	.7	1.0	•			2.3
Bad Debts and Unbilled Services[6]	1.1	4.5	.2				5.8

* 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/ 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.

NATIONAL SPENDING UNDER KENNEDY PLAN IN FY 1981 FOR SERVICES COVERED BY BILL*
OTHER POPULATION
(Billions of 1980 Dollars)

	Part A 1/	Part B 2/	Mental 3/	Prevent 4/	Drugs 5/	Admin.	Total
Total	41.8	67.4	4.6	2.0	2.3	11.8	131.9
Private Payments							
Paid Out of Pocket							
Private Insurance							
Other Private Payments							
Government Required Insurance	39.3	63.1	4.2	1.9	2.2	10.7	121.4
Medicare							
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
Medicare							
Medicaid/SSI Beneficiary Costs							
Employment Subsidies 6/	2.5	3.8	.3	.1	.1	.7	7.5
Federal Facilities & Grants	2.0	.5	.1			.4	3.0
State and Local Taxpayers							
Medicaid/AFDC Recipient Costs							
State or Local Facilities & Grants							

* 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.

DETAILED

EXPLANATION

OF

HEALTH CARE

FOR ALL AMERICANS

PLAN

Description 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 confidentiality 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 cards. 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 or 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 hospital 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 post-natal 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 met Board-set standards.

8. Outpatient 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 Board-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 prescribed 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 Standards 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 schedules.

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 HMOs

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. p · 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.

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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 addition, 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 Baord 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 prospective 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 providers 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 elections of negotiating groups and all negotiating sessions would be matters of public record.

J. Negotiations with Insurers and HMOs

Insurers and HMOs 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 HMOs 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 procecures 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.

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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 severly 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 Preimum

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 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 premiums 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 severly 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 Govenor 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 schudules 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 underserved 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 agencies, 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 recomment 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 consumers 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, payments to all radiologists and pathologists 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 provision

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 disirability 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 non-physician) 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 reimburses 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.

May 14, 1979

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, employers, 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.

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.

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. Individuals 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 the 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 premium for this new insurance exceed their current premium as a percentage of wages by more than three percentage 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 national 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, government, 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.

TESTIMONY OF SENATOR RICHARD S. SCHWEIKER, RANKING REPUBLICAN, SENATE LABOR AND HUMAN RESOURCES COMMITTEE, BEFORE THE SENATE COMMITTEE ON FINANCE ON THE SUBJECT OF NATIONAL HEALTH INSURANCE

JUNE 19, 1979

Mr. Chairman, I appreciate the opportunity to present my views on the subject of "national health insurance" to this distinquished 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 to 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.

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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 cost-sharing provision for hospital services up to 20% 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 intense debate in Congress for the past two 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 non-competitive 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 re-orient 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 1400%. During that same period, consumer prices as a whole had risen by less than 200%. 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 five 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%. Rising hospital costs account for more than 40% 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 decision-making. And it will preclude promising private sector efforts to attack the problem in a non-regulatory 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 anti-inflationary 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 five years will be only one tenth of one percent annually (see table #1). This is understandable since hospital expenses represent only 3.5% of the gross national product.

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

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)

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 ineffective 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% 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% to 10%. 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.

Anther 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 ensure 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%, effective until annual family medical expenses exceed 20%

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 competition 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 patient 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 plans 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 pro-competitive 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 re-involving the patient in hospital care pricing decisions will result in considerable savings. If third-party payors picked up 85% of the hospital bill instead of the present 90%, then the dollar value of ineffectual hospital care and testing eliminated by doctors and patients acting together would exceed the Congressional Budget Office's 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 ten cents a patient had to pay, a third party paid ninety cents. If the patient paid fifteen cents for every dollar's worth of care he received, the third party payor would finance eighty-five cents. The financial leverage facing the patient would be fundamentally altered. Instead of each $.10 patient payment resulting in a $.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 five years, assuming gradually increasing acceptance of the 25% 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% copayment up to a level of $3100 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% 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 SCHEIKER COMPREHENSIVE HEALTH PLAN

I. Federal Government	
Savings From Hospital Cost Containment [1]	-$2.5 billion
Cost of Medicare Improvements	$0.8 billion
Reduction in Tax Revenue [2]	$1.5 billion
Net Savings	$0.2 billion
II. State and Local Government	
Savings From Hospital Cost Containment [1]	- $0.7 billion
Reduction in Tax Revenue [2]	$0.2 billion
Net Savings	$0.5 billion
III. Private Sector	
Savings From Hospital Cost Containment [1]	-$4.3 billion
Reduction in Taxes	-$1.7 billion
Cost of Preventive Health Programs [3]	$2.0 billion
Cost of Catastrophic Pooling Program	$4.0 billion
Net Savings	$0.0 billion

Summary of Fiscal Impact

Savings From Hospital Cost Containment [1]	-$7.5 billion
Cost of Medicare Improvments	$0.8 billion
Cost of Preventive Health Programs [3]	$2.0 billion
Cost of Catastrophic Pooling Program	$1.0 billion
Net Savings	$3.7 billion

1. Assumes that 41% of population enrolls in 25% 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 ($ billions) 1980 - 1984

	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 - 1984

($Billions)

YEAR	Total	Private Sector	State and Local Government	Federal Government
1980	2.4	1.4	0.2	0.8
1981	4.5	2.6	0.4	1.5
1982	7.0	4.0	0.7	2.3
1983	10.1	5.8	1.0	3.3
1984	13.8	7.9	1.4	4.5
	$37.8	$21.7	$3.7	$12.4

Assumptions:

1. Enrollment changeover to 25% co-payment option:

1980	18%	of privately employed populatio
1981	29%	"
1982	41%	"
1983	53%	"
1984	65%	"

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% co-payment option will order 20% less in hospital services than one who has an 18% co-payment 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 appropriate 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 ensure 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% of annual family income. For the employed population, tax deductions for insurance premiums will not be allowable 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, uninsurable 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 90% 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 re-orient 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% to the Health Insurance

Institute's estimate of 12%. 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 benefits 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 ensure 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 benefits 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% 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%, 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 non-group enrollees in larger 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% 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% 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% 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 six 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-policy holder.

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
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 cost 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% 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 couseling 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 tha 100. Whooping cough, doptheria, 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 thousand 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 non-immunized 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 best 40-45% 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 dollars. 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% annually.

CONCLUSION

In sum, Mr. Chairman, I believe that in national health policy we are faced with three primary inter-related 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 non-competitive 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 catastrophic 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 ensuring 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 this proposal and to enact a non-regulatory approach to ensuring that all Americans have access to quality health care at a reasonable cost.

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