92d Congress
1st Session

COMMITTEE PRINT

# ANALYSIS OF HEALTH INSURANCE PROPOSALS INTRODUCED IN THE 92D CONGRESS

PRINTED FOR THE USE OF

## THE COMMITTEE ON WAYS AND MEANS

AUGUST 1971

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# FOREWORD

The material in this committee print was prepared by the Department of Health, Education, and Welfare at the request of the Committee on Ways and Means and is printed for the use of the committee.

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# INTRODUCTION

This document presents an analysis of the health insurance proposals introduced in the 92d Congress through April 30, 1971. Part I decribes each health insurance proposal in terms of the population covered, benefit structure, administration, relationship to other Government programs, financing, standards for and reimbursement of providers of services, and provisions affecting the delivery of and resources for health care services. Part II is a cost study of the proposals. In preparing the cost estimates, a methodology was developed by which the costs of various national health insurance proposals can be estimated, and this methodology was applied to each bill, except the Scott-Percy bill, S. 1598. Certain features of S. 1598 make its cost estimation difficult, and there has been insufficient time for the analysis of its cost effects.

The cost estimating methodology, and its application to the various proposals, is designed to be understandable, consistent, and unbiased, in order that Congress can make intelligent comparisons of the proposals within its scrutiny. The difficulties inherent in making cost estimates in the health field are substantial, however, and at best the results must be viewed as reasonable approximations.

This document was prepared in the Social Security Administration by the staff of the Office of the Actuary and the Office of Research and Statistics.

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# I. DESCRIPTION OF HEALTH INSURANCE PROPOSALS INTRODUCED IN THE 92D CONGRESS

## BYRNES BILL—H.R. 7741

H.R. 7741, the "National Health Insurance Partnership Act of 1971," was introduced by Representative John W. Byrnes, of Wisconsin, on April 27, 1971. A similar bill, S. 1623, was introduced by Senator Wallace F. Bennett, of Utah, on April 22, 1971, on behalf of the Administration (see page 53).

*General concept and approach*

The proposal would establish a two-part national health insurance plan that would cover almost all of the population under age 65. These include (1) a plan requiring employers to provide for employees and their families private health insurance with specified benefits and (2) a federally-operated family health insurance plan for low-income families with children. The proposal includes provisions designed to encourage the formation and use of health maintenance organizations.

### NATIONAL HEALTH INSURANCE STANDARDS ACT

The "National Health Insurance Standards Act" would require employers to make available to employees and their families a health care plan under private insurance providing specified benefits. Most benefits could be subject to cost sharing by the patient. The program would be administered by private insurance companies, under Federal supervision, and would be financed by employer-employee premium contributions.

*Coverage of the population*

The Act would apply to all employers and employees except (1) employees of Federal, State and local government (2) ministers and members of religious orders and (3) aged persons under the Medicare program. All other employers must make coverage available to all full-time and part-time employees (who work at least 25 hours a week for 10 weeks, or a total of 350 hours in a 13-week period). The participation of the employee would be on a voluntary basis.

Coverage would be continued, at the option of the employee, for at least 90 days after employment terminated (if he was under the plan for at least 13 weeks) and could be continued further, but the employer would not be required to pay any premiums after the 90-day period.

Special group plans developed by insurance carriers would be available to small employers (those with less than 100 employees working 90 days during a 180-day period). Also, group plans would be de-

veloped for self-employed persons and other persons not under an employer plan. These special group plans would have to provide the same benefits and meet the same requirements as employer plans.

Employers with a collectively bargained health care plan in effect at the time the bill is enacted (and still in effect when the program began) would not have to establish a required plan until the contract expired.

*Subsidies to employers*

Employers would receive subsidy payments from the Federal Government if their premium costs for employees covered under a required plan exceed 4 percent of the average wages paid to those employees. These payments would be equal to the amount of the excess for a maximum of 10 employees.

All employers, including those who are not engaged in a trade or business, would be able to take their unsubsidized premium contributions toward a required plan as a tax deduction.

(The Bennett bill, S. 1623, does not contain these provisions.)

*Benefit structure*

The required employer plan would have to provide specified benefits and meet certain requirements. The plan could not exclude payment of benefits because of pre-existing conditions for more than 6 months. (There would be no waiting period for maternity care.) Hospital care is subject to a 2-day deductible which refers to the reasonable cost for room and board for 2 days of care. Most other benefits would be subject to an annual deductible of $100 per person, with a family maximum of $300, plus 25 percent coinsurance (referred to below as "deductible and coinsurance"). This deductible is the total annual amount payable per person for all services subject to deductibles. After a person had received $5,000 of services in a year, all the cost sharing would be waived for him and his family for that year and the next 2 years.

There would be a lifetime maximum limit of $50,000 on total payments per person, with a $2,000 annual restoration. The covered benefits are shown below.

Institutional services:

- Hospital inpatient care: 2-day deductible and 25 percent coinsurance for room and board per year. All other hospital services subject to deductible and coinsurance.
- Hospital outpatient care: subject to deductible and coinsurance.

Personal services:

- Physicians' services (nonpsychiatric): generally subject to deductible and coinsurance. Periodic exams for children under age 5 (including immunizations and preventive care) with no cost sharing: six exams, birth to 6 months; six exams, age 7 months—2 years; three exams, age 2—5 years. Annual eye examination for children up to age 12 subject to deductible and coinsurance.
- Laboratory and X-ray: subject to deductible and coinsurance.
- Outpatient physical therapy services: subject to deductible and coinsurance.

Other services and supplies:

- Medical supplies and appliances: subject to deductible and coinsurance (prosthetic devices excluded).

Ambulance services (emergencies) : subject to deductible and coinsurance.

An employer plan could also make available benefits additional to those specified (or reduce or eliminate the cost sharing requirements). The employee would not be required to accept (or pay for) these additional benefits to be covered under the required plan. These additional benefits would not be subject to the requirements or conditions applicable to the required plan.

*Administration*

Employers would purchase basic health care plans from private insurance carriers who would collect the premiums and process the claims for benefits. They could also operate a plan on a self-insured or similar basis. Employees would have the option of enrolling with an approved health maintenance organization (these organizations are described later) and the employers would contract with these organizations for those employees who chose to enroll. Individuals and small employers could purchase coverage under special group plans.

The Department of Health, Education, and Welfare would be responsible for approving the employer plans and the special group plans. It would determine whether providers of services (including health maintenance organizations) meet standards and other requirements of the bill. It would also establish procedures for hearings in cases of denial of benefits by health maintenance organizations.

If the Department finds that an employer is not making a required plan available to his employees, the Federal Government could bring suit to compel the employer to do so. Employees may also bring suit.

*Financing*

Basic health care plans would be financed by premium contributions, with the employer paying at least 75 percent of the cost (for the first 2½ years of the program, at least 65 percent). The provisions do not apply to the cost of any additional benefits included in the plan. The employer could, of course, pay the entire cost of the plan if he wishes to do so.

Employees who enroll in a health maintenance organization would pay no more than the regular premium for a required employer plan, but could be required to pay an additional premium for any additional types of services provided (and for the actuarial value of the deductibles and coinsurance if these are reduced or eliminated by the organization).

## FAMILY HEALTH INSURANCE PLAN

The "Family Health Insurance Plan" would establish a plan for low-income families with children not covered under a required employer plan. Benefits would generally be subject to cost sharing, which would vary with family income and size, but the lowest income group would pay nothing. The program would be administered by the Federal Government and would be financed by Federal general revenues and premium contributions (except for the lowest income group) graduated according to family income and size. The Medicaid program would be limited to the aged, blind, and disabled; persons age 65 and over would remain under Medicare.

*Coverage of the population*

Low-income families with children could enroll in the family health insurance plan provided:

(1) their total annual family income does not exceed specified levels and total family resources do not exceed $1,500,

(2) the family member is not covered by Medicare or a required employer plan,

(3) the family includes at least one dependent child under age 18 (or a student under age 22).

Families receiving payments under the (proposed) Family Assistance Plan would automatically be covered (if these payments, including the payments under a State plan supplemental to FAP, are larger than their health insurance premiums).

*Income levels*

Eligibility for coverage would depend on the family's annual income level as follows:

| | |
|---|---|
| One-member family | $2,500 |
| Family of 2 | 3,400 |
| Family of 3 | 4,200 |
| Family of 4 | 5,000 |
| Family of 5 | 5,800 |
| Family of 6 | 6,400 |
| Family of 7 or more | 7,000 |

Both earned and unearned income would be counted in determining family income, including payments under FAP, but food stamps and payments for foster children would not. In determining the $1,500 maximum on family resources, a family's home, household goods and other personal effects would not be counted, nor would property essential to the family's self-support. Eligibility would be redetermined every 6 months. Coverage would end 9 months after notification that a person is no longer eligible (6 months if he becomes eligible for Medicare or is covered under a required employer plan).

*Benefit structure*

The benefits provided under the family health insurance plan are shown in table 1. For the purpose of determining any deductibles and coinsurance amounts which may be applicable (as well as any premiums required, as discussed later) the eligible families are divided into five classes, depending on their income and size, according to the following table:

| Family size | Income class | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| 1 | 0–$500 | $501–$1,000 | $1,001–$1,500 | $1,501–$2,000 | $2,001–$2,500 |
| 2 | 0–1,400 | 1,401–1,900 | 1,901–2,400 | 2,401–2,900 | 2,901–3,400 |
| 3 | 0–2,200 | 2,201–2,700 | 2,701–3,200 | 3,201–3,700 | 3,701–4,200 |
| 4 | 0–3,000 | 3,001–3,500 | 3,501–4,000 | 4,001–4,500 | 4,501–5,000 |
| 5 | 0–3,800 | 3,801–4,300 | 4,301–4,800 | 4,801–5,300 | 5,301–5,800 |
| 6 | 0–4,400 | 4,401–4,900 | 4,901–5,400 | 5,401–5,900 | 5,901–6,400 |
| 7 | 0–5,000 | 5,001–5,500 | 5,501–6,000 | 6,001–6,500 | 6,501–7,000 |

Class 1 families would not be subject to any cost sharing, Class 2 would pay only a hospital deductible, and Class 3 a deductible for various services but no coinsurance. Classes 4 and 5 would be subject to both deductibles and coinsurance. However, no cost sharing requirement would apply to maternity care, well-baby care or family planning services.

*Administration*

The Department of Health, Education, and Welfare would be responsible for general administration of the program including the determination of eligibility and the regulations, standards and hearings procedures for the program. As under the Medicare program, private insurance carriers under agreement with the Department would act as fiscal agents for payment of claims for services and State agencies would determine whether providers of services qualify for participation in the program.

At their option, States could establish supplemental benefit plans to provide benefits additional to those under the national program. The Department would administer these plans on behalf of the State, if the State wished. In this case, the State would pay the cost of its benefits and the Federal Government would pay the administrative cost in connection with these benefits.

Eligible families under the program would have the option of enrolling in a health maintenance organization as a method of receiving the benefits.

*Financing*

The Family Health Insurance Plan would be financed by premium payments from those enrolled families required to pay premiums, and from Federal general revenues.

The amount of the annual premium payment would depend on the class of the family, as described above. The lowest income class (Class 1) would pay no premiums. For others, the premium is shown below.

| | |
|---|---|
| Income class 2 | $25 |
| Income class 3 | 50 |
| Income class 4 | 75 |
| Income class 5 | 100 |

Premium payments could be deducted from the cash benefits payable under the FAP program, the social security program (OASDI) or a State program supplemental to FAP.

Persons who enroll with a health maintenance organization would be required to pay the same premium (if any) for the specified benefits. If the organization provides additional services, or reduces or eliminates the deductible and coinsurance, it may charge an additional reasonable premium.

## PROVISIONS AFFECTING ALL PLANS

*Relationship to other Government programs*

The Medicare program would continue to operate; persons age 65 and over entitled to Medicare benefits would not be eligible under the employer or FHIP plans. The Medicaid program would be limited to the aged, blind, disabled and children in foster care. Most other government programs would not be affected.

*Standards for providers of services*

*Institutions*

Hospitals, extended care facilities and home health agencies would have to meet the same standards as under the Medicare program (see page 73).

*Physicians and dentists*

As under Medicare, physicians and dentists would have to be legally authorized to render services by the State in which they provide their services.

*Other providers*

Providers of outpatient physical therapy services, independent laboratories, and other suppliers of services would have to meet the same requirements as under Medicare.

*Professional standards review organizations (PSRO)*

The bill would apply the provisions of the Professional Standards Review Organizations (PSRO) proposal for Medicare and Medicaid to the required employer plans and FHIP program. The PSRO proposal would establish boards of physicians at the local level to review the quality and appropriateness of services provided and payments claimed by providers of services.

*Reimbursement of providers of services*

*Institutions*

Payments to hospitals, extended care facilities and home health agencies would be based on the "reasonable cost" of services, as under the Medicare law.

*Physicians and other suppliers*

Payments to physicians, dentists, and other health care personnel and suppliers would be based on the "reasonable charges" for their services, as under the Medicare law. However, under the FHIP program physicians and others would have to accept the reasonable charge as their full payment (and could not make additional charges to the patient).

*Health maintenance organizations*

Under the employer plan, health maintenance organizations (HMO's) would be paid on a per capita basis for persons enrolled (as negotiated between the employer and the HMO). Under the FHIP program, HMO's would be paid a prospective per capita rate equal to 95 percent of the estimated amount needed if the services were furnished by other providers in the area.

The HMO could make various arrangements to reimburse its physicians. The physicians could be employees or partners of the HMO, or the organization could make arrangements with physician groups which, in turn, would pay the individual physicians on a fee-for-service or other basis.

Special provisions relating to the rate of retention (the organization's revenue minus its expenses) require that the retention applicable to the FHIP enrollees must be slightly less (90 percent) than the retention rate applicable to other groups enrolled in the organization. Any excess amount must be used to provide additional benefits or reduce premium rates for FHIP enrollees.

*Delivery and resources*

*Health maintenance organizations*

Provision is made for health maintenance organizations—public or private organizations which provide health services to enrollees on a per capita prepayment basis—to participate in the program. As described previously, persons under both the employer and FHIP plans would have the option of enrolling with an HMO. The organization would have to meet the following requirements:

(1) provide all of the services and benefits covered under the program, either directly or under arrangement with others,

(2) assure that health services are furnished promptly and appropriately,

(3) utilize institutions, facilities and health care personnel that meet the standards of the Medicare program and any additional quality standards established by regulation,

(4) demonstrate it is financially responsible and capable of providing comprehensive health care services efficiently and economically,

(5) have not less than 10,000 enrolled members; this requirement may be delayed up to 3 years if the HMO is making progress to reach this number; it also may be waived (for an indefinite period) if, because of geographical location or other circumstances beyond its control, the HMO is unable to comply,

(6) if participating in the FHIP program, at least half of its members have to be persons not covered under FHIP or Medicaid,

(7) have an open enrollment period at least every year,

(8) permit the Department, or its designee, to evaluate the services and records of the HMO.

Any State law or regulation which prevents an HMO from carrying out its agreement with the Department under FHIP would be inapplicable, as would any State law or regulation that limits a physician affiliated with an HMO from delegating certain duties to appropriate personnel.

*Health planning*

The bill would impose the same provisions, if imposed under Medicare and Medicaid, limiting reimbursement to providers of services in connection with their capital expenditures, if these expenditures are not in conformity with the comprehensive plan of a State or area-wide planning agency. These provisions are contained in proposed legislation (H.R. 1).

*Related health bills*

Two related health bills introduced on behalf of the Administration by Senator Jacob K. Javits of New York incorporate several of the recommendations presented by President Nixon in his health message to the Congress on February 18, 1971. S. 1182 would authorize grants, loans and loan guarantees to health maintenance organizations to assist them in their establishment, construction of facilities, and to meet their initial operating costs. S. 1183 would authorize special project and capitation grants to medical and other health profession schools for the education of health professionals; grants to schools and institutions for programs or projects designed to alleviate shortages

of health personnel and improve the delivery of health services; grants, loan guarantees and interest subsidies for the construction of facilities for health education and research; and assumption of loans to health profession students.

COSTS

See Part II, page 86, for the cost estimate of the Byrnes bill.

*Identical bills and cosponsors*

| *Number* | *Sponsors* |
|---|---|
| H.R. 7741 | Mr. Byrnes of Wisconsin (for himself, Mr. Gerald R. Ford, Mr. Betts, Mr. Schneebeli, Mr. Conable, Mr. Chamberlain, and Mr. Pettis) |

TABLE 1.—*Byrnes bill: Benefit provisions under the Family Health Insurance Plan*

| Type of service | Benefits | Cost sharing for income class [1] | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| ***Institutional services*** | | | | | | |
| **Hospital:** | | | | | | |
| Inpatient | 30 days per year. | | | | | |
| Room and board | See above | None | 1-day deductible | 1-day deductible | 1-day deductible | 2-day deductible |
| Other services | See above | None | None | $50 deductible | $50 deductible, 10% coinsurance | $100 deductible, 25% coinsurance |
| Outpatient | No limit | None | None | $50 deductible | $50 deductible, 10% coinsurance. | $100 deductible, 25% coinsurance. |
| Extended care | 3 days in an extended care facility substituted for 1 day of hospital care. | | | | | |
| Room and board | See above | None | 2-day deductible | 2-day deductible | 2-day deductible | 4-day deductible |
| Other services | See above | None | None | $50 deductible | $50 deductible, 10% coinsurance. | $100 deductible, 10% coinsurance |
| ***Personal services*** | | | | | | |
| **Physicians' services:** [2] | | | | | | |
| In hospital, extended care facility or while receiving home health services. | No limit while receiving inpatient hospital, extended care or home health services. | None | None | $50 deductible | $50 deductible, 10% coinsurance. | $100 deductible, 25% coinsurance |
| Outpatient, home or office [3] | 8 visits per year | None | None | $50 deductible | $50 deductible, 10% coinsurance. | $100 deductible, 25% coinsurance. |

TABLE 1.—*Byrnes bill: Benefit provisions under the Family Health Insurance Plan*—Continued

| Type of service | Benefits | Cost sharing for income class [1] | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| *Personal services*—Continued | | | | | | |
| Physicians' services [2]—Continued | | | | | | |
| Emergency services | No limit | None | None | $50 deductible | $50 deductible, 10% coinsurance. | $100 deductible, 25% coinsurance. |
| Maternity care | No limit | None | None | None | None | None |
| Family planning | No limit | None | None | None | None | None |
| Periodic examinations [3] | Birth–6 mos.: 6 exams. 7 mos.–2 yrs.: 6 exams. Age 2–5 yrs.: 3 exams. | None | None | None | None | None. |
| Eye examinations | Children under age 12: 1 exam. per year. | None | None | $50 deductible | $50 deductible, 10% coinsurance. | $100 deductible, 25% coinsurance |
| Home health services | 7 days of home health services substituted for 1 day of hospital care. | None | None | $50 deductible | $50 deductible, 10% coinsurance. | $100 deductible, 25% coinsurance. |
| Laboratory and X-ray | No limit | None | None | $50 deductible | $50 deductible, 10% coinsurance. | $100 deductible, 25% coinsurance. |
| Outpatient physical therapy services | No limit | None | None | $50 deductible | $50 deductible, 10% coinsurance. | $100 deductible, 25% coinsurance. |
| *Other services and supplies* | | | | | | |
| Medical supplies and appliances | No limit | None | None | $50 deductible | $50 deductible, 10% coinsurance. | $100 deductible, 25% coinsurance. |
| Ambulance services | Emergencies only | None | None | $50 deductible | $50 deductible, 10% coinsurance. | $100 deductible, 25% coinsurance. |
| Prosthetic devices | Emergencies only | None | None | $50 deductible | $50 deductible, 10% coinsurance. | $100 deductible, 25% coinsurance. |

[1] The $50 and $100 deductible is the total annual amount payable per family for all services subject to deductibles.

[2] Psychiatric services excluded.

[3] Includes preventive care, immunications and check-ups.

# GRIFFITHS-CORMAN BILL—H.R. 22

H.R. 22, "The Health Security Act," was introduced on January 22, 1971, by Representative Martha W. Griffiths of Michigan and Representative James C. Corman of California. An identical bill, S. 3, was introduced on January 25, 1971, by Senator Edward M. Kennedy of Massachusetts.

*General concept and approach*

The bill would establish a national health insurance program covering the entire population and providing a broad range of health services, with no payment required of the patient. The program would be financed by a Federal payroll tax on employers and employees, a tax on unearned income, and Federal general revenues. The program would be administered by the Department of Health, Education, and Welfare. The proposal includes provisions designed to reorganize the delivery of health services, improve health planning and increase the supply of health care manpower and facilities.

*Coverage of the population*

All residents of the United States would be covered, including aliens admitted as permanent residents or for employment. Alien residents employed by a foreign government or an international organization would be eligible for coverage under special agreements. Persons would be eligible for benefits without regard to whether they have contributed to the program.

*Benefit structure*

Benefits covering nearly all types of recognized health services are provided, with limitations on psychiatric, nursing home, and dental services and on prescription drugs, as indicated in the listing of the major benefits below. There would be no payment required of the patient when the services are furnished.

Institutional services:

General hospital inpatient care

Psychiatric hospital inpatient care: 45 consecutive days in a spell of illness

Hospital outpatient care

Skilled nursing home care: 120 days in a spell of illness; number of days may be increased by regulation for homes owned or managed by a hospital, and for all homes depending on the availability of funds.

Personal services:

Physicians' services (nonpsychiatric)

Physicians' psychiatric services: 20 visits during a spell of illness, but without limit if furnished by a comprehensive health service organization, hospital (on an outpatient basis) or mental health clinic.

Dentists' services: In first year of program for children up to age 15. Each year thereafter, extended to persons 2 years older (e.g., in the second year to age 17) up to age 25. Once eligible, coverage continues throughout lifetime. Cosmetic orthodontia excluded.

Podiatrists' services

Home health services

Laboratory and X-ray

Other personal services: Psychological, physiotherapy, nutritional, social work, health education and related services furnished by an institution, comprehensive health service organization, or other agency under contract.

Other services and supplies:

Optometrists' services and eyeglasses

Medical appliances: Therapeutic devices, appliances, and equipment, as established by regulation. Expenditures to be limited to 2 percent of total expenditures of program, if possible.

Ambulance services: As prescribed by regulations.

Prescription drugs: Drugs required for chronic conditions and for specified conditions involving financial hardship, but without this limitation if provided by a comprehensive health service organization.

Experimental services which, because of cost or shortages, could not be provided on a nationwide basis would be excluded.

*Administration*

The program would be administered by the Department of Health, Education, and Welfare. A 5-member, full-time Health Security Board, appointed by the President with the consent of the Senate, would serve under the Secretary of Health, Education, and Welfare. Board members would have 5-year overlapping terms and no more than three could belong to the same political party. The Board would be responsible for general administration of the program including policy and regulations, control of expenditures, standards and reimbursement for providers of services.

A National Advisory Council, appointed by the Secretary, would advise on general policy, regulations, and allocation of funds. The Council would include the Chairman of the Health Security Board and 20 members including representatives of consumers (who would constitute a majority) and of providers of services.

The program would be administered through the 10 regional offices of the Department and approximately 100 local health service areas. Regional and local advisory councils, comparable to the National Advisory Council, would advise the regional and local offices. Individuals or providers with grievances would be entitled to hearings, appeals and judicial review in Federal courts.

*Relationship to other Government programs*

The Medicare program for the aged is specifically eliminated by the bill. The Federal Government would not financially participate in the cost of covered services for the Medicaid, vocational rehabilitation and maternal and child health programs. (The intent of this provision is that these programs not pay for covered services.) Services under

the CHAMPUS program (for military dependents and retirees) would be limited to noncovered services.

Federal providers of services including the Defense Department, Veterans Administration, and the Department of Health, Education, and Welfare facilities for merchant seamen, Indians and Alaskan natives would not be eligible providers under the national plan. OEO and HEW health centers would be eligible providers. Agencies providing school health services would also be eligible for reimbursement. Medical services under a Federal or State's workmen's compensation law are not affected by the proposal. The bill requires a study of methods of coordinating HEW and the veterans programs with the proposed plan.

*Financing*

The program would be financed by (a) a 1.0 percent tax on wages of employees and on unearned income, (b) a 3.5 percent tax on employers' payrolls, (c) a 2.5 percent tax on self-employment earnings (d) contributions from Federal general revenues equal to the total receipt from taxes.

The total income of an individual subject to tax (from wages, self-employment income and unearned income) would be limited to $15,000 annually. For an employer, the entire payroll would be taxed. In addition to workers under social security, Federal, State and local government employees would be subject to the tax, but State and local governments would not pay the employer tax. Members of the armed forces would not be taxed.

The funds of the program would be held in a Health Security Trust Fund with three accounts: (1) a health service account to pay benefit costs, (2) an account for administrative costs, and (3) a health resources development fund. The present hospital and medical insurance trust funds of Medicare would be transferred to the new trust fund.

*Standards for providers of services*

The standards for participation by providers of services would be similar to those of Medicare, but would also include others as indicated below. (Medicare standards are shown on page 73.) In addition, all providers must agree that (1) services would be furnished without discrimination on the basis of race, color or national origin, (2) no charge would be made to the patient for covered services, and (3) required information and records would be supplied.

*Hospitals*

Standards for general hospitals are similar to those under Medicare, with two additional requirements. Hospitals cannot refuse to grant staff privileges on grounds other than professional qualifications, and they must have a pharmacy (and a committee to supervise drug therapy).

*Skilled nursing homes*

In addition to Medicare standards, nursing homes must be affiliated with a hospital or comprehensive health service organization whose medical staff assumes responsibility for professional services in the nursing home.

*Home health agencies*

Standards are similar to Medicare. Agencies would need to be public agencies or nonprofit organizations.

*Comprehensive health service organization*

To qualify as a comprehensive health service organization, an organization would need to provide services to an enrolled population through prepaid group practice or similar approved arrangements. The organization would be required to furnish all covered ambulatory health services (except mental health and dental services) and could furnish other covered or noncovered services. Premiums or other charges for noncovered services must be reasonable. It must accept all persons in the area who wish to enroll. The organization must provide preventative services, assure continuity of care and make services readily available to enrollees. It must have a committee which would establish medical standards and review utilization and quality of services and would need to meet the general requirements of the program concerning continuing education of professional personnel and other requirements (to be established) concerning quality of care. It must employ paramedical personnel to the extent possible. The organization would have to be nonprofit.

*Medical society foundation*

A medical foundation sponsored by a State or local medical society could qualify as a provider of service. The foundation, which would be organized on a nonprofit basis, would be required to furnish covered physicians' services and could also provide other types of covered and noncovered services. The foundation must permit all qualified physicians to participate (including those not members of the medical society). It would take responsibility for compensating professionals and other providers furnishing services on its behalf.

The foundations would need to meet requirements similar to those for comprehensive health service organizations (described above) regarding open enrollment for the public, reasonableness of charges for noncovered services, and requirements for continuing education and quality of care. (The requirement that services be provided through prepaid group practice or similar arrangements is not applicable to the foundations.) Similar arrangements could be made to establish dental society foundations.

*Other health service organizations*

Other types of organizations, including public or nonprofit agencies which provide comprehensive health care services, but not necessarily to an enrolled population, could qualify as providers. Also, organizations (such as community health centers) could qualify to furnish primary medical care and make arrangements to furnish and coordinate other medical services.

*Professional practitioners*

Physicians, dentists, optometrists, and podiatrists licensed in a State before the start of the program would be eligible to participate, but would need to meet requirements for continuing education established by regulations. National standards for professionals would be established by regulation for those licensed after the program began. A

State-licensed practitioner who met the national standards would be considered qualified in any other State. Major surgery and certain other specialist care could be furnished only by qualified specialists. Services of professional practitioners provided in a nonparticipating hospital would not be covered.

*Other providers*

An independent laboratory or radiology service or a provider of drugs, medical appliances, or ambulance services, would need to meet requirements of State law and additional ones established by regulation.

*Utilization review*

The requirements for utilization review in hospitals and skilled nursing homes include all those of Medicare. In addition, the hospital utilization committee would report its findings, on request, to the Health, Education, and Welfare regional office. For skilled nursing homes, utilization review would be conducted by a State or local public health agency, under contract with the Department, or by the regional office.

For specified types of surgery, prior consultation and approval by a qualified specialist would be required.

Independent physicians and dentists in general practice must maintain records and make reports, as required by regulations, for purposes of medical audit.

*Scope of services*

Participating hospitals and other providers (except individual practitioners) could be directed by the Department to add or discontinue covered services, provide services in a new location, arrange for transfer of patients and medical records, and establish coordination or linkages with other providers. Such an order could be issued only on the recommendation of, or after consultation with, the State health planning agency and is subject to hearings, appeals and judicial review.

*Reimbursement of providers of services*

*National health budget*

Each year, a national health budget for the coming year would be established. The budget would be based on the cost of the program in the current year adjusted for estimated changes in the Consumer Price Index, population, and the number and capacity of providers. Consideration would also be given to the extent to which costs are being controlled by improvements in delivery. However, the budget could not exceed the estimated total receipts for that year from taxes and general revenues.

The budget could be modified if later estimates or experience indicated that tax receipts or expenditures differed significantly from the estimates or if an epidemic or similar event required higher expenditures. A needed increase in a budget would be promptly reported to Congress.

*Allocation of funds*

Funds would be allocated to each region on a per capita basis for institutions, physicians' services, dental services, drugs, appliances,

and other professional and miscellaneous services. The amount for each category would be based on that spent during the past year modified for estimated changes in various factors (as described previously). The regional funds would be further allocated on a similar per capita basis to the health service areas. The bill provides authorization to eliminate unwarranted differences in average costs of health service among the regions by curtailing increases in funds to high expenditure regions and increasing the availability of services in low expenditure regions.

*General hospitals*

Hospitals would receive, after a process of negotiation, a predetermined annual budget under regulations establishing the costs and services to be recognized in the budget. A uniform accounting system would be required. The compensation of professional practitioners (such as pathologists and radiologists) associated with the hospital would be included in the budget.

*Psychiatric hospitals*

A psychiatric hospital rendering primarily active treatment to patients would be paid on the same basis as a general hospital. Those also providing noncovered services (such as custodial care) would be paid a predetermined rate per patient-day for the covered services.

*Skilled nursing homes and home health agencies*

Payments would be based on an annual budget, as for general hospitals.

*Comprehensive health service organizations and medical foundations*

A comprehensive health service organization or medical foundation would receive a per capita amount for enrolled persons for ambulatory services they are required to provide, based on the per capita allocation for the various services in the local area.

If they also provide hospital or nursing home care in their own facilities, they would receive an annual budget amount for these services. If they arrange for hospital or skilled nursing home services through other providers, they would be reimbursed on the basis of an amount per patient-day for services used by their enrollees. The organization or foundation would be entitled to 75 percent of any savings resulting from its lower utilization of institutional services (whether furnished by the organization or through other providers) compared to that of a similar population group.

As an alternative, the payment for hospital and nursing home care would be based on a reasonable per capita payment per enrollee, in which case the organization or foundation would retain any savings resulting from lower than estimated use of these services.

*Other health service organizations*

Other organizations such as health centers and State or local health agencies could be paid by any agreed method, other than fee-for-service. Independent pathology laboratories or radiology services could elect fee-for-service, approved budget, or any other agreed basis. Methods of payment for other types of providers would be specified in regulations.

*Payment to professional practitioners*

The major methods of payment available to physicians, dentists, and other professionals would be fee-for-service, capitation and salary.

Fee-for-service would be generally available to all. The amount of fees would be determined by fee schedules or relative value scales, prescribed by regulation after consultation with representatives of the professions. The administration of fees could be delegated to a medical or professional society (or an agency selected by the society).

Capitation would be available only to independent physicians and dentists in general or family practice. An annual amount would be paid for each person enrolled to receive all services from the practitioner. These professionals could receive fee-for-service payments for services to persons not enrolled with them on a capitation basis.

By agreement with the local or regional office, a practitioner could be paid a full-time salary, or he could receive a part-time salary as a supplement to other methods of compensation. By agreement, specialists could also be paid per session or per case.

From the predetermined fund for physicians, dentists and other professional services for an area (based on the per capita allocation for these types of services in the area), funds would be allocated to professionals selecting salary, capitation and fee-for-service. If, during the year, total payments for fee-for-service were greater than estimated, the amount of the fees would be reduced proportionately.

The law authorizes experimentation with other methods of reimbursement if they would not increase costs.

*Delivery and resources*

*Preparing for the program*

Financial assistance would be provided, before the start of the program, for the purpose of increasing health planning, alleviating shortages and maldistribution of facilities and manpower, and improving the organization and delivery of health services. The appropriations for this purpose would amount to $200 million and $400 million, respectively, for the 2 years before the program begins. In addition, Public Health Service funds for State comprehensive and areawide health planning would be increased to the extent necessary.

After the program starts, all expenditures for improvement in delivery and resources would come from the Health Resources Development Fund (except as noted below). This fund would receive in the first year 2 percent of the total income of the program and this allocation would be increased by 1 percent (at 2-year intervals) until it reached its ultimate rate of 5 percent.

*Health planning*

The bill directs the Department of Health, Education, and Welfare to undertake planning to improve the supply and distribution of manpower and facilities and the organization of health services. State comprehensive health planning agencies (approved under the Public Health Service Act) would be given primary responsibility for coordinating the work of health planning groups within the State and interstate health planning agencies. The Department would assume these functions in States that do not carry out their responsibilities.

The bill states that priority is to be given to the provision of ambulatory services on a comprehensive basis, including the development

of comprehensive health service systems and the strengthening of coordination and linkages among providers of services.

*Comprehensive health service systems*

Grants could be made to a public agency or nonprofit organization for up to 90 percent of the expenses of planning and developing a new comprehensive health service system. In addition, loans could be made for the construction costs of a new system, up to 90 percent of cost. Existing comprehensive health service systems could receive similar development grants and construction loans, for expansion of their facilities, to a maximum of 80 percent of costs.

In addition, the operating deficit of newly established or enlarged comprehensive systems could be paid as long as 5 years, if the system is making progress toward self-support.

Under the special improvement grants provision of the bill, comprehensive systems could receive grants for the (1) purchase of diagnostic and therapeutic equipment, (2) purchase of equipment and other expenses for improving methods of utilization review, budgeting and recordkeeping, and (3) costs involved in improving coordination and linkages of services.

The grants for improvement of coordination and linkages would also be available to all hospitals, nursing homes and other providers of services outside the comprehensive systems.

*Manpower training*

The Health Security Board, consulting with State planning agencies, would establish priorities for education and training of health manpower. Funds for this training would be provided by contracts with educational or other organizations, and allowances could also be paid directly to students. Funds may be provided for the following purposes:

(1) Training of medical students for general or family practice or for specialties in critical shortage.

(2) Training for professional and paramedical occupations, if other Federal financial assistance is not available. Priority would be given to those professionals who agree to work in shortage areas and in comprehensive health service systems.

(3) Development of new kinds of health personnel, especially those useful in connection with comprehensive health service systems. The new occupations could include teaching of personal health care, liaison with health care organizations, and consumer representatives. Under this provision, additional grants could be made to study the usefulness of the new occupations.

(4) For members of disadvantaged groups who are training for health occupations, special remedial education could be provided and additional allowances paid to the students.

*Other Federal assistance*

Financial assistance under the program could not be used to replace funds available under other Federal programs and the Executive Branch of the Government is directed to use these funds to further the objectives of the national program. The Health Security program could loan 90 percent of the non-Federal share (the funds which the sponsor of a project ordinarily contributes) required under another government program. Where a loan has been obtained under another

Federal program, the Health Security program could pay the interest on the loan that exceeds 3 percent.

*Studies*

The bill requires a study of the problems of long-term care including the possibility of providing additional home health services and long-term facilities. A study would also be conducted on the subject of malpractice liability and would include investigation of alternative means of providing protection.

COSTS

See Part II, page 89, for the cost estimate of the Griffiths-Corman bill.

*Identical bills and cosponsors*

| *Number* | *Sponsors* |
|---|---|
| H.R. 22 | Mrs. Griffiths (for herself, Mr. Corman, Mr. Mosher, Mr. Reid of New York, Mr. Blatnik, Mr. Bolling, Mr. Celler, Mr. Conyers, Mr. Dulski, Mr. Edwards of California, Mr. Fraser, Mr. Green of Pennsylvania, Mr. Hathaway, Mr. Hawkins, Mr. Holifield, Mr. Miller of California, Mr. Madden, Mr. O'Hara, Mr. Pepper, Mr. Perkins, Mr. Roybal, Mr. Sisk, Mr. Thompson of New Jersey, Mr. Udall, and Mr. Van Deerlin). |
| H.R. 23 | Mrs. Griffiths (for herself, Mr. Corman, Mr. Mosher, Mr. Reid of New York, Mr. Annunzio, Mr. Bingham, Mrs. Chisholm, Mr. Clay, Mr. Eckhardt, Mr. Harrington, Mr. Hechler of West Virginia, Mr. Howard, Mr. Koch, Mr. Meeds, Mr. Mikva, Mr. Ryan, Mr. Stokes, Mrs. Sullivan, and Mr. Reuss). |
| H.R. 2162 | Mrs. Griffiths (for herself, Mr. Corman, Mr. Mosher, Mr. Reid of New York, Mr. Anderson of California, Mr. Ashley, Mr. Badillo, Mr. Bergland, Mr. Brademas, Mr. Byrne of Pennsylvania, Mr. Carney, Mr. Daniels of New Jersey, Mr. Danielson, Mr. Diggs, Mr. Drinan, Mr. William D. Ford, Mr. Halpern, Mr. Johnson of California, Mr. Mitchell, Mr. Morse, Mr. Moss, Mr. Nix, Mr. O'Neill, Mr. Price of Illinois, and Mr. Pucinski). |
| H.R. 2163 | Mrs. Griffiths (for herself, Mr. Corman, Mr. Mosher, Mr. Reid of New York, Mr. Begich, Mr. Rees, Mr. St Germain, Mr. Sarbanes, and Mr. Vanik). |
| H.R. 2478 | Mr. Helstoski. |
| H.R. 3124 | Mrs. Griffiths (for herself, Mr. Corman, Mr. Mosher, Mr. Reid of New York, Mr. Burton, Mr. Dellums, Mr. Hicks of Washington, Mr. McCormack, Mr. Podell, Mr. Rangel, Mr. Roncalio, and Mr. Seiberling). |

| *Number* | *Sponsors* |
|---|---|
| H.R. 4124 | Mrs. Griffiths (for herself, Mr. Corman, Mr. Mosher, Mr. Reid of New York, Mr. Clark, Mr. Donohue, and Mrs. Hansen of Washington). |
| H.R. 4141 | Mr. Kee. |
| H.R. 5007 | Mr. Nedzi. |
| H.R. 5246 | Mr. Minish. |
| H.R. 7339 | Mrs. Griffiths (for herself, Mr. Corman, Mr. Mosher, Mr. Reid of New York, Mr. Eilberg, and Mr. Scheuer). |
| S. 3 | Mr. Kennedy (for himself, Mr. Cooper, Mr. Saxbe, Mr. Bayh, Mr. Case, Mr. Cranston, Mr. Gravel, Mr. Harris, Mr. Hart, Mr. Hughes, Mr. Humphrey, Mr. Inouye, Mr. Magnuson, Mr. McGovern, Mr. Metcalf, Mr. Mondale, Mr. Moss, Mr. Muskie, Mr. Pastore, Mr. Pell, Mr. Randolph, Mr. Stevenson, and Mr. Tunney). |

# FULTON-BROYHILL BILL—H.R. 4960

H.R. 4960, the "Health Care Insurance Act of 1971," was introduced by Representative Richard H. Fulton of Tennessee and Representative Joel T. Broyhill of Virginia on February 25, 1971. The bill, referred to as the Medicredit proposal, is endorsed by the American Medical Association.

*General concept and approach*

The Medicredit proposal would provide tax credits against individual income taxes to offset, in whole or in part, the premium cost of qualified private health insurance policies. A qualified policy must provide specified basic and catastrophic benefits and the maximum amount of the tax credit would be based on the premium cost of this policy. The amount of the credit for a family would be graduated on the basis of the family's income tax liability (the amount of tax payable for the year) with the larger credits available to lower income groups. Families with little or no tax liability would receive a payment voucher for purchase of the insurance. All persons could voluntarily elect coverage under the plan, except those age 65 and over.

*Coverage of the population*

Since all families and individuals potentially subject to the Federal individual income tax would be eligible, virtually the entire population could voluntarily elect coverage under the plan. However, persons age 65 and over (who would remain under the Medicare program) would not be covered by the proposal.

*Benefit structure*

The amount of the tax credit would be based on the premium cost of a qualified policy which provides specified basic and catastrophic benefits. For the catastrophic benefits, the amount of tax credit would be equal to the full premium cost applicable to those benefits. For the basic benefits (which constitute the major part of the benefit package) the amount of the credit would be equal to the premium only for persons with no tax liability, and would be slowly graduated downward (for each $10 increase in tax liability) with a credit of 10 percent available to those with taxes of $891 or more.

This schedule of credits is applicable to all types of returns including individual returns and joint returns of married couples. In computing the amount of tax liability for Medicredit purposes, the taxes of dependent children would be included (even though the child files

an individual return). Also, the tax liability of a husband and wife filing separate returns would be combined.

The table below shows the percentage of the premium cost of the basic benefits that could be taken as a credit at selected levels of tax liability, as shown in the Medicredit bill. Also a column has been added showing the equivalent adjusted gross income, for a family of four taking the standard deduction, at specified tax liability levels (in 1973 when the Tax Reform Act of 1969 becomes fully effective).

| Amount of tax liability | Amount of adjusted gross income | Amount of tax credit (percent) |
|---|---|---|
| None | $4,000 or less | 100 |
| $100 | $4,710 | 90 |
| $300 | $6,060 | 70 |
| $500 | $7,400 | 50 |
| $700 | $8,720 | 30 |
| $891 | $9,910 or more | 10 |

Individuals or families with no tax liability would receive a voucher certificate which would be accepted by a carrier for the purchase of a qualified insurance policy. Those with tax liability less than the amount of the credit could receive a certificate, or claim the additional credit like an overpayment of taxes.

Taxpayers who elect a tax credit could not claim the health insurance premium as a medical expense deduction for income tax purposes.

*Employer-employee plans*

Under present law, an employer may take the full cost of his premium contributions for health insurance for his employees as a business deduction. Under the proposal, he must maintain a qualified plan (providing the specified benefits) to continue to take a full deduction; otherwise, only one-half the contributions could be taken.

The employee, in computing the amount of premiums against which he may take a tax credit on his personal tax return, would count 80 percent of the employer contribution to a qualified plan (as if it were his own contribution).

*Qualified insurance policy*

As indicated, a qualified policy under the plan would offer specified basic benefits and catastrophic benefits. The policy would need to be guaranteed renewable and benefits could not be refused because of preexisting medical conditions. The benefits of the policy are shown in table 2.

TABLE 2.—*Fulton-Broyhill bill: Benefit provisions under a qualified insurance policy*

| Type of service | Basic benefits | Catastrophic benefits [1] |
|---|---|---|
| Institutional services: | | |
| Hospital inpatient care. | 60 days in a year, subject to a $50 deductible for each stay. | Additional hospital days. |
| Hospital outpatient care. | Subject to 20 percent coinsurance on 1st $500 expenses per family. | None. |
| Extended care..... | 2 days in an extended care facility substituted for 1 day of hospital care, subject to a $50 deductible for each stay. | None. |
| Personal services: | | |
| Physicians' services. | Physicians' services subject to 20 percent coinsurance on 1st $500 of expenses per family. | None. |
| Laboratory and X-ray. | Subject to 20 percent coinsurance on 1st $500 of expenses per family. | None. |
| Other services and supplies: | | |
| Medical appliances. | None..... | Prosthetic appliances. |
| Blood..... | None..... | Blood in excess of 3 pints. |

[1] Payable after family meets a corridor deductible (see text).

The family's total payment for coinsurance under the basic coverage for physicians', laboratory, and X-ray services combined would be limited to $100 annually (20 percent of the first $500). An additional limit of $100 annually would apply to hospital outpatient services.

Benefits under the catastrophic coverage (which applies to additional hospital days, prosthetic appliances and blood) would first become payable after a corridor deductible (out-of-pocket payment) which would vary according to family income. Cost sharing payments made under the basic plan would be creditable toward meeting the corridor deductible under the catastrophic plan. The deductible would be based on the family's taxable income (after exemptions and deductions) including the income of dependents. It would be an amount equal to 10 percent of the first $4,000 of taxable income, 15 percent of the next $8,000 and 20 percent of any additional income. The following table shows for 1973 the amount of the deductible for a family of four with specified adjusted gross income taking the standard deduction (or itemized deductions equal to 15 percent of income).

| Adjusted gross income: | *Deductible* |
|---|---|
| $4,000 or less | None |
| 5,000 | $100 |
| 7,500 | 338 |
| 10,000 | 625 |
| 15,000 | 1,400 |
| 20,000 | 2,250 |
| 25,000 | 3,100 |

*Administration*

Persons would purchase qualified health insurance from private health insurance carriers who would issue policies, collect premiums (or vouchers) and process claims for benefits.

State insurance departments would determine whether insurance carriers and policies are qualified under the Medicredit program. Carriers would be required to participate in assigned-risk pools and accept the poor risks assigned them by the State insurance departments.

The Department of Health, Education, and Welfare would issue and redeem the health insurance voucher certificates. Also at the national level, a Health Insurance Advisory Board would be established, consisting of the Secretary of Health, Education, and Welfare (chairman), the Commissioner of Internal Revenue and nine additional members (the majority of whom would be physicians) appointed by the President with Senate approval. The Board would establish the regulations for the administration of the program and issue the Federal standards to be used by the State insurance departments in determining whether insurance carriers and policies are qualified. In consultation with carriers, providers, and consumers, it would study methods to maintain the quality of care and the effective use of resources through utilization and peer review.

*Relationship to other government programs*

The bill provides that benefits claimed under Medicredit may not be duplicated under other programs financed by the Federal Government. The Medicredit proposal would affect the Medicaid and other assistance programs by covering those services for the low-income population that were provided by the assistance programs.

*Financing*

The Medicredit program would be financed from Federal general revenues. The granting of tax credits would result in a reduction in Federal income tax receipts and the voucher certificates would be redeemed from general revenues through a special trust fund created for this purpose.

*Standards and reimbursement of providers of services*

The bill includes a clause which prohibits Federal supervision and control over the practice of medicine, the manner in which services are provided, the selection or compensation of providers of services, or the operations of providers of services.

The insurance carriers participating in the program would reimburse the providers of services. The bill requires that payment for services under the program must be on the basis of usual and customary charges.

*Delivery and resources*

There are no specific provisions regarding these subjects.

COSTS

See Part II, page 93, for the cost estimate of the Fulton-Broyhill bill.

*Identical bills and cosponsors*

| *Number* | *Sponsors* |
|---|---|
| H.R. 4901 | Mr. Abernethy. |
| H.R. 4960 | Mr. Fulton of Tennessee (for himself, Mr. Broyhill of Virginia, Mr. Watts, Mr. Flowers, Mr. Minshall, Mr. Jarman, Mr. Sikes, Mr. Carter, Mr. Addabbo, Mr. Kuykendall, Mr. Lennon, Mr. Derwinski, Mr. Thompson of Georgia, Mr. Wampler, Mr. Casey of Texas, Mr. Findley, Mr. Fuqua, Mr. Don H. Clausen, Mr. Burleson of Texas, Mr. Duncan, Mr. Kyl, Mr. Bow, Mr. Michel, Mr. Brown of Ohio, and Mr. Conable). |
| H.R. 4961 | Mr. Fulton of Tennessee (for himself, Mr. Broyhill of Virginia, Mr. Bevill, Mr. Byrne of Pennsylvania, Mr. Gubser, Mr. Stubblefield, Mr. Teague of California, Mr. Bennett, Mr. Collier, Mr. Shriver, Mr. Dorn, Mr. Baring, Mr. Wyatt, Mr. Camp, Mr. Bray, Mr. Cederberg, Mr. Pettis, Mr. Nelsen, Mr. Andrews of North Dakota, Mr. Downing, Mr. Giaimo, Mr. Esch, Mr. Goodling, and Mr. Haley). |
| H.R. 4962 | Mr. Fulton of Tennessee (for himself, Mr. Broyhill of Virginia, Mr. Griffin, Mr. Zion, Mr. Fisher, Mr. Henderson, Mr. Byron, Mr. Pelly, Mr. Hull, Mr. Wylie, Mr. Tiernan, Mr. Mizell, Mr. Kyros, Mr. Myers, Mr. Yatron, Mr. McCollister, Mr. Harsha, Mr. Abbitt, Mr. Sebelius, Mr. Miller of Ohio, Mr. Robinson of Virginia, Mr. Bob Wilson, Mr. Powell, Mr. Davis of Wisconsin, and Mr. O'Konski). |
| H.R. 4963 | Mr. Fulton of Tennessee (for himself, Mr. Broyhill of Virginia, Mr. Steiger of Arizona, Mr. Johnson of Pennsylvania, Mr. Ruth, Mr. Broyhill of North Carolina, Mr. Jones of Tennessee, Mr. Frey, Mr. Ashbrook, Mr. Rhodes, Mr. McClure, Mr. King, Mr. Thone, Mr. Belcher, Mr. Nichols, Mr. Talcott, Mr. Snyder, Mr. Hillis, Mr. Chappel, Mr. Carey of New York, Mr. Hogan, Mr. Kemp, and Mr. Springer). |
| H.R. 5487 | Mr. Tiernan. |
| H.R. 5711 | Mr. Quillen. |

| *Number* | *Sponsors* |
| --- | --- |
| H.R. 6372 | Mr. Fulton of Tennessee (for himself, Mr. Blanton, Mr. Baker, Mr. Buchanan, Mr. Burke of Florida, Mr. Bryon, Mr. Hansen of Idaho, Mr. Arends, Mr. Scherle, Mr. Mayne, Mr. Caffery, Mr. McDonald of Michigan, Mr. Bloomfield, Mr. Ruppe, Mr. Montgomery, Mr. Galifianakis, Mr. Taylor, Mr. Latta, Mr. Spence, Mr. Dorn, Mr. Price of Illinois, Mr. Whitehurst, and Mr. Scott). |
| H.R. 7124 | Mr. Whitten. |
| S. 987 | Mr. Hansen (for himself, Mr. Baker, Mr. Beall, Mr. Bennett, Mr. Dole, Mr. Dominick, Mr. Eastland, Mr. Fannin, Mr. Goldwater, Mr. Gurney, Mr. Hruska, Mr. Jordan, Mr. Thurmond, and Mr. Tower). |

# BURLESON BILL—H.R. 4349

H.R. 4349, the "National Healthcare Act of 1971," was introduced by Representative Omar Burleson of Texas on February 17, 1971. It is endorsed by the Health Insurance Association of America.

*General concept and approach*

The bill provides three voluntary health insurance plans to make coverage available to almost the entire population. The plans include: (1) an employee-employer plan, (2) an individual plan, and (3) a plan for the poor and uninsurable. All plans would provide after a phasing-in period a broad range of medical care services, with benefits generally subject to cost sharing by the patient. Also, all plans would be administered through private insurance carriers, supervised by the State and Federal Governments. The employee-employer plan and the individual health plan would be financed by premium contributions, and contributors would receive tax advantages. The plan for the poor would be financed mainly by Federal and State general revenues. The bill includes provisions designed to increase the supply of health manpower, the development of ambulatory care centers and the expansion of health planning.

The relationship to other government programs, reimbursement, standards for providers of services, and delivery and resources are similar for all three plans. The program would begin in July 1972 for the poor and January 1973 for the other plans.

## EMPLOYEE HEALTHCARE PLAN

The employee healthcare plan would, through use of the tax mechanism, encourage employers to provide qualified health insurance plans with specified benefits for employees and their dependents. Private insurance carriers would collect the premiums and process the claims for benefits. The premiums would be paid by the employer and employees, as arranged between them. The plan would be supervised by State insurance departments. The Federal Government would determine the status of a plan under the tax laws.

*Coverage of the population*

Persons working for employers who voluntarily establish a qualified plan would be covered. Such a plan must cover all full-time and part-time employees (who work at least 20 hours a week for at least 26 weeks during the year) and their dependents. New employees must be covered within 3 months. Coverage under the plan would continue, as follows:

(1) 3 months after termination of employment, if the employee pays the total employee-employer premiums for the 3-month period on the last day of work.

(2) 12 months during a layoff or labor dispute, if the employee pays the employee contribution for the first month and the total employee-employer contributions for later months, when due.

(3) 24 months if absent because of illness or disability, if the employee pays the employee contributions when due.

(4) 3 months of coverage for the surviving family in case of the employee's death, if the total employer-employee premium for the 3-month period is paid by the survivors within 15 days of death.

*Benefit structure*

Under present law an employer may take the full cost of his premium contributions for health insurance as a business deduction for tax purposes. Under the bill unless an employer has a qualified plan, he may take only one-half of his premium contributions as a business expense. If a medical care plan established through a collectively bargained agreement was in effect when the program started, this provision would not apply until the expiration of the agreement, but not later than 3 years after the program started.

In addition, under present income tax law, employees and other persons who itemize their deductions on their individual income tax returns may deduct one-half of the premiums for private health insurance up to a maximum of $150, with the remainder deductible only to the extent that total medical expenses exceed 3 percent of adjusted gross income. Under the proposal, the employees who itemize may take their entire contributions toward a qualified plan as a medical expense deduction.

The required standard health care benefits are shown in table 3. These benefits would be phased-in, with Priority I benefits becoming available at the start of the program; Priority II, 3 years later; and Priority III, 6 years later. If the Health Council (established under the bill) advises that facilities and services are not available, the President may defer the phasing-in of benefits.

In lieu of the specific dollar co-payments applicable to various services, coinsurance up to 20 percent may be required (except where a higher coinsurance percentage is specified in the table). Also, in addition to the other requirements, an annual deductible of up to $100 per family may be imposed, but the deductible for a service cannot be larger if given on an ambulatory basis rather than in an institution. The total payment for a family for all cost sharing (deductibles, co-payments and coinsurance) is limited to $1,000 in a year.

The plan may provide benefits in addition to those required under a qualified policy.

*Administration*

Employers would purchase qualified policies from private insurance companies which would collect the premiums and process the claims for benefits. The policies must be approved by the State insurance department as satisfying the requirements for a qualified policy. The Department of the Treasury may accept the approval of the State insurance department in determining the tax status of the premiums for income tax purposes.

*Financing*

The premiums for an employee plan would be paid by employers to the insurance carrier. As arranged between employers and employees, the employees may be required, without limitation on the amount, to contribute to the premiums.

### INDIVIDUAL HEALTHCARE PLAN

The individual healthcare plan would provide income tax incentives to encourage the purchase of individual (nongroup) qualified insurance providing specified health insurance benefits. The premiums would be paid by the policyholder. The State and Federal Governments would have supervisory responsibilities similar to those under the employee plan.

*Coverage of the population*

All persons would be eligible to voluntarily purchase a qualified individual healthcare policy for themselves and their families. This plan would make qualified insurance available to self-employed persons and others not eligible under the employee or State plans.

*Benefit structure*

Persons purchasing a qualified individual policy may, if they itemize their deductions on their personal income tax return, take the entire premium cost as a medical expense deduction (as explained previously for employee contributions toward a plan).

The medical care benefits of an individual policy are identical to those under the employee plan and would be phased-in at the same time (table 3). As in the employee plan, coinsurance up to 20 percent may be substituted for the co-payments applicable to the various benefits and an additional deductible may be imposed (which must not be larger for ambulatory than for institutional care). For an individual plan, no limit is placed on the amount of this deductible or on the total amount of cost sharing that could be required in a year.

The policy could include benefits in addition to those required under a qualified policy.

The insurance policy must be renewable, but the insurance carrier may adjust the premium rates for a class of policies according to the experience for that class. Coverage under the policy ends when the policyholder becomes covered under another type of qualified policy or becomes eligible for Medicare benefits.

*Administration*

The individual would purchase the insurance from a private insurance carrier. Policies must be approved by the State insurance department as being qualified and the Treasury Department may accept this approval in determining the tax deductibility of the premium cost.

*Financing*

The policyholder would pay the entire premium cost to the insurance carrier.

STATE HEALTH CARE PLAN

The State health care plan is designed to provide the standard benefits for the needy, the uninsurable and certain others. It would be administered by a private insurance carrier (or group of carriers) in each State and financed by premium payments from covered persons and contributions from State and Federal general revenues. States that did not establish a plan could not receive Federal funds due them under the Federal-State Medicaid and maternal and child health programs.

*Coverage of the population*

Coverage under the State health care plan would be available to the groups of persons indicated below.

(1) *Needy persons.*—Individuals and families could voluntarily enroll in the State plan if their adjusted gross income for income tax purposes was less than the following amounts:

| | |
|---|---|
| Individual | $3,000 |
| Family of two | 4,500 |
| Family of three or more | 6,000 |

Public assistance recipients would be eligible for coverage under the State plan without regard to their actual income. Persons eligible under a qualified employee health care plan could not elect the State plan.

(2) *Uninsurable persons.*—Coverage under the State plan would be available on a voluntary basis to persons who are not eligible under a qualified employee plan and cannot obtain a qualified individual policy because they are uninsurable (usually because of poor health). The person is considered uninsurable if he applies to three insurance carriers who either refuse to issue a policy or offer one at a premium cost greater than twice that of the State plan.

(3) *Special groups.*—Groups of persons who are receiving substantially all their medical care under a Federal or State program may be enrolled as a group under the plan. (These could include, for example, dependents of servicemen and inmates of an institution.) Under this provision (which does not apply to public assistance recipients as a group) the Federal or State Government would pay the entire premium for the group.

*Enrollment*

Families and individuals may voluntarily enroll by filing application with an administering carrier during an open enrollment period each year. Those becoming eligible later may apply within 30 days of their eligibility. Public assistance cash recipients must be enrolled by the State public assistance agency. Coverage for all enrollees continues for the balance of the policy year regardless of change in the eligibility status of an individual family member.

*Benefit structure*

The benefits under the State plan would be phased-in earlier than for the other plans, with Priority II benefits effective at the start of the program and Priority III, 4 years later. A delay by the President in the phase-in of benefits would also apply to these benefits, as described earlier. The same cost sharing requirements applicable to the other plans apply to the State plan, but special provisions limit the total amount of cost sharing to $30 in a year for individuals and families having adjusted gross income less than the specified amounts shown below.

| | |
|---|---|
| Individuals | $2,000 |
| Family of two | 3,000 |
| Family of three or more | 4,000 |

For those with higher income, the maximum amount of cost sharing would be limited to 6 percent of their income over these specified amounts (but not less than $30). For example, a family of three or more with income of $5,000 would pay a maximum of $60 (6 percent of $1,000).

The State plan could provide benefits in addition to the standard benefits, but the Federal Government would not share in the cost of additional benefits.

*Administration*

The State plan would be administered by an insurance carrier under an agreement between a State and the carrier, with the approval of the Department of Health, Education, and Welfare. The administering carrier could be a commercial insurance company, a service benefit organization, or any of several other types. The administering carrier would determine eligibility for enrollment in the plan, collect the premiums and government contributions, process claims for benefits, pay providers of services and administer the State plan insurance pool. Individuals and families enrolled in the plan would be issued health insurance policies.

The operation of the plan would be under the supervision of the State insurance department, and payment to providers would need to meet the standards of the State Cost Commission.

At the Federal level, the Department of Health, Education, and Welfare would issue regulations for operation of the plan. These regulations would need to be issued in final form at least 9 months before the policy year to which they apply.

As a condition of receiving Federal Government contributions for the State plan, the State must agree that it will not impose a tax on premiums or a similar tax on the State plan, and that it will levy taxes on health insurance business in the State equally on all carriers.[1]

*Financing*

The State plan would be financed by premium payments of enrolled families, graduated according to income, and by contributions from State and Federal general revenues.

The amount of the full premium would be determined for each family size by the administering carrier. The full premium would be an amount actuarially sufficient to meet the total cost of the program. The premium amount would be based on the previous year's experience (adjusted for estimated increase in costs) and would include an allowance for the benefit cost and for costs of administration, and a risk charge equal to 1 percent of the benefit cost. It would also include an allowance for repayment in full of State insurance pool losses for past years.

The premium rates determined by the carrier would be reviewed by the Chief Actuary of the Social Security Administration, who could recommend a reduction to the Department of Health, Education, and Welfare. If so, at the request of the State, a hearing would be held before a board of three actuaries appointed by the Department (including one with the concurrence of the State and one with the con-

[1] In many States, Blue Cross and Blue Shield are exempt from premium taxes and other taxes applicable to other carriers.

currence of the carrier). If the hearing board determined the premium rates were too high, the Federal contributions to the State plan could be reduced.

*Contributions of policyholders*

Policyholders would pay a premium based on their adjusted gross income. Needy persons under the State plan would not pay any premium if their income for the year was below the amounts specified below:

| | |
|---|---|
| Individuals | $2,000 |
| Families of two | 3,000 |
| Families of three or more | 4,000 |

Those with income above the specified limit would pay 18 percent of the amount above this limit. For example, a family of three or more with an income of $5,000 would pay $180 (18 percent of $1,000) toward the premium.

Uninsurable persons under the State plan would pay the full premium rate. The State and Federal Governments would pay the rest of the premiums of the State plan—in effect, the premiums for those who do not contribute and the balance of the premiums for those who pay part. Thus, the plan would receive a full premium for all enrolled persons. The Federal share of the total government contribution would be 70 to 90 percent, depending on the per capita income of the State.

*State insurance pool*

The premiums and other income of the plan would be deposited in a State insurance pool from which all benefits and expenses of the plan would be paid. The pool would be reinsured by all health insurance carriers licensed in the State and if the pool suffered a loss in the year, the loss would be borne by the carriers according to an agreed formula, up to a maximum of 3 percent of premiums. Any additional loss would be absorbed by the State and Federal Governments (according to the sharing formula). If the pool showed a gain, it would be retained by the pool and used to reduce the State's future premium contributions to the pool.

*Provisions for the aged*

Persons age 65 and over could be covered under the State plan under special provisions applicable to that group. Aged persons must be enrolled in the voluntary supplementary medical insurance plan (Part B) of Medicare to be eligible for State plan coverage. If their income is above the specified limits, so that they would be required to pay premiums, the amount of the premium would be reduced by the amount of the Part B premium. If their income is below the specified limits, the State would pay the Part B premium on their behalf from State general revenues. The Medicare program would continue to operate and would have initial liability in paying for services.

*Relationship to other Government programs*

As indicated, the Medicare program would continue to operate. The proposal specifies that the Medicaid and maternal and child health programs would not pay for medical services provided under a State plan, nor for cost sharing required by the plan. Most other government programs would not be affected.

*Standards for providers of services*

*Institutions*

Health care institutions (hospitals, extended care facilities and home health agencies) would have to meet the same standards as under the Medicare program (see page 73).

*Health maintenance organizations*

Health maintenance organizations which furnish health care services to enrollees on a per capita prepayment basis would be required to meet quality standards established by regulation.

*Physicians and dentists*

Physicians and dentists would have to be legally authorized to render services by the State in which they provide their services.

The bill does not specify any standards for independent laboratories, optometrists, independent speech and physical therapists, or drug providers.

*Reimbursement of providers of services*

*Institutions*

Payments to health care institutions (hospitals, extended care facilities and home health agencies) would be based on prospectively approved rates for different categories of institutions. Institutions would be required to prepare a budget, based on a standard accounting system, and recommend a schedule of charges which would apply to all patients. Annually, a State Healthcare Institutions Cost Commission, following its review of the budgets and proposed charges, would determine the rates.

The charges for services would need to be reasonably related to the cost of efficient production of the services. In its review, the Commission would take into account economic factors in the area, costs of comparable institutions providing comparable services, capital requirements and the need for incentives to improve service and institute economies.

The State Commission could approve the use of a single charge for a group of services commonly rendered to a class of patients, or a single all-inclusive daily charge for all inpatient services. The level of rates approved for different categories of institutions would be reviewed by the Department of Health, Education, and Welfare. If the Department determined the rates for a given category were unjustifiably high in relation to other States, Federal funds for Medicaid and for the State plan under this proposal would be reduced.

Health maintenance organizations would be paid on the basis of per-capita charges, which could not exceed the regular premiums for the plan.

*Physicians and dentists*

Payment to physicians, dentists and other health care personnel would be based on reasonable charges, taking into account the customary charge of the practitioner and the prevailing charge in his locality. Payment could not exceed the prevailing charge (which would be set at 75th percentile of the distribution of actual charges made for similar services during the previous year).

*Other Government programs*

Payments to providers for reasonable costs or reasonable charges under the Medicare, Medicaid and maternal and child health programs could not exceed the reasonable cost or charge as determined under the proposal.

*Delivery and resources*

*Health maintenance organizations*

Provision is made for health maintenance organizations—organizations which provide health care services to enrollees on a per capita prepayment basis—to participate in the program. A health maintenance organization would have to provide—either directly or under arrangements—all of the standard health care benefits.

The State plan and employee plans must make health maintenance organizations available as an option for those enrolled in the plans. For an individual plan, the policyholder could select a health maintenance organization.

*Comprehensive ambulatory healthcare centers*

The bill includes provisions designed to encourage development of comprehensive ambulatory health care centers. These are facilities (located in or apart from a hospital) that are organized to provide a broad range of ambulatory health services and that have the following services and facilities:

(1) Medical, surgical and preventive care services, including health education.

(2) Arrangements for treatment at a general hospital and other institutions when inpatient care is needed.

(3) Operating and recovery rooms.

(4) Laboratory and X-ray facilities.

(5) Unified medical records.

(6) Peer review programs.

(7) A plan to use allied health personnel.

Grants, loans and loan guarantees are authorized for the construction or modernization of centers in areas designated by the State comprehensive health plan, and to pay their operating deficits for the first 3 years of operation. Priority would be given to putting facilities in densely populated areas where none exist. Special project grants are authorized for training personnel to staff the centers, as described below.

*Health planning*

(1) A Council of Health Policy Advisors to the President would be created for the purpose of (a) recommending improvements in the organization, financing, delivery, and quality of health care; (b) recommending guidelines for the allocation of funds for health care; and (c) appraising Federal health programs and recommending procedures for interagency coordination.

(2) The bill increases appropriations under existing Federal programs for grants for comprehensive health planning at the State and local level and expands the scope of planning agency responsibilities.

(3) Comprehensive health planning agencies would have to certify as to the need for the health project before grants, loans or other financial aid in excess of $100,000 could be made under Federal programs.

*Health manpower*

(1) The bill expands the student loan provisions of the Public Health Service Act for training in the health professions by removing the dollar limit on loans and allowing the loan to cover the full cost of tuition and fees, room and board, supplies, books and other related costs. For physicians, dentists and optometrists, 20 percent of the student loan would be cancelled for each year of practice (up to 100 percent) in an area certified by the State planning agency to have a shortage of such personnel.

(2) Similar loans are provided for the training of nurses and allied health professions. If the person after graduating is employed full-time in these occupations, 20 percent of the loan may be cancelled each year (up to 50 percent of the total loan). If employed in a shortage area, one-third of the loan may be cancelled each year (up to 100 percent of the total loan). The bill also provides for scholarship grants to students training in allied health professions, covering the full cost of tuition and other student expenses.

(3) Grants are provided to trained health professionals, allied health professionals or nurses for serving in areas of critical need for at least 2 years. These individuals would receive guaranteed income payments equal to 110 percent of the annual median income for persons of comparable education and training, or 110 percent of their own earnings in the previous year, whichever is greater.

(4) Special project grants are provided to schools of medicine, training centers for allied health professionals and other educational institutions to develop and evaluate curriculums to train and coordinate teams of personnel to staff ambulatory health care centers.

COSTS

See Part II, page 96, for the cost estimate of the Burleson bill.

*Identical bills and cosponsors*

| *Number* | *Sponsors* |
|---|---|
| H.R. 4349 | Mr. Burleson of Texas (for himself, Mr. Roberts, Mrs. Chisholm, Mr. Garmatz, Mr. Fuqua, Mr. Lennon, Mr. Gallagher, Mr. Yatron, Mr. Abbitt, Mr. Sikes, Mr. Carter, Mr. Byrne of Pennsylvania, and Mr. Casey of Texas). |
| H.R. 4980 | Mr. Jarman. |
| H.R. 5227 | Mr. Halpern. |
| H.R. 5984 | Mr. Monagan. |
| S. 1490 | Mr. McIntyre (for himself, Mr. Fannin, Mr. Hruska, Mr. McGovern, Mr. Metcalf, Mr. Pastore, and Mr. Stevens). |

TABLE 3.—*Burleson bill: Standard health care benefits*

| Benefit | Cost sharing | Benefits and effective date | | |
|---|---|---|---|---|
| | | Priority I | Priority II | Priority III |
| | | Private plans 1/73 | State plans 7/72, Private plans 1/76 | State plans 7/76, Private plans 1/79 |
| **INSTITUTIONAL SERVICES** | | | | |
| Hospital: | | | | |
| Inpatient [1] | $10, 1st day, then $5 per day. | 30 days per illness | 120 days per illness | 300 days per illness. |
| Outpatient [2] | | | | |
| Extended care: Inpatient [1] | $2.50 per day | 60 days per illness | 120 days per illness | 180 days per illness. |
| **PERSONAL SERVICES** | | | | |
| Physicians' services: | | | | |
| In hospital | $2 per day | 30 days | 120 days | 300 days. |
| | $5 per day | After 30 days | After 120 days | After 300 days. |
| In extended care facility | $2 per day | 60 days | 120 days | 180 days. |
| | $5 per day | After 60 days | After 120 days | After 180 days. |
| Office visits: | | | | |
| Diagnosis-treatment | $2 per visit (mental—50 percent after 6th visit). | 3 visits per year | 6 visits per year | No limit. |
| Surgery and radiation therapy | $2 per visit | No limit | No limit | No limit. |
| Laboratory and X-ray | None | No limit | No limit | No limit. |
| Family planning | None | None | No limit | No limit. |
| Periodic exams: | | | | |
| Under age 5 | None | 6 exams (birth to 6 months). | 6 exams (age 7 months to 2 years). | 3 exams (age 2 to 5 years). |
| Age 5 to 39 | None | None | None | 1 exam. every 5 years. |
| Age 40 and over | None | None | None | 1 exam. every 2 years. |
| Eye examinations: | | | | |
| Under age 19 | None | None | None | 1 exam. per year. |
| Age 19 and over | 50 percent | None | None | 1 exam. every 3 years. |
| Home visits | $5 per visit (mental 50 percent). | None | None | No limit. |

| | | | | |
|---|---|---|---|---|
| Dentists' services: | | | | |
| Examination: | | | | |
| Under age 19 | None | None | 1 exam. per year | 1 exam. per year. |
| Age 19 and over | None | None | None | 1 exam. per year. |
| Fillings, extractions, and dentures: | | | | |
| Under age 19 | 20 percent | None | No limit | No limit. |
| Age 19 and over | 20 percent | None | No limit | No limit. |
| Other [3] | 50 percent | None | No limit | No limit. |
| Home health services | $2.50 per day | 90 days | 180 days | 270 days. |
| Independent laboratory | None | No limit | No limit | No limit. |
| Optometrist, eye examination [3] | | | | |
| Physical therapy | 20 percent | None | No limit | No limit. |
| Speech therapy | 20 percent | None | None | No limit. |
| **Other Services and Supplies** | | | | |
| Prescription drugs | $1 per prescription | None | No limit | No limit. |
| Contraceptives | None | None | No limit | No limit. |
| Prosthetic appliances [4] | 20 percent | None | No limit | No limit. |
| Eyeglasses: | | | | |
| Under age 19 | None | None | None | 1 pair per year. |
| Age 19 and over | 50 percent | None | None | 1 pair in 3 years. |
| Pregnancy: Physicians' services, hospital, extended care, independent laboratory, home health services. | 20 percent | None | 9 months prior to and 3 months after end of pregnancy. | |

[1] 2 (or more) separate stays considered a single period of illness unless separated by 60 days or more.
[2] Same as equivalent service rendered as in-office physicians' service.
[3] Orthodontia excluded.
[4] Hearing aids excluded.

# DINGELL BILL—H.R. 48

H.R. 48, the "National Health Insurance Act," was introduced on January 22, 1971, by Representative John D. Dingell of Michigan. It is similar to the Wagner-Murray-Dingell national health insurance proposal originally introduced in 1943.

*General concept and approach*

This proposal would establish a national health insurance program covering almost all residents of the United States. Standard benefits are broad and they would be financed through payroll taxes and Federal-State general revenues. The program would be administered by the Federal Government but would be decentralized with major administrative responsibilities placed at the State and local level. The bill contains provisions designed to improve the supply, quality, and distribution of health manpower and facilities.

*Coverage of the population*

Virtually all U.S. residents would be covered. Almost all employees and self-employed persons would be covered and all persons eligible for social security benefits would be protected. Funds appropriated for various Federal-State health care programs could be used to obtain coverage for recipients of public assistance and the unemployed.

*Benefit structure*

The proposal permits broad medical benefits but, in implementing the program, benefits would be made available in accordance with a State plan. The standard benefits are:

Institutional services:
- General hospital inpatient care: 60 days
- Psychiatric and tuberculosis hospital care: 30 days; length of stay can be extended by regulation if funding and facilities are adequate
- Hospital outpatient care

Personal services:
- Physicians' services
- Dentists' services
- Physical checkups: periodic medical and dental examinations
- Home health services
- Podiatrists' services
- Optometrists' services and eyeglasses
- Laboratory and X-rays
- Physical therapy and related services

Other services and supplies:
- Medical appliances
- Prescription drugs: types of drugs which are unusually expensive

If the National Health Insurance Board in consultation with the National Advisory Medical Policy Council (both created by this

bill) finds that available resources are inadequate to provide dental, home health or certain other specified services, it may limit these services for a period. In the case of dental services, priority would be given to children. The bill does not provide coverage for nursing home care.

*Administration*

The program would be administered at three levels of government—Federal, State and local—with the major operating responsibility falling to the State and local jurisdictions. Each State would evaluate its health resources and capabilities and, in accordance with national guidelines, would develop a health care plan. The State plans would be submitted to the National Health Insurance Board and, when approved, the Board would contract with the State for the administration of the program within that State.

*Federal level*

A National Health Insurance Board with five members would be established in the Department of Health, Education, and Welfare. Three members would be appointed by the President to serve with the Surgeon General and the Commissioner of Social Security. The Board would establish the regulations and standards for the program, supervise the States and allocate funds. If the Board finds that a State is not complying with the provisions of its plan, the Board can administer the program in that State.

A National Advisory Medical Policy Council would be established, consisting of the chairman of the National Board and 16 members appointed by the Secretary of Health, Education, and Welfare. At least eight members would serve as consumer representatives and at least six as representatives of providers of medical services. The Advisory Council would advise the Board on matters of general policy and administration, establishment of professional standards and other matters.

*State level*

The administrative agency in each State would, if possible, be the same agency that administers its public health or maternal and child health programs. State plans would:

(1) provide for a State advisory committee with a majority of members representing consumers and the remaining members representing providers,

(2) establish local health-service areas and provide methods for selecting their advisory committees,

(3) provide for surveys of resources and needs of the State,

(4) give assurance that maximum use would be made of available health personnel and facilities and that funds would be allocated to local areas in such a way as to correct maldistributions and inadequacies.

Local area agencies, with the assistance of a similar advisory council representing consumers and providers, would administer the program at the local level, make payment to providers and carry out related administrative duties.

*Relationship to other Government programs*

Initially, aged persons could receive those benefits of the program not provided under Medicare. The Department of Health, Education,

and Welfare would be required to study the relationship between the national health insurance plan and the Medicare program and devise methods of incorporating Medicare into the national plan. Funds appropriated for Medicaid and other Federal-State assistance programs could be used by States to finance the cost of covering needy persons who do not make regular contributions required by the program.

*Financing*

A Personal Health Service Account would be established to hold the funds of the national program. The account would receive an amount equal to 3 percent of total earnings. (The definition of earnings would be the same as under the social security law.) In addition, for the specific purpose of financing the cost of dental, home health and certain other services, the account would receive an additional amount equal to one-half of 1 percent in the first year of the program. This additional amount would increase to an ultimate rate of 1 percent in the third year. Further, in the first year of the program, an additional 1 percent of earnings would be appropriated as a reserve and the bill authorizes any additional funds required to meet expenditures. While the bill does not specify the source of any of these funds, the apparent intent is that they be obtained from a payroll tax on employers and employees covered under social security.

*Standards for providers of services*

Standards of participation for providers of services under the program would include the following:

*Hospitals and institutions*

Hospitals or institutions qualified under State standards could participate in the program. If a State has not established standards, the National Board would establish them for the State.

*Professional practitioners*

Physicians, dentists, and podiatrists legally authorized to practice in a State would qualify. Specialists would be required to meet standards established by regulation.

*Nurses*

Professional nurses registered in the State would qualify. Practical nurses qualified under State standards or standards established by regulation could provide home health services.

*Reimbursement of providers of services*

The National Board would allocate funds among the States for each of five classes of health services (medical, dental, hospital, home health and auxiliary) on the basis of population, availability of health resources and the costs of services, as indicated in the State plan. The allocation would be designed to assure that adequate health benefits are provided in all States and to improve the adequacy of services where they are below the national average.

The State agencies would contract with providers of care for services under the program and determine rates of payments. The payments could be administered by the State agency or the local health-service area. Nonprofit health-service insurance plans could be used as agents or intermediaries.

*Hospitals and other institutions*

Hospitals and other institutions would be reimbursed on the basis of reasonable costs. In calculating costs, the payment for room and board would be based on the least expensive multiple bed accommodations. However, a maximum rate for hospitalization could be established (after consultation with representatives of provider organizations) and it could vary according to locality and class of service.

*Professional practitioners*

Physicians and dentists could select reimbursement under various methods, including fee-for-service (based on a fee schedule), capitation (with maximum limits on the number of registered patients), full- or part-time salary, or a combination of these methods. Specialists could choose the same methods and, in addition, payment on a per session or per case basis.

Rates of payment would be geared to local conditions. In deriving the rates of payment under the various methods, consideration would be given to the annual income that would accrue to practitioners. Further, reimbursement would be designed to provide incentives to practitioners to advance in their professions, pursue postgraduate studies, maintain high quality service, allow for adequate vacation, and practice in areas where their services are needed.

*Home health and other services*

Methods of payment for home health and other services would be determined by the State agency administering the program.

*Delivery and resources*

The National Health Insurance Board, after consultation with the National Advisory Council and other Federal agencies, is authorized to make grants-in-aid for training and education to students and educational institutions. To finance this program, $10 million would be available for the first year of the program, $15 million for the second and, for each following year, an amount equal to one-half of 1 percent of benefit expenditures in the previous year.

COSTS

See Part II, page 99, for the cost estimate of the Dingell bill.

*Identical bills and cosponsors*

| *Number* | *Sponsor* |
|---|---|
| H.R. 211 | Mr. Matsunaga. |

# HALL BILL—H.R. 177

This proposal, titled "Extra Care" by its sponsor, was introduced on January 22, 1971, by Representative Durward G. Hall of Missouri.

*General concept and approach*

The proposal would establish a two-part national health insurance program called the "National Health Care Program" and abolish the Medicaid program. All persons would be covered under one of the parts, depending on their annual income.

Part A of the proposal would provide the poor with basic coverage under private health insurance plans, as well as coverage of catastrophic health care costs. The program would be administered by the States, and financing would come from Federal and State general revenues.

Part B, a federally administered program, would insure the remaining population against catastrophic health care costs beyond a specified amount. It would be financed by a tax on wages, self-employment income, and other income of individuals.

PROVISIONS FOR THE MEDICALLY INDIGENT (PART A)

*Coverage of the population*

All persons at or below a State level of medical indigence would be covered under this plan. Each State would determine the level of medical indigence for its residents, i.e., the level of income below which an individual or family cannot meet their normal health care costs.

*Benefit structure*

The State would purchase a qualified private health insurance policy for eligible individuals and families. The bill does not specify the benefits that a qualified policy must include, but permits the inclusion, at the option of the State, of any services defined as medical care under the present income tax laws relating to medical expense deductions. (This definition encompasses a very broad range of health care services.) The value of the policy would be at least equal to the average annual cost of adequate health care in that State. The State is also required to provide catastrophic coverage of all costs for health care beyond the limits of the basic insurance policy.

*Administration*

The program would be administered by the States under agreement with the Department of Health, Education, and Welfare. If a State refuses to enter into an agreement, or fails to comply with requirements of an agreement, the Federal Government would administer the program in the State. In either case, the health benefits plans would be operated and administered by private insurance carriers.

*Relationship to other Government programs*

The proposal would replace the current Medicaid program. No specific reference is made to other Government health programs, but the bill calls for a report on provisions of law which require modification or repeal.

*Financing*

The program would be financed by State and Federal revenues. The Federal Government would pay States 85 percent of the cost of premiums for the purchase of the basic insurance coverage. States would pay the balance of the cost of basic coverage and the entire cost of coverage for the catastrophic program.

If a State does not participate in the program, the Federal Government would pay the entire cost of both types of coverage, and would recover those amounts (that the States would otherwise have been required to pay) by withholding Federal funds otherwise payable to the States.

*Delivery and resources*

There are no provisions directly affecting the organization and delivery of medical services.

CATASTROPHIC HEALTH INSURANCE FOR NON-INDIGENTS (PART B)

*Coverage of the population*

All persons with incomes above the State-determined level of medical indigency would be eligible for coverage under this part.

*Benefit structure*

A program of catastrophic health insurance would be established that would cover 90 percent of health care costs above a specified annual deductible. As for the plan for the medically indigent, benefits could include any services defined as medical care under the present income tax laws.

The deductible amount that would have to be met before payment could begin (which could include expenses that were already paid under private insurance or public programs) would consist of the larger of the following:

$5,000 for all persons or families under age 65, or
$1,000 for persons aged 65 or over, or
25 percent of individual or family gross income for the year.

*Administration*

The catastrophic program would be administered by the Department of Health, Education, and Welfare and would follow, to the extent possible, the same procedures and requirements used under Medicare.

*Relationship to other Government programs*

The bill calls for a report, as discussed above.

*Financing*

The plan would be financed by a special tax of 0.4 percent on the sum of an individual's wages, self-employment income, and other

earned or unearned income over $2,000, up to a maximum of $7,800.[2] The wages and self-employment income subject to tax would be the same as under social security. Revenues would be placed in a Federal Health Care Trust Fund, managed by a Board of Trustees, from which all benefits and expenses would be paid.

*Other*

The bill provides that, to the extent feasible, the reimbursement standards and procedures under Medicare be utilized for the catastrophic health insurance program (Part B). The bill does not include specific provisions regarding the organization and delivery of health services.

COSTS

See Part II, page 102, for the cost estimate of the Hall bill.

*Identical bills and cosponsors*

| *Number* | *Sponsors* |
|---|---|
| H.R. 177 | Mr. Hall (for himself, Mr. Collier, Mr. Davis of Georgia, Mr. Derwinski, Mr. Andrews of North Dakota, Mr. Camp, Mr. Hull, Mr. Carter, Mr. Esch, Mr. Dorn, Mr. Cleveland, Mr. Edwards of Alabama, Mr. King, Mr. Findley, Mr. Gubser, Mr. Hunt, Mr. McClory, and Mr. Kuykendall). |
| H.R. 178 | Mr. Hall (for himself, Mr. Wylie, Mr. Ichord, Mr. Conable, Mr. Poage, Mr. Myers, Mr. Ruth, Mr. Stafford, Mr. Williams, Mr. Jones of North Carolina, Mr. Michael, Mr. O'Konski, Mrs. Reid of Illinois, Mr. Randall, Mr. Rhodes, Mr. Saylor, Mr. Shriver, Mr. Skubitz, Mr. Talcott, Mr. Teague of California, and Mr. Bob Wilson). |
| H.R. 576 | Mr. Ashbrook. |
| H.R. 3847 | Mr. Teague. |

[2] The bill does not include any provision for a tax on employers, although the sponsor indicated in his introductory remarks that the tax on an individual's wage would be matched by an equal amount by the employer.

# HOGAN BILL—H.R. 817

H.R. 817, the "National Catastrophic Illness Protection Act of 1971," was introduced by Representative Lawrence J. Hogan of Maryland on January 22, 1971.

*General concept and approach*

The proposal would establish a program of private health insurance protection against the cost of catastrophic illness. Persons could voluntarily buy private insurance policies that would pay for medical expenses after the expenses exceed a specified amount, depending on family income and size. The program would be administered by private insurance carriers under State supervision. The insurance would be paid by the policyholder, but the Federal Government could subsidize the premium, using funds from general revenues. The Federal Government would also administer a reinsurance plan for insurance carriers under the plan.

*Coverage of the population*

All persons could obtain coverage on a voluntary basis.

*Benefit structure*

For the purpose of this program, any services defined as medical care under the present Federal income tax law relating to medical expense deductions, could be included in a State plan.

The policies would pay the medical expenses of individuals and families whose expenses exceed a specified amount (referred to as the annual deductible). This deductible would vary according to family income and number of dependents. For low-income people no annual deductible would be applicable (and thus the plan would pay for all covered medical expenses) but the deductible would rise rapidly as family income increased.

The amount of the deductible would be based on the family's "adjusted income," which is the "adjusted gross income" shown on the Federal income tax return reduced by the total amount of personal exemptions. In calculating the deductible, the first $1,000 of "adjusted income" would be disregarded and the deductible would be equal to (1) 50 percent of adjusted income between $1,000 and $2,000, plus (2) 100 percent of adjusted income over $2,000. An illustrative schedule based on this formula for a family of four appears below.

| Adjusted gross income | Adjusted income [1] | Annual deductible |
|---|---|---|
| $1,000 | None | None |
| $4,000 | $1,000 | None |
| $5,000 | 2,000 | $500 |
| $7,500 | 4,500 | 3,000 |
| $10,000 | 7,000 | 5,500 |
| $20,000 | 17,000 | 15,500 |
| $30,000 | 27,000 | 25,500 |

[1] Based on personal exemption of $750 per person, which would become effective for 1973.

In figuring the family's medical expenses, medical costs paid in a year for continuous, uninterrupted care which began in an earlier year would be considered to have been paid in the earlier year.

All medical expenses incurred would count toward meeting the deductible including expenses paid by other private insurance or covered by Medicare, Medicaid or other public programs.

*Administration*

Each State would design its own health insurance plan under regulations of the Department of Health, Education, and Welfare. The State insurance department would make arrangements with, and supervise, private health insurance carriers who would sell the insurance, collect premiums and administer claims.

A carrier organization would be established in each State that would attempt to distribute the risks equitably among the insurers and would obtain coverage, through assigned risk pools, for persons unable to obtain coverage at the regular premium rate.

The Department of Health, Education, and Welfare could administer a plan in any State that has not established one.

*Relationship to other Government programs*

Medicaid and other assistance programs would be affected because they would not make payment for the services covered by the insurance. Most other Government programs would not be affected.

*Financing*

Periodically, the Department of Health, Education, and Welfare would determine the actuarial value, according to family size and composition, of the catastrophic insurance policy in each State. The Department would then establish a premium rate which could be lower than the actuarial value, if the Department believed that a lower rate was desirable in order to obtain more widespread coverage. The Federal Government would pay the insurance carrier the difference between the actuarial value and the established premium. These payments, referred to as premium equalization payments, would be paid from Federal general revenues through a National Catastrophic Illness Fund.

The Department would also arrange for reinsurance for carriers who have incurred extraordinary losses in connection with the catastrophic insurance. The premiums for this reinsurance would be paid by participating carriers as determined by the Department. This reinsurance plan would be administered through the National Catastrophic Illness Fund and the Department could contract with private firms to handle the reinsurance claims.

*Other*

There are no provisions in the bill concerning standards for providers of service, reimbursement of providers, or health care delivery and resources.

COSTS

See Part II, page 105, for the cost estimate of the Hogan bill.

*Identical bills and cosponsors*

| *Number* | *Sponsors* |
|---|---|
| H.R. 817 | Mr. Hogan (for himself, Mr. Andrews of North Dakota, Mr. Byrne of Pennsylvania, Mr. Carter, Mr. Halpern, Mr. Hastings, Mr. Hawkins, Mr. Kyros, Mr. Pucinski, Mr. Roe, Mr. Scott, and Mr. Williams). |
| H.R. 4133 | Mr. Hogan (for himself, Mr. Begich, Mr. Córdova, Mr. Gallagher, Mr. Johnson of Pennsylvania, Mr. Roy, and Mr. Wright). |
| H.R. 6396 | Mr. Roush. |
| S. 191 | Mr. Boggs (for himself, Mr. Tower, and Mr. Beall). |

## FISHER BILL—H.R. 1283

H.R. 1283, the "Health Insurance Assistance Act," was introduced by Representative O. C. Fisher of Texas on January 22, 1971. This bill is identical to the Medicredit proposal (H.R. 18567) introduced by Representatives Fulton and Broyhill in the 91st Congress. The new Medicredit proposal endorsed by the American Medical Association was described earlier.

*General concept and approach*

The Medicredit proposal would provide tax credits against individual income taxes to offset, in whole or in part, the premium cost of qualified private health insurance policies. All persons could voluntarily elect coverage under the plan except those eligible for military medical care.

The maximum tax credit would be an amount equal to the total premium cost of a qualified health insurance policy. The amount of credit would be graduated on the basis of a family's income tax liability (the amount of tax payable for the year) with the larger credits available to lower income groups. Families with little or no tax liability would receive a payment voucher for purchase of the insurance. The bill establishes a mechanism for peer review of the utilization, charges, and quality of medical services.

*Coverage of the population*

Since all families and individuals potentially subject to the Federal individual income tax would be eligible, virtually the entire population could voluntarily elect coverage under the plan, with the exception of persons eligible for military medical care who are specifically excluded. A State could enroll its Medicaid population as a group. Persons aged 65 and over would remain under the Medicare program, but could participate in the Medicredit plan under special provisions applicable to this group.

*Benefit structure*

Families and individuals could deduct a specified percentage of the premium cost of a qualified health insurance policy as a tax credit against their personal income tax. The amount of the credit would be 100 percent of the premium for persons with tax liability of less than $300.[3] The percentage would be slowly graduated downward (for each $25 increase in tax liability) with a credit of 10 percent available to

[3] The tax liability limit of $300 should not be confused with the cost of a qualified policy or the amount of the tax credit. The cost of a family policy, for example, could be considerably greater than $300.

those with a tax liability of over $1,300.[4] The following table shows the percentage of the premium cost of a policy that could be taken as a credit at selected levels of income tax liability.

| Tax liability: | *Percent of premium allowed as tax credit* |
|---|---|
| $300 or under | 100 |
| $325 | 98 |
| $500 | 73 |
| $700 | 45 |
| $900 | 22 |
| $1,100 | 20 |
| $1,300 | 12 |
| Over $1,300 | 10 |

This schedule is applicable to all types of tax returns including individual returns and joint returns of married couples. In computing the amount of tax liability for Medicredit purposes, however, the tax liability of a dependent child would be included. Also, the tax liability of a husband and wife filing separate returns would be combined.

Individuals or families with no tax liability, or a tax liability less than the amount of their credit, would receive a voucher certificate which would be accepted by a carrier for the purchase of a qualified insurance policy.

Taxpayers who elect a tax credit could not claim the health insurance premium as a medical expense deduction for income tax purposes.

*Qualified insurance policy*

An insurance policy would have to meet certain standards to be a qualified policy eligible for a tax credit. It would have to offer specified basic benefits and one or more specified supplemental benefits. The policy would have to be guaranteed renewable and could not exclude payment of benefits because of preexisting medical conditions.

Coverage under the hospital and medical insurance parts of the Medicare program (Parts A and B) would be considered as meeting the requirements of a qualified basic policy. (Medicare benefits are roughly comparable to Medicredit's basic benefits). Aged persons could use the tax credit to pay the premiums for medical insurance under Medicare and to purchase the supplemental benefits of Medicredit.

The basic and supplemental benefits of the Medicredit plan are shown in table 4.

The deductibles and coinsurance would not apply to individuals or families with tax liability of less than $300. For others, the total amount of coinsurance under the basic benefits would be limited to $100 per person in a year (20 percent of the first $500) for hospital outpatient service and an additional $100 for physicians' and diagnostic services. A policyholder could elect (as a supplemental benefit) to eliminate the cost sharing on the basic benefits. The catastrophic insurance, which is offered as a supplemental benefit, would cover the same types of hospital and medical services provided in the qualified policy, beyond the limits imposed by the policy. Thus, the benefit package and premium cost of a qualified policy would vary, depending upon the individual's selection of supplemental benefits.

[4] For families of four taking the standard deduction a tax liability of $300 is approximately equivalent to an adjusted gross income of $5,000; a tax liability of $1,300 is equivalent to an income of $11,500. For individuals, the comparable income figures are $3,000 and $8,500.

TABLE 4.—*Fisher bill: Benefit provisions under a qualified insurance policy*

| Type of service | Basic benefits | Supplemental benefits |
|---|---|---|
| Institutional benefits: | | |
| Hospital inpatient care. | 60 days in a year, subject to a $50 deductible for each stay. | Additional hospital days, subject to 20 percent coinsurance. |
| Hospital outpatient care. | Subject to 20 percent coinsurance on 1st $500 of expenses per person. | None. |
| Extended care | 2 days in an extended care facility may be substituted for 1 day of inpatient hospital care, subject to a $50 deductible for each stay. | None. |
| Personal services: | | |
| Physicians' services | Physicians' services, subject to 20 percent coinsurance on 1st $500 of expenses per person.[1] | None. |
| Laboratory and X-ray. | Subject to 20 percent coinsurance on 1st $500 of expenses per person.[1] | None. |
| Services of other health professionals. | None | Furnished by licensed provider under written direction of a physician, subject to 20 percent coinsurance. |
| Other services and supplies: | | |
| Prescription drugs | None | Subject to 20 percent coinsurance. |
| Blood | None | Cost of blood furnished in excess of 3 pints. |
| Deductibles and coinsurance. | None | Waiver of deductibles and coinsurance imposed on basic benefits. |
| Catastrophic health insurance. | None | Up to $25,000 per family in a year, after a deductible of $300, for hospital and medical services. |

[1] The limit on coinsurance applies to expenses for physicians' services and laboratory and X-ray services combined.

*Administration*

Persons would purchase qualified health insurance from private health insurance carriers who would issue policies, collect premiums (or vouchers) and process claims for benefits.

State insurance departments would determine whether carriers and policies are qualified under the Medicredit program and would register the carriers. Carriers could be organized into a pool and would be required to accept the risks assigned them by the State insurance department.

At the national level, a Health Insurance Advisory Board would be established, composed of the Secretary of Health, Education, and Welfare (chairman), the Commissioner of Internal Revenue, and nine additional members appointed by the President with Senate approval. The Board would issue regulations for the administration of the program and establish Federal standards for use by the State insurance departments in determining whether carriers and policies are qualified. It would consult with carriers, providers, and consumers in studying methods to maintain the quality of care and the effective utilization of resources. The Department of Health, Education, and Welfare would be responsible for issuing and redeeming the health insurance certificates.

*Relationship to other Government programs*

The bill provides that benefits claimed under Medicredit may not be duplicated under other programs financed by the Federal Government. It also specifically provides that payments would not be made for services covered by Medicare. The Medicredit proposal would affect the Medicaid and other assistance programs by covering those services for the low-income population that were provided by the assistance programs.

*Financing*

The Medicredit program would be financed from Federal general revenues. The granting of tax credits would result in a reduction in income taxes received by the Federal Government, and voucher certificates would be redeemed from general revenue funds. A special trust fund would be created for the purpose of redeeming certificates.

*Standards and reimbursement of providers of services*

The bill includes a clause which prohibits Federal supervision and control over the practice of medicine and over the manner in which services are provided.

Insurance carriers would deal with providers of service and reimburse them, as under present insurance methods. A Peer Review Organization (PRO) would be established for the review of the utilization and quality of medical and other health services and review of the fees charged for these services. The PRO would apply to medical benefits under the Medicaid program, maternal and child health program, and the supplementary medical insurance program (Part B) of Medicare, as well as the proposed Medicredit program. The cost of operating the PRO would be financed from the supplementary medical insurance trust fund under Medicare.

*PRO administration*

A PRO program in a State would be established by agreement between the State medical society and the Department of Health, Education, and Welfare. The State medical society would appoint a five-member commission of physicians to administer the program and review cases from the local PRO panels. Each local panel would be composed of three local physicians appointed by the State PRO commission. A State advisory council of consumers, providers, and carriers would be appointed by the State medical society. The State PRO commission would appoint advisory counsels to the local review panels.

*Hearings and appeals*

The local review panel would have initial responsibility for considering a complaint against a provider, which could be initiated by consumers, institutions, providers, carriers, and Government agencies. In addition, sample reviews could be initiated by the State PRO commission or a local panel. The panel could hold a hearing, if necessary, in which the provider could be represented by counsel.

A panel could recommend censure or disciplinary action. If so, the case would be reviewed by the State PRO commission and if the commission approved the disciplinary action, the case would be reviewed by the Department of Health, Education, and Welfare, which could reverse or reduce the recommended action. The Department could discipline a provider by suspending or excluding him from participating in Federal health care programs, but a first suspension would be limited to 1 year. The provider could appeal the Department's decision to the courts as a civil action.

Under penalty of further disciplinary action, the suspended provider would be responsible for notifying patients that services provided during his suspension would not be reimbursable under the Federal health care programs.

The bill protects witnesses and members of the panels and commissions against libel actions for peer review activities. Evidence in connection with peer review would not be available for use in other civil or criminal actions.

*Delivery and resources*

There are no provisions, other than the PRO, regarding the organization and delivery of health service or manpower and facilities.

COSTS

See Part II, page 108, for the cost estimate of the Fisher bill.

*Identical bills and cosponsors*

| *Number* | *Sponsor* |
|---|---|
| H.R. 3167 | Mr. Tiernan |

## BENNETT BILL—S. 1623

S. 1623, the "National Health Insurance Partnership Act of 1971," was introduced by Senator Wallace F. Bennett of Utah on April 22, 1971, on behalf of the Administration. The provisions of the Bennett bill are identical with the Byrnes bill, H.R. 7741 (see page 1), except that the Bennett bill does not include the provisions for subsidy payments to employers by the Federal Government which are contained in the Byrnes bill.

COSTS

See part II, page 111, for the cost estimate of the Bennett bill.

*Identical bills and cosponsors*

| *Number* | *Sponsors* |
|---|---|
| S. 1623 | Mr. Bennett (for himself, Mr. Jordan of Idaho, Mr. Hruska, Mr. Hansen, Mr. Fannin, Mr. Griffin, and Mr. Scott). |

# LONG BILL—S. 1376

S. 1376, the "Catastrophic Illness Insurance Act," was introduced by Senator Russell B. Long of Louisiana on March 24, 1971.

*General concept and approach*

The bill would provide catastrophic health insurance protection for almost all persons under age 65. The types of medical services covered would be the same as under the Medicare program; however, benefit payments would begin only after large medical expenses were incurred. The program would be administered through the Medicare program and financed by special payroll taxes.

*Coverage of the population*

Persons under age 65 who are fully or currently insured under the social security program [5] or entitled to social security benefits would be covered, as well as their spouses and dependent children.

State and local governments would have an option to "buy" into the program and cover, as a group, all their employees and annuitants not covered by social security, under an agreement with the Federal Government. The State would reimburse the program for the cost of benefits and related administrative expenses for these persons. (The regular payroll tax for catastrophic illness benefits would not be applied to State and local government employment.)

*Benefit structure*

The catastrophic health insurance program would cover the same kinds of benefits as provided under the Medicare program. There are, however, significant differences in the scope of benefits and in the provisions for deductibles and coinsurance. Covered services would include the following:

Institutional services:
- Hospital inpatient services
- Extended care services following hospitalization

Medical services:
- Physicians' services
- Home health services
- Outpatient physical therapy services
- Laboratory and X-ray services
- Other medical and health services such as medical supplies, appliances and equipment, and ambulance services

The major benefits excluded under the Medicare program (and thus excluded under the catastrophic program), would be prescription drugs, hearing aids, eyeglasses, dentures and dental care.

[5] A person who has social security credit for at least 1½ years of work within a 3-year period is currently insured. To be fully insured, a person needs at least one quarter of coverage for each calendar year elapsing after 1950 or, if later, after the year in which he attained age 21, up to the year he becomes entitled to benefits. A person who has 10 years of work is fully insured for life.

*Hospital inpatient care and extended care*

Hospital inpatient care would be covered, with no limit on the number of days, but the first 60 days of hospitalization during a year for each person would not be covered. Payment would begin with the 61st day of hospitalization in each year and would be subject to a coinsurance amount of $15 a day.[6]

Extended care services following a hospital stay would be covered with no limit on the number of days. However, payment would be made only after the person had met the 60-day hospital deductible and was covered for at least 1 hospital day under the catastrophic program. There would be a coinsurance payment of $7.50 for each day in an extended care facility.

Days spent in a hospital in the last 3 months of the year that are not covered days under the proposal would be counted toward meeting the 60-day hospital deductible for the next year. As under the Medicare program, there would continue to be a lifetime limit of 190 days of care in psychiatric hospitals.

*Physicians' services, home health services and other medical services*

Physicians' services, home health visits and other types of medical and health services covered under Medicare would be covered without limit (except that the Medicare limitation on psychiatric physicians' services on an ambulatory basis would be retained). Before payment could be made, however, a family must meet an annual medical deductible of $2,000. The medical deductible would have to be met separately from the hospital deductible and only those types of medical services covered under Medicare could be counted toward meeting the medical deductible. Payment would be subject to a 20 percent coinsurance requirement.

Covered medical expenses incurred in the last 3 months of the year for which payment could not be made would be counted toward meeting the $2,000 medical deductible for the next year.

The $2,000 medical deductible would be adjusted each year, based on the physicians' fee component of the Consumer Price Index.

*Administration*

The program would be administered through the Medicare program and use the same administrative mechanisms. Under Medicare, the Department of Health, Education, and Welfare is responsible for general administration of the program. Private carriers under agreement with the Department act as fiscal intermediaries and are responsible for administration of claims and payments to providers of services. State agencies are responsible for determining whether providers of services meet the conditions for participation under the program.

*Relationship to other Government programs*

Since the program is based on the requirements and provisions of the Medicare law, its relationships to other Government programs would be essentially the same as the Medicare program. (See discus-

[6] The coinsurance under the proposal is related to the Medicare inpatient hospital deductible which, effective January 1, 1971, was $60. For hospital care under the proposal, the coinsurance is one-quarter of the Medicare deductible and, for extended care services, one-eighth. The amount of the Medicare deductible is changed January 1 of each year if the average per diem rate for inpatient hospital services rises.

sion of Javits bill.) The Medicare program itself would not be affected since the catastrophic program applies only to persons under age 65.

*Financing*

The program would be financed, in a manner similar to Medicare, by a special tax on the wages and self-employment income which are subject to social security taxes. The tax rates for employers, employees and the self-employed against the first $9,000 of taxable wages or self-employment income would be 0.3 percent from 1972 through 1974, rising to 0.35 percent in 1975, and then to 0.4 percent in 1980.

A separate Catastrophic Health Insurance Trust Fund would be established to handle program receipts and expenditures. Appropriations to the trust fund from Federal general revenues are authorized for the first 3 years of operation to provide an operating fund and to establish a contingency reserve. The amount of appropriation could not exceed the estimated benefit expenditures of the program for one-half of the year. These appropriations from general revenues are repayable to the Treasury, without interest.

*Standards for providers of services*

The program would apply the same standards and requirements for providers of services and physicians as exist under the Medicare program. (See page 73.)

*Reimbursement of providers of services*

Providers of services, physicians and suppliers would be reimbursed on the same basis as under the Medicare program. Under Medicare, hospitals, extended care facilities, home health agencies, and providers of outpatient physical therapy services are reimbursed on the basis of the reasonable cost of services. Payments to physicians and suppliers are determined on the basis of reasonable charges. The program also incorporates the cost and utilization controls of the Medicare program.

*Delivery and resources*

There are no specific provisions regarding these subjects.

COSTS

See Part II, page 113, for the cost estimate of the Long bill.

*Identical bills and cosponsors*

| *Number* | *Sponsors* |
|---|---|
| S. 1376 | Mr. Long (for himself, Mr. Anderson, Mr. Bible, Mr. Burdick, Mr. Byrd of Virginia, Mr. Gravel, Mr. Hansen, Mr. Hollings, Mr. Jordan of Idaho, Mr. McGee, Mr. Pastore, Mr. Pearson, Mr. Randolph, and Mr. Ribicoff). |

# SCOTT-PERCY BILL—S. 1598

S. 1598, "The Health Rights Act of 1971," was introduced by Senator Hugh Scott of Pennsylvania and Senator Charles Percy of Illinois on April 21, 1971.

*General concept and approach*

The bill would establish two health insurance programs for which all residents of the United States would be eligible. A Government-administered plan would provide inpatient hospital care and related institutional services. A voluntary plan, operated through private health insurance with government financial assistance to low-income families would offer supplementary outpatient services. The bill provides for utilization review, incentives for the development of health maintenance organizations, the training of health manpower and increased health planning.

### INPATIENT HEALTH CARE PROGRAM

Inpatient care in hospitals and other institutional services would be provided under a federally-administered program financed by payroll taxes and Federal general revenues. Benefits would be subject to cost sharing by the family, graduated according to family income and size.

*Coverage of the population*

All residents of the United States would be covered, including aliens admitted as permanent residents or for employment. Aliens in the United States employed by a foreign government or an international organization would be eligible for coverage under special agreements.

*Benefit structure*

The following services would be covered under the proposal:

- Inpatient hospital services (including tuberculosis hospitals)
- Inpatient psychiatric hospital services: lifetime limit of 180 days per patient
- Extended care services
- Home health services: 365 days following discharge from a hospital or extended care facility

*Benefit payments*

The benefits for covered services would be subject to a payment by the family before benefits begin. The payment would be based on a formula that takes into account family income and size, referred to as the family health cost ceiling.[7]

[7] The "family health cost ceiling" is computed by first dividing the total of the adjusted gross income for all family members, plus any nontaxable cash income such as welfare, by a factor based on family size (1.25 for the first adult plus .50 for a spouse and .50 for each dependent) to obtain the "per person family income." Then the "family health cost ceiling" is computed by taking 10 percent of the "per person family income" if it is $2,000 or less, or 15 percent if such income is over $2,000. The family would pay for inpatient care expenses an amount equal to one-half of the "per person family income" and 50 percent of any additional expenses up to the ceiling.

The following tabulation shows for a family of four, at selected income levels, the amount the program would pay for a $500, a $1,000, and a $2,000 hospital bill (or other covered services):

| Total family income | $500 bill | $1,000 bill | $2,000 bill |
|---|---|---|---|
| $2,000 | $427 | $927 | $1,927 |
| $4,000 | 355 | 855 | 1,855 |
| $6,000 | 173 | 673 | 1,673 |
| $10,000 | 114 | 455 | 1,455 |
| $20,000 | 0 | 227 | 910 |

*Administration*

The Department of Health, Education, and Welfare would administer the program through regional offices (and sub-regional offices where necessary). It would establish the regulations for the program and contract with providers of services. An appeal procedure would be provided for grievances concerning entitlement or adequacy of benefits.

*Financing*

The Medicare program for the aged would be abolished and the payroll tax for Medicare's hospital insurance program would be allocated to finance the new program. The use of Federal general revenues is also authorized, to the extent needed. A new trust fund would be established to hold the funds and the present Medicare hospital insurance trust fund transferred to the new program.

SUPPLEMENTARY MEDICAL INSURANCE

The supplementary medical insurance program would provide outpatient and ambulatory services to supplement the institutional services program described above. The program would be administered by insurance carriers under supervision of the Federal Government. Benefits would be subject to deductible of $10 to $50 per person a year, depending on family income and size. The Federal Government would pay all or part of the premium cost for low-income families. All U.S. residents would be eligible for coverage on a voluntary basis.

*Benefit structure*

The following services would be provided under the supplementary medical insurance program:

Institutional services:
- Hospital outpatient care

Personal services:
- Physicians' services: lifetime limitation of 104 visits for psychiatrists' outpatient services
- Physical checkups: as prescribed by regulation but including two examinations a year for children under 5, and three examinations during a pregnancy
- Dentists' services: for children under 12 (orthodontia excluded)
- Other professional services: optometrists and podiatrists
- Home health services: 100 visits a year

Laboratory and X-ray: diagnostic X-ray and laboratory tests; X-ray, radium and isotope therapy
Outpatient physical therapy services
Other services and supplies:
Durable medical equipment, prosthetic devices (nondental), artificial limbs
Ambulance service: as prescribed by regulation
Prescription drugs: for long-term or chronic illnesses

Benefits would be subject to an income-related deductible ranging from $10 to $50 a person in a calendar year for medical benefits and from $10 to $25 for dental services. The amount of the deductible would be determined by family income and size (based on "per person family income" as described previously). The following tabulation shows the amount of the deductible, per person, in a family of four:

| Total family income | Deductible (per person) | |
|---|---|---|
| | Medical | Dental |
| Under $2,750 | $10 | $10 |
| $2,750 to $5,499 | 25 | 15 |
| $5,500 or over | 50 | 25 |

*Administration*

Insurance carriers (and health maintenance organizations) would collect the premiums and pay claims for services furnished under the program. The Department of Health, Education, and Welfare would contract with and supervise the private carriers participating in the program. Persons with grievances involving benefits would be entitled to a hearing.

*Financing*

The program would be financed by premium payments of families and individuals with the Federal Government paying part of the premium cost for low-income groups. The amount of this Government contribution would be based on "per person family income" using the formula described above. The following schedule shows for a family of four the percent of the premium paid by the Government:

| Total family income: | *Percent of premium* |
|---|---|
| Under $2,750 | 100 |
| $2,750 to $4,124 | 75 |
| $4,125 to $5,499 | 50 |
| $5,500 to $6,874 | 25 |
| $6,875 and over | 0 |

The premium contributions of the Government would be paid, on behalf of the famly, to the insurance carriers. Also on behalf of the family, premiums could be deducted from the cash benefit payments of beneficiaries of Social Security, Railroad Retirement and Civil Service Retirement.

A new trust fund would be created for the supplementary program to hold the Government contribution and deductions on behalf of beneficiaries. To this trust fund would be transferred the assets and liabilities of the present Federal Supplementary Medical Insurance Trust Fund.

PROVISIONS APPLICABLE TO BOTH PLANS

*Relationship to other Government programs*

The bill would repeal the Medicare law, the Federal Employees Health Benefits Act, and the Retired Federal Employees Health Benefits Act. Federal financial participation in Medicaid would be limited to those services not provided under the new program.

*Standards for providers of services*

*Institutions*

Hospitals, extended care facilities, and home health agencies must meet Medicare standards. In certain situations, institutions that are prohibited from incorporating by State law may be incorporated by the Federal Government.

*Health maintenance organizations*

To qualify as a health maintenance organization, a public or private organization would have to provide directly, or through arrangements, ambulatory and inpatient services to an enrolled population on a per capita, prepaid basis.

The health maintenance organization must be financially responsible and be capable of delivering or arranging for prompt, efficient and economical health services that meet quality standards established in regulations. The membership enrolled in an organization must reflect, to the extent possible, the age distribution of the population area in which it is located.

*Physicians and other health personnel*

Physicians and other practitioners including optometrists, podiatrists, dentists, nurses and allied health personnel who are legally authorized to practice in one State and who meet the national standards established by the Health Services National Review Board would be authorized to practice in any State.

*Utilization review*

The requirements for utilization review for institutions would be similar to those of Medicare. In addition, the utilization review committees of the institutions in an area would be required to meet periodically to study the area's health care facilities and to make recommendations to the regional Health Services Review Committee for the sharing of facilities and personnel to improve delivery and reduce costs.

The regional Health Services Review Committee would be appointed by the Department of Health, Education, and Welfare and would represent the providers and the consumers in the region. The committee would (1) review on a sample basis the utilization reviews performed by the institutions in the region, (2) study the administration of the legislation and its effectiveness in delivering the health services and (3) recommend new legislation, if needed, to the Health Services National Review Board.

The National Board would be established in HEW and consist of five members appointed by the President. The Board, in addition to reviewing the reports of the regional committee, would:

(1) Establish, after hearings and consultation with appropriate organizations, minimum national training requirements for physicians and other professions, and for allied health personnel.

(2) Develop special programs to train allied health personnel who are employed by providers but fail to meet the Board's training standards.

(3) Prescribe national standards for health service organizations, corporations, and associations.

(4) Incorporate institutions and health maintenance organizations to allow them to provide services under the legislation, if they meet the Board's standards but are ineligible to incorporate under State law.

(5) Compile a list of generic prescription drugs for use in the inpatient and outpatient programs.

(6) Review the administration and effectiveness of the legislation and make legislative recommendations to Congress if necessary.

*Reimbursement of providers of services*

The bill specifies that the Department of Health, Education, and Welfare would issue regulations on methods for payment for the inpatient health care part of the program. Services under the supplemental medical insurance program would be reimbursed on the basis of reasonable cost, as defined by Medicare.

Health maintenance organizations would receive a per capita payment for outpatient services which could not exceed the average cost paid to carriers in the area for supplementary medical insurance. If the health maintenance organization makes arrangements with an organized group of professionals to provide physician or other professional services, it would reimburse the professional group on a per capita or budgeted (aggregate fixed-sum) basis.

*Delivery and resources*

The bill guarantees patients freedom of choice among qualified providers in obtaining health care.

*Health delivery committee*

A Health Delivery Committee of nine health experts appointed by the President would be established in the Department of Health, Education, and Welfare for a two-year period to study the country's current and long-range needs for medical personnel and facilities. It would be required to prepare recommendations for the establishment of prepaid or health maintenance organizations.

*Health maintenance organizations*

The bill authorizes Federal loans and grants for a 3-year period for the development and construction of public and private prepaid health maintenance organizations. Grants may cover 50 percent of an organization's development costs and, in areas short of physicians, 70 percent of costs. Loans at 3 percent interest are also authorized. Interest payments and repayment of principal would be over a 20-year period.

*Health manpower*

Medical and nursing student loan programs under the Public Health Service Act would be liberalized. Loans would be increased to cover the full cost of tuition, laboratory fees, texts and materials, and a special living allowance of up to $1,000 a year would be provided. The period for repaying the loan would be extended from 10 to 20 years.

Also, for a period of 5 years, accredited medical schools would receive $20,000 for each additional student (compared to the number in the prior year's entering class) and $20,000 for each additional graduating student over the last year's graduating class.

COSTS

The cost estimate for the Scott-Percy bill was not available at the time of printing.

# JAVITS BILL—S. 836

S. 836, the "National Health Insurance and Health Services Improvement Act of 1971," was introduced by Senator Jacob K. Javits of New York on February 18, 1971.

*General concept and approach*

The bill would establish a national health insurance program based on an expansion of the Medicare program to the general population. The proposal would provide a broad range of medical benefits to all U.S. residents, following a "phasing-in" period. Benefits would generally be subject to cost sharing by the patient. The program would be financed by payroll taxes and general revenue contributions, and be administered by the Federal Government. Options would be available to obtain approved alternative coverage under private insurance outside the Government program. The bill includes provisions to encourage the formation of comprehensive health service systems.

*Coverage of the population*

The first groups to become eligible at the start of the program would be U.S. citizens aged 65 and over (and aliens aged 65 and over residing in the U.S. for at least 5 years, or eligible for social security benefits). Persons of any age entitled to social security disability benefits would also be covered.

In the second stage, 2 years later, coverage would be extended to all persons not previously covered who are resident U.S. citizens or aliens admitted for permanent residence. Persons would be eligible for benefits without regard to whether they have made contributions to the program.

*Benefit structure*

In its final form, the proposal would provide the benefits of the present Medicare program and three new services: annual physical checkups, dental care for children under 8 years of age, and prescription drugs for chronic illness. The bill would combine the Medicare supplementary medical insurance program (Part B) with the hospital insurance program (Part A), and thus eliminate the premium payments for supplementary insurance.

The major benefits of the proposal and their limitations and cost-sharing provisions are as follows.[8] Several types of services are subject to the present Part B provision of the Medicare law which requires a $50 annual deductible, per person, and a 20 percent coinsurance payment:

Institutional services:

Hospital inpatient care: 90 days of inpatient hospital services per benefit period with a "lifetime reserve" of 60 additional

[8] Cost-sharing rates given are effective January 1, 1971. The amount of the hospital deductible is increased January 1 of every year if the average per diem rate for inpatient hospital services rises.

days. (A 190-day lifetime limit applies to stays in psychiatric hospitals.) The patient pays a deductible of $60 in each benefit period and, in addition, $15 co-payment for each day after the 60th. There would be a $30 co-payment for each day of the lifetime reserve.

Hospital outpatient care: subject to Part B cost sharing.

Extended care: extended care services, following a hospital stay, for 100 days per benefit period with co-payment of $7.50 for each day following the 20th.

Personal services:

Physicians' services: subject to Part B cost sharing. Psychiatric physicians' services limited to a maximum annual payment of $250 for ambulatory care.

Physical checkups: annually, including eye and ear examinations and diagnostic tests, subject to a 20 percent coinsurance payment (with no deductible). The amount of payment would be the smaller of $75 or the amount charged by the most efficient provider in the locality. The benefit would begin 3 years after the start of the program.

Dentists' services: dental care for children under age 8, including examination and diagnosis, cleaning, filling and removal of teeth. Orthodontia is excluded. Payment is subject to 20 percent coinsurance (with no deductible). Coverage would begin 3 years after the start of the program.

Home health services: 100 post-hospital home health visits per benefit period, without deductibles or coinsurance, plus an additional 100 visits per calendar year subject to Part B cost sharing.

Laboratory and X-ray: Outpatient diagnostic X-ray and laboratory tests, X-ray, radium and isotope therapy, subject to Part B cost sharing.

Outpatient physical therapy services: subject to Part B cost sharing.

Other services and supplies:

Medical supplies and appliances, and ambulance service: subject to Part B cost sharing.

Prescription drugs: maintenance drugs for the treatment of chronic diabetes, cardiovascular diseases, kidney conditions and respiratory conditions. There would be a $1 charge per prescription and this amount would be adjusted in future years according to changes in the per capita cost for drugs. The benefit would begin 1 year after the start of the program.

*Administration*

As under the Medicare program, the Department of Health, Education, and Welfare would be responsible for general administration of the program, including the regulations and standards for the program. Private insurance carriers under agreement with the Department would act as fiscal intermediaries for payment of claims for services, under standards established by the Department. If the Department determined that the fiscal intermediary in an area has not performed its duties adequately, a federally-chartered quasi-governmental corporation could be established to replace the intermediary

State agencies would continue to determine whether providers of services meet the conditions for participation in the program. The Health Insurance Benefits Advisory Council would be retained to advise the Department on policy and administrative matters.

The bill also authorizes the Department to make agreements with States to administer the entire program on behalf of the Department.

*Optional alternatives to the Government program*

The bill automatically covers all eligible persons under the Government program unless they are covered under an approved alternate private insurance plan.

*Employer-employee health plan option*

An employer by contract with the Department could establish for his employees a qualified plan which meets the following requirements:

(1) health benefits are provided through an insurance carrier or a union-management health and welfare plan,

(2) all employees and their dependents are covered,

(3) the employer pays at least 75 percent of the cost,

(4) the benefits are superior to those under the Government program,

(5) hearings are available for dissatisfied claimants, and

(6) methods of payment of physicians must be the same as under the Government program.

Employers and employees covered under an approved plan would be exempt from the regular insurance tax.

*Private health insurance option*

Private carriers by contract with the Department could offer alternative health insurance policies, which meet the following conditions:

(1) the insurance is offered to all living in a specified area,

(2) the selection of policyholders meet regulations concerning selection of risks,

(3) benefits are equal to those furnished under the Government program and the cost is no greater than under the Government program,

(4) premiums for additional (noncovered) benefits are reasonable, and

(5) hearings are available for dissatisfied claimants.

The bill does not specifically exempt persons under an approved private insurance plan from payment of the health insurance tax.

*Comprehensive health service system option*

The bill also provides for coverage under a comprehensive health service system for persons under the Government program. If an approved employer-employee plan or an individual health plan offers the choice of enrollment in a comprehensive system, this option would also be available under private plans.

*Relationship to other Government programs*

The bill would, in effect, absorb the Medicare program and include its beneficiaries in the Government-administered program.

Since the Javits proposal is based on the Medicare law, its relationship to other Government programs would be essentially the same as Medicare. In general, Medicare will not cover services paid by a Gov-

ernment entity, but exceptions can be made in certain cases. Arrangements have been made for Medicare to reimburse OEO health agencies and HEW community health centers for the cost of covered medical services and to pay providers for services rendered to persons eligible under the CHAMPUS program.

For State and local health programs, Government hospitals have been approved for payment and Medicare will pay for services which otherwise would be financed by vocational rehabilitation agencies.

In the case of Medicaid and the maternal and child health program, both of which are part of the social security legislation, the law specifically provides that Medicare would have initial liability in paying for services.

*Financing*

The Government program would be financed by a health insurance tax on wages and self-employment income, with additional contributions from Federal general revenues.[9] The tax rates are graduated over a 5-year period to meet the increasing financial needs as new benefits and additional persons are phased into the program. Contribution rates for employers and employees (and for self-employed persons) would be 0.7 percent of taxable wages for calendar year 1972 and would increase each year to the ultimate rate of 3.3 percent for 1976 and thereafter.

The health insurance tax would apply to the first $15,000 of earnings of employees and the self-employed, and to the employer's total payroll. The contribution from Federal revenues would be an amount equal to 50 percent of receipts from the payroll tax (plus the additional amount that would have been received if no alternative employer-employee plans had been established).

Workers under social security and Federal, State and local government employees would be subject to the tax. However, State and local governments would not pay the employer tax.

In effect, the program would be financed roughly one-third by employees, one-third by employers and one-third by Federal general revenues.

Funds would be held in two accounts within a Federal Health Insurance Trust Fund. The "general account" would be primarily the existing Medicare trust funds for the aged, combining the hospital insurance and the supplementary medical insurance trust funds. This account would be used for the payment of benefits for the aged and the disabled. A "special account" would be established to pay the benefits for the remaining population.

*Standards for providers of services*

Standards of participation for providers of services would be the same as those of the Medicare program. The Medicare standards are shown on page 73. In addition, the Department would be authorized to adopt additional standards for physicians dealing with requirements for continuing professional education, national licensing and qualifications to perform major surgery and specialist services. These standards could be established only after considering those established by professional organizations, and receiving the recommendations of

[9] As noted previously, employers and employees covered under an approved employer-employee health plan would be exempt from the special health insurance tax.

the Health Insurance Benefits Advisory Council, and following public hearings.

*Reimbursement of providers of services*

In the first 2 years of the program, providers of services would be reimbursed as they are under the present Medicare law. Under Medicare, hospitals, extended care facilities and home health agencies are reimbursed for the "reasonable cost" of services. Payment for medical services would be based on "appropriate and reasonable charges" rather than "reasonable charges," however.

The Department would be required, in the interim, to study alternative methods of reimbursement to determine those methods which would best control costs and utilization, improve the organization and delivery of health services, and assure that providers receive fair and reasonable compensation. Another possible objective would be to encourage medical societies or other organizations to assume greater responsibility for the quality, utilization and efficiency of care provided by their members, as well as the continuing education of professional and paramedical personnel. Following its study, the Department (with Presidential approval) would issue regulations concerning new reimbursement methods which would take effect in the third year of the program.

*Comprehensive health service systems*

Payment to qualified comprehensive health service systems (which are discussed later) could be based on the reasonable cost of services or could be a capitation rate for persons enrolled in the comprehensive system. Additional incentive payments are authorized if the average cost of services is less than the average cost of a comparable population group. Incentive payments are limited to a maximum of two-thirds of this difference in cost per member.

*Providers of drugs*

Payment to drug providers would be based on "reasonable" charges including acquisition and dispensing allowances as determined by regulation. The physician's prescription would be filed with the drug provider. For a nonlegend drug, the physician would be required to certify that it is medically necessary.

*Delivery and resources*

The plan authorizes the Department to contract for health services with comprehensive health service systems. These systems could be prepaid group practice organizations, other providers of health services, health insurance carriers, or a combination of them.

A comprehensive health service system is defined as one which provides health care to an identified population in an area, directly or through contractual arrangements with other providers. It must furnish all services covered under the Government program without any cost sharing by the patient and the following additional services: a full range of prescription drugs, extended care services without regard to the requirement concerning prior hospitalization, and immunizations and other approved services. The system would also need to meet the following requirements:

(1) it must assure the availability of services to enrollees, continuity of care, and appropriate referral and transfer of patients.

(2) all persons in the area may enroll, and it would encourage enrollment from a broad range of socioeconomic groups,

(3) preventive health services and health education are provided,

(4) a committee of physicians is established to consult with membership representatives, fix the professional policies, supervise the delivery of services, and review the utilization of health services,

(5) employment and training are given to allied health personnel,

(6) the premiums charged for noncovered services are reasonable, and

(7) the system is approved by State and areawide health planning agencies.

*Financial assistance to comprehensive systems*

The Department is authorized to provide loans, grants and technical assistance to comprehensive health service systems as follows:

(1) Grants and technical assistance to pay 80 percent of the cost of planning a comprehensive health service system. (Application for these grants could be made by a hospital, school, an insurance organization or a community group).

(2) Grants of 80 percent of the non-Federal share (the funds that the sponsor of a project ordinarily contributes) required under the Hill-Burton program for construction of hospitals and medical facilities.

(3) Grants of 50 percent of the cost of construction of needed ambulatory care facilities, and loans at 3 percent interest for the remaining cost.

(4) Payment of the operating deficit of an approved system during its first 5 years of operation, provided the organization is making reasonable progress toward becoming self-supporting.

(5) For planning of comprehensive systems in poverty areas, or demonstration projects designed to develop new methods of delivering care, special grants of 100 percent of costs, up to $100,000, would be available.

COSTS

See Part II, page 117, for the cost estimate of the Javits bill.

# PELL-MONDALE BILL—S. 703

S. 703, the "Minimum Health Benefits and Health Services Distribution and Education Act of 1971," was introduced by Senator Claiborne Pell of Rhode Island and Senator Walter S. Mondale of Minnesota on February 10, 1971.

*General concept and approach*

The proposal would establish a program of required health benefits for employees and their families as an obligation of the employer and at his expense. The bill also authorizes the creation of health services corporations which would provide comprehensive health services, build and operate health care facilities and train health care personnel. In addition, regional health planning councils would be established in major geographic regions of the country.

*Coverage of the population*

Businesses and organizations engaged in interstate commerce or affected with a Federal interest, including Federal, State and local government agencies, would be required to provide specified health care benefits for their employees (and their families). Where undue hardship for an employer could be demonstrated because of long-term wage contracts or other reasons, an exemption of up to 5 years could be given.

*Benefit structure*

The bill requires that specified health benefits be provided without any cost sharing by the patient, except for hospital inpatient care. The required benefits are as follows:

- Institutional services:
  - Hospital inpatient care: 12 days a year after the first 2 days
  - Hospital outpatient care
  - Skilled nursing home: 10 days for recovery from serious illness, accident or surgery
- Personal services:
  - Physicians' services
  - Physical checkup: one diagnostic examination per year
  - Optometrist services
  - Podiatrists' and chiropractors' services: if important to maintain employability
  - Laboratory, X-ray and supporting services
  - Pre- and post-natal care
- Other services and supplies:
  - Therapeutic devices, appliances, and equipment: if important to maintain employability
  - Prescription drugs
- Catastrophic coverage:
  - Coverage of medical costs which exceed 25 percent of an employee's annual gross income, as prescribed by regulation

Medical or surgical services which cannot practicably be furnished on a nationwide basis because of costs or lack of resources would be excluded.

*Administration*

The health benefits could be provided by employers under various arrangements including contracts with prepaid health care plans, prospective contracts with providers of health services, directly by the employer himself or through other "economic and appropriate means." In addition, the benefits could be provided through the health services corporations created under the bill, as described later.

The Department of Health, Education, and Welfare would be responsible for establishing regulations and standards for the program, and provide for hearing procedures in cases of denial of benefits. If a Federal court finds that a person has been denied benefits by his employer, the President may withhold all Federal funds, services, or contracts from the employer.

*Relationship to other Government programs*

The bill excludes services provided under workmen's compensation and school health programs. Medicare, Medicaid and other existing Government programs would continue to operate.

*Financing*

Employers are required to provide the health benefits as a cost of doing business and without charge to employees.

*Standards for providers of services*

Regulations of the Department of Health, Education, and Welfare would:

(1) require that properly accredited professional health services and facilities be used,

(2) establish standards of quality for services, and

(3) insure that services be medically needed or be for a preventive purpose.

*Reimbursement of providers of services*

The method of reimbursement of providers of service would depend on the arrangements made by the employer for provision of health services, as described earlier.

*Delivery and resources*

The bill provides incentives for creation of "area health services and health education" corporations. The corporations would provide medical services, operate health facilities, establish and operate medical schools and health care training schools and conduct related activities. They would provide comprehensive health care services, as well as the health benefits required under the bill, and could contract to provide health services under the Medicare and Medicaid programs.

The corporation could purchase the facilities of existing health care providers, employ professional and nonprofessional personnel and enter into agreements with providers of services. Medical services would be rendered through prospective contracts with providers, prepaid group practice arrangements, or under other "efficient and effective" arrangements.

Upon determination by the Department of Health, Education, and Welfare that an area needs a health services corporation, a corporation would be established in the area. The corporation would be managed by a 15-man board of directors representing consumers, health professionals, health organizations, and the Department. Eight of these board members would be appointed by the Department and the remainder elected by the stockholders.

*Financing of corporations*

Corporations would be for-profit organizations and would issue interest-bearing common and preferred stock with voting rights, and other certificates of indebtedness. Initially, common shares could be issued only to State and local governments and to health service providers, including institutions and physicians in the area. The initial price of common stock would be set by the Board, or in consideration of the value of health facilities and related properties transferred to the corporation. The Department would establish property evaluation methods. Preferred shares could be issued to any person or organization, except those initially eligible to receive common shares. No shares could be redeemed or repurchased for 5 years after incorporation.

The bill provides that Federal financial assistance may be given to the corporations for:

(1) initial organization and operation,
(2) financing health care for the poor,
(3) financing benefits for employees of small businesses and charitable organizations, if the Department determines that the cost of providing the required benefits under the program (as described earlier) would cause financial hardship,
(4) subsidizing medical education, if personnel are in short supply,
(5) building and staffing medical care and medical education facilities where shortages exist, and
(6) developing improved health care delivery methods.

The Department may also make direct loans to corporations and guarantee their loans.

Corporations which do not make a profit could receive grants, loans, and interest subsidies or guarantees from existing programs under the Public Health Service Act, if their components (such as hospitals) would otherwise be eligible for such aid. The corporations would be given priority consideration for such financial assistance.

*Requirements of corporations*

Corporations would need to meet the following requirements:

(1) provide comprehensive services to all persons in the area and assure continuity of care, referral and consultation arrangements,
(2) would not discriminate against patients,
(3) maintain accredited hospitals and other facilities,
(4) employ allied health personnel,
(5) appoint physician committees to establish medical care standards, oversee delivery of care, and to monitor and review utilization (including drugs),

(6) conduct university-related medical educational programs,
(7) cooperate in area planning and arrange for reciprocity among area corporations, and
(8) conduct health care delivery systems research

*Standards for providers of services associated with corporations*

Standards for hospitals, skilled nursing homes and home health agencies associated with the corporation would be similar to those established under Medicare. (See page 73.)

Physicians and other health professionals associated with the corporations would have to meet national standards established by the Department. Continuing education requirements would be established and major surgery and other specified services could be performed only by physicians who hold specialty certification (or were previously engaged in the specialty), meet standards set by the Department of Health, Education, and Welfare and are recommended by their participating hospitals. Persons who received their education with financial assistance from a corporation would have to agree to work for it at least 3 years. Hospitals cannot refuse to grant physicians staff privileges on grounds other than professional qualifications.

*Establishment of regional planning councils*

Under a separate section of the bill, the Department of Health, Education, and Welfare would establish planning councils in the major geographic regions of the country. Council members would be appointed by the Department to represent that office, the governors of States in the regions, the health corporations and the medical personnel in the region. The Councils would develop plans for comprehensive health services and for allocating manpower and facilities in the regions. They would work with State and local planning agencies and approve their plans for construction of health facilities. They would also approve the budgets of the health services corporations which would be required to submit 5-year plans to the Council. No Federal funds could be spent on projects or programs not approved by the regional councils.

COSTS

See Part II, page 121, for the cost estimate of the Pell-Mondale bill.

# MEDICARE PROGRAM—STANDARDS FOR PROVIDERS OF SERVICES

In order to participate in the Medicare program, providers of services have to meet certain statutory requirements and other health and safety requirements established by the Department of Health, Education, and Welfare.

*Hospitals*

General hospitals must be licensed under State law, maintain clinical records for all patients, have by-laws for their medical staff, have every patient under the care of a physician, provide 24-hour nursing service and have a utilization review plan in effect. They must also meet health and safety requirements regarding their physical environment and the operation of their facilities and services.[10]

Hospitals accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association are deemed to meet all the conditions of participation except utilization review.

Tuberculosis and psychiatric hospitals must meet the same requirements as general hospitals and must be accredited by the Joint Commission as well as meet special requirements for medical records and staffing.

*Extended care facilities*

Extended care facilities must be licensed under State law, must maintain clinical records for all patients, have established policies regarding patient care, have every patient under physician supervision, provide 24-hour nursing service, have established procedures for dispensing drugs and have a utilization plan in effect. They must also have a transfer agreement with a hospital and meet health and safety requirements regarding their physical environment and the services they provide.

*Home health agencies*

Home health agencies must provide skilled nursing services and other therapeutic services, be licensed under State law, maintain clinical records for all patients, have established policies for their services and meet additional health and safety requirements.

*Providers of outpatient physical therapy services*

These providers include participating hospitals, extended care facilities and home health agencies. Clinics, rehabilitation agencies, and public health agencies can also be providers of outpatient physical therapy services if they are licensed under State law, maintain clinical records for all patients, provide an adequate program of physical therapy services for outpatients, have established policies for their services and meet additional health and safety requirements.

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[10] Nonparticipating hospitals may provide emergency services under Medicare and these hospitals must be licensed under State law and provide 24-hour nursing service.

*Independent laboratories*

Independent laboratories must be licensed under State law and meet health and safety requirements regarding the qualifications of their personnel, record keeping and the operation of their equipment and facilities.

*Physicians and other professionals*

Physicians must be legally authorized to practice medicine or surgery by the State in which they provide their services. Dental surgeons and podiatrists have to meet similar requirements with respect to their services.

*Other suppliers of services*

Suppliers of portable X-ray services must be licensed under State law, and must meet health and safety requirements relating to physician supervision, qualifications of personnel and safety standards for their equipment. Suppliers of ambulance service have to meet safety requirements for their ambulances and have trained personnel.

*Discrimination prohibited*

Participating hospitals, extended care facilities and home health agencies must comply with the requirements of Title VI of the Civil Rights Act of 1964, which prohibits discrimination based on race, color, or national origin.

# II. COST STUDY OF HEALTH INSURANCE PROPOSALS INTRODUCED IN THE 92D CONGRESS

## PURPOSE OF STUDY

The purpose of the study reported here is essentially twofold:

1. To develop and to present a methodology by which the costs of various national health insurance proposals can be estimated.
2. To apply the methodology to the various bills introduced in the 92d Congress prior to April 30, 1971.

The methodology, and its application to the various proposals, is designed to be understandable, consistent, and unbiased, in order that Congress can make intelligent comparisons of the proposals within its scrutiny. The difficulties inherent in making cost estimates in the health field are substantial, however, and at best the results must be viewed as reasonable approximations.

## DEFINITION OF COSTS AND SUMMARY OF RESULTS

The concept of the cost of any proposal is more complex than it might at first appear. Costs can be expressed from the point of view of the Federal taxpayer, or from the point of view of the Nation as a whole. They can be defined in terms of total cost after the proposal is in effect, or in terms of additional cost brought about by a proposal. When specific financing is provided by a proposal it may be appropriate to estimate the costs of the program for which the financing is intended. Costs can also be expressed both before and after the effect of income taxes.

This cost study will focus on two of the many possibilities. The initial emphasis will be on *total cost to the Nation* after a proposal becomes effective. The second emphasis will be on the *additional cost to the Federal taxpayer* arising from any proposal. Costs in both of these forms will be *after* the effect on Federal income tax.

*Total national health expenditures*

If a proposal, through its effect on either the supply of or particularly the demand for health services, can be presumed to add to the Nation's total expenditure for health services, then any additional expenditure will be referred to as the *induced cost.*

The total cost to the Nation after a proposal becomes effective is the sum of (1) all health expenditures prior to the proposal and (2) any induced costs arising from the proposal. This total national health expenditure can then be subdivided to indicate by whom the expenditure is paid.

TABLE 1.—*National health expenditures after tax adjustment by proposal, fiscal year 1974*

[Amounts in billions]

| Proposal | Total | Total | Private sector | | | Governmental sector | | |
|---|---|---|---|---|---|---|---|---|
| | | | Individual direct payments | Health insurance | Other | Total | State and local | Federal |
| None | $105.4 | $62.3 | $32.0 | $26.4 | $3.9 | $43.1 | $11.1 | $32.0 |
| Byrnes | 107.2 | 62.2 | 28.3 | 30.0 | 3.9 | 45.0 | 10.0 | 35.0 |
| Griffiths-Corman | 113.8 | 15.9 | 11.2 | 1.9 | 2.8 | 97.9 | 6.5 | 91.4 |
| Fulton-Broyhill | 109.5 | 61.9 | 26.5 | 31.5 | 3.9 | 47.6 | 9.3 | 38.3 |
| Burleson | 110.2 | 62.3 | 21.7 | 36.7 | 3.9 | 47.9 | 8.6 | 39.3 |
| Dingell | 116.8 | 13.9 | 6.9 | 3.1 | 3.9 | 102.9 | 9.6 | 93.3 |
| Hall | 107.6 | 59.0 | 28.5 | 26.6 | 3.9 | 48.6 | 13.4 | 35.2 |
| Hogan | 107.7 | 59.0 | 27.8 | 27.3 | 3.9 | 48.7 | 13.4 | 35.3 |
| Fisher | 109.1 | 58.1 | 27.5 | 26.7 | 3.9 | 51.0 | 8.7 | 42.3 |
| Bennett | 107.2 | 62.6 | 28.3 | 30.4 | 3.9 | 44.6 | 10.0 | 34.6 |
| Long | 106.5 | 60.3 | 30.0 | 26.4 | 3.9 | 46.2 | 11.1 | 35.1 |
| Javits | 113.0 | 31.3 | 19.9 | 8.2 | 3.2 | 81.7 | 8.1 | 73.6 |
| Pell-Mondale | 114.9 | 67.3 | 17.3 | 46.1 | 3.9 | 47.6 | 10.7 | 36.9 |

Table 1 summarizes the cost estimates of this study, expressed in terms of the total expenditures by the Nation if each of the 12 proposals become effective, and by whom these expenditures are borne. Since it also shows the expenditures expected if *no* proposal becomes effective, the total induced costs (to the Nation as a whole) are obtained by subtraction.

*Additional cost to Federal taxpayer*

The additional Federal expenditure arising from a health proposal will be viewed in three parts.

That portion of the cost which arises from the transfer of health expenditure from other sectors of the economy to the Federal taxpayer will be referred to as *transferred cost.*

The Federal share of induced cost becomes the second portion of additional cost to the Federal taxpayer.

To the extent that any proposal results in a revenue loss to the Federal Government under the Internal Revenue Code, there arises a third or *tax adjustment* portion of additional Federal cost. Tax adjustments are normally small in comparison with transferred or induced costs, but become important with respect to those proposals which provide income tax credits.

Table 2 summarizes the estimates of this cost study, expressed in terms of additional cost to the Federal taxpayer.

TABLE 2.—*Summary of additional costs to Federal taxpayers after tax adjustment, by proposal, fiscal year 1974*

[Amounts in billions]

| Proposal | Total | Transferred costs | Induced costs | Change in tax adjustments |
|---|---|---|---|---|
| Byrnes | $3.0 | $2.0 | $0.4 | $0.6 |
| Griffiths-Corman | 59.4 | 56.0 | 8.4 | −5.0 |
| Fulton-Broyhill | 6.3 | −1.9 | .2 | 8.0 |
| Burleson | 7.3 | 8.2 | 2.1 | −3.0 |
| Dingell | 61.3 | 55.2 | 11.3 | −5.2 |
| Hall | 3.2 | 2.4 | 1.0 | −.2 |
| Hogan | 3.3 | 2.5 | 1.0 | −.2 |
| Fisher | 10.3 | −2.4 | .2 | 12.5 |
| Bennett | 2.6 | 1.6 | .3 | .7 |
| Long | 3.1 | 2.4 | .8 | −.1 |
| Javits | 41.6 | 37.8 | 6.9 | −3.1 |
| Pell-Mondale | 4.9 | −0.5 | .3 | 5.1 |

# METHODOLOGY

*Assumptions as to time*

To facilitate comparison between proposals, all cost estimates are made as of the same period of time. Health expenditures are changing rapidly, and the cost estimate for any bill will depend considerably on the year chosen for estimation. Fiscal year 1974 is here chosen as a year that is neither (1) so far into the future that projections become unnecessarily unreliable, nor (2) so close to the present that proposals could not become effective so soon.

Use of fiscal year 1974 for cost estimation purposes for all proposals makes necessary certain timing assumptions. All estimates in this cost study are based on the following:

(*a*) All benefit provisions of each proposal are assumed to be in effect for the entire fiscal year 1974, whether or not this is in accordance with the proposal itself. Where the effective date of some benefit is later than July 1, 1973, comment is made in the text, but the cost estimate is nonetheless made as if the provision were effective on July 1, 1973.

(*b*) Induced costs due to increased services arising from a proposal are assumed to have full and complete impact in fiscal year 1974 even though in reality several years may elapse before all the induced services will have appeared. In a sense, the induced services of all years have been telescoped into fiscal year 1974. No attempt, however, has been made to telescope induced price changes. Induced price changes are estimated only for fiscal yea 1974, but in accordance with the assumption that induced services all appear by that year.

(*c*) Any adjustments to a proposal, which the health insurance industry or the persons it serves are likely to make, are assumed to have been completed prior to July 1, 1973.

(*d*) Changes in the structure of the health delivery system are important features of many proposals, but these changes must be measured against the length of time that would likely elapse before they could become effective. Changes in structure and creation of health resources necessarily take place slowly, and their impact on the cost of health services is most difficult to predict. Attempts were made to identify the structural changes which could be fully effective immediately, and the estimated cost impact of those changes are included in the results. The decision not to attempt to estimate the cost effect of changes in structure which might take a longer time does not imply that such cost effects are negligible, or that attempts to affect the health delivery system through legislation will in the long run be ineffective.

*Fiscal year 1970 model*

The starting point for the cost estimation process is the model of national health expenditures for fiscal year 1970 developed by the Office of Research and Statistics (ORS) of the Social Security Administration. The most recent data in this series are published in the *Social Security Bulletin* of January 1971. For the purposes of this cost study, the ORS model has been somewhat recast, with emphasis on identification of the ultimate payer of health expenditures.

Table 3 is a summary. Column (1) indicates $67,240 million of national health expenditures, made up of:

| | *Amount (in millions)* |
|---|---|
| Private sector | $44,277 |
| Direct payments by individuals | 22,909 |
| Health insurance | 17,499 |
| Others (including voluntary givers) | 3,869 |
| Governmental sector | 22,963 |
| State and local taxpayers | 7,304 |
| Federal taxpayers | 15,659 |

In the last analysis, people pay health expenditures. They do so directly out-of-pocket, through health insurance, through voluntary gifts, or through taxes. It may appear that the employer portion of the health insurance expenditure is an exception; but employers pass on their contributions to employee health plans to people as consumers (in the form of higher prices), pass them to people as employees (in the form of lower cash wages), or pass them to people as investors (in the form of lower profits). To the extent that some of the voluntary givers are corporations, the same considerations apply.

TABLE 3.—*National health expenditures: Fiscal year 1970*

[In millions]

| Financing channels | Before tax adjustment (1) | Tax adjustment (2) | After tax adjustment (3) |
|---|---|---|---|
| Total | $67,240 | ---------- | $67,240 |
| Private sector | 44,277 | −$3,980 | 40,297 |
| Individual direct payments | 22,909 | [1] −1,350 | 21,559 |
| Health insurance | 17,499 | −2,130 | 15,369 |
| Individual policies | 3,483 | [1] −200 | 3,283 |
| SMI premiums | 989 | [1] −50 | 939 |
| Employees, group plans | 3,630 | [1 2] −1,880 | 1,750 |
| Employers, group plans | 9,397 | ---------- | 9,397 |
| Others (including voluntary givers) | 3,869 | [3] −500 | 3,369 |
| Governmental sector | 22,963 | +3,980 | 26,943 |
| State and local taxpayers | 7,304 | ---------- | 7,304 |
| Federal taxpayers | 15,659 | +3,980 | 19,639 |
| Social insurance: | | | |
| Payroll tax, HI | 4,378 | ---------- | 4,378 |
| General revenue, HI and SMI | 1,781 | ---------- | 1,781 |
| General revenue | 9,500 | ---------- | 9,500 |
| Revenue loss through income tax | ---------- | +3,980 | 3,980 |

[1] Estimated revenue loss from deductions for medical expenses in the tax returns of individuals.
[2] Estimated revenue loss from employer contributions to health insurance plans for employees not taxable to employee.
[3] Estimated revenue loss from deductions for charitable gifts in tax returns of individuals and corporations.

It is important to note that $989 million of enrollee premiums to the Supplementary Medical Insurance part of Medicare are shown as paid by the private sector. Although these premiums flow through the Medicare system, they are not borne by taxpayers. Certain health expenditures under State disability plans and under workmen's compensation plans are treated as expenditures by employees or employers, because they are not borne by State or local taxpayers.

Column (2) indicates certain adjustments to Column (1) to recognize that special provisions of the Internal Revenue Code concerning health expenditures have the effect of transferring such expenditures from individuals, employees, employers, and voluntary givers to the Federal taxpayer.

(*a*) Under certain conditions, health expenditures of individuals are deductible under the personal income tax, thereby passing to the general body of Federal taxpayers the tax foregone.

(*b*) Similarly, voluntary givers to health organizations are entitled to income tax deductions and pass the tax foregone to other Federal taxpayers.

(*c*) Employees, because they pay no tax on their employer's contribution for group health insurance, also pass on to Federal taxpayers the tax that, in the absence of special provisions, they would otherwise pay. Note that the deductibility of the group health insurance premium in the employer's tax return is not considered a special provision if employer-contributed health premiums are viewed, as they are in this analysis, as a part of wages.

Column (3) is the display of the $67,240 million national health expenditure in fiscal year 1970 after tax adjustment.

A somewhat more detailed two-way analysis of the $67,240 million shown in Column (1) of table 3, by type of expenditure as well as by whom paid, appears as appendix A to this study. Appendix A also indicates how the fiscal year 1970 model has been recast from the National Health Expenditure series.

The fiscal year 1970 model is the best available information as to current national health expenditures. It must nonetheless be recognized as only approximate since there are many technical difficulties in the compilation of such statistics.

*Fiscal year 1974 model*

The fiscal year 1970 model previously described has been projected forward four years to fiscal year 1974. The results appear as table 4 and in more detail as appendix B. Appendix B also gives some detail as to how the projection was made. The basic assumption in this projection is that no new health or tax legislation importantly affecting national health expenditures will be enacted during the period, and that the legislative environment in fiscal year 1974 remains essentially as it was in fiscal year 1970.

The total health expenditure for fiscal year 1974 is projected as $105,400 million (7.8 percent of estimated GNP for the same year), greater in both absolute amount and as a percent of GNP than the $67,240 million for fiscal year 1970 (7.0 percent of GNP). The substantial increase between the two models results from assumed changes in unit prices for health services, assumed changes in utilization rates for the various health services, assumed demographic changes, and certain minor factors.

The estimation of these effects, based largely on past trends, introduces an important dimension of uncertainty into the estimates. Projection errors are not likely, however, to be biased for or against any specific proposal, and relative costs between proposals should not be greatly affected by the model chosen. Since estimation of relative costs is the real purpose of this cost study, the fiscal year 1974 model is considered to serve its purpose satisfactorily.

TABLE 4.—*National health expenditures: Fiscal year 1974*

[In millions]

| Financing channels | Before tax adjustment (1) | Tax adjustment (2) | After tax adjustment (3) |
|---|---|---|---|
| Total | $105,400 | ---------- | $105,400 |
| Private sector | 68,633 | −$6,300 | 62,333 |
| Individual direct payments | 33,846 | [1] −1,900 | 31,946 |
| Health insurance | 30,344 | −3,900 | 26,444 |
| Individual policies | 4,911 | [1] −300 | 4,611 |
| SMI premiums | 1,613 | [1] −100 | 1,513 |
| Employees, group plans | 6,743 | [1 2] −3,500 | 3,243 |
| Employers, group plans | 17,077 | ---------- | 17,077 |
| Others (including voluntary givers) | 4,443 | [3] −500 | 3,943 |
| Governmental sector | 36,767 | +6,300 | 43,067 |
| State and local taxpayers | 11,108 | ---------- | 11,108 |
| Federal taxpayers | 25,659 | +6,300 | 31,959 |
| Social insurance: | | | |
| Payroll tax, HI | 8,600 | ---------- | 8,600 |
| General revenue, HI and SMI | 2,297 | ---------- | 2,297 |
| General revenue | 14,762 | ---------- | 14,762 |
| Revenue loss through income tax | ---------- | +6,300 | 6,300 |

[1] Estimated revenue loss from deductions for medical expenses in the tax returns of individuals.
[2] Estimated revenue loss from employer contributions to health insurance plans for employees not taxable to employee.
[3] Estimated revenue loss from deductions for charitable gifts in tax returns of individuals and corporations.

*Estimation of induced cost*

The concept of induced cost of health services is an important but complicating factor in the cost estimation problem. Although evidence of the existence of induced cost is difficult to refute, such cost is not always recognized; or is thought not to exist for some of the proposals under study. The quantification of induced cost is extremely difficult and is largely based on subjective judgments. Little agreement can be expected in this area. It is nonetheless the estimator's job to attempt quantification; and in doing so to apply the same principles to all proposals.

This section of the cost report consists of (1) a rationale based on general economic, sociological, and psychological principles as to why and under what conditions induced cost is presumed to exist, (2) a brief reference to past studies in which induced cost has been demonstrated and/or measured, and (3) a statement of the principles used in this cost study for the estimation of induced costs.

(*1*) *Rationale*

An induced cost is most likely to result from the additional demand for health services when the necessity for the individual to make out-of-pocket payments for such services is reduced or eliminated.

There may be individuals whose behavior with respect to their health or that of their families is independent, or nearly so, of personal economic variables. At one extreme are those whose use of health service is minimal, no matter what the economic circumstances. At the other are those who tend to be under continual treatment for a multitude of health problems even though a large personal financial sacrifice is involved.

Despite the existence of groups of people whose health behavior is independent of financial circumstances, the majority of people probably respond in some degree to economic motivations in seeking health services, much as they do in the purchase of other services. If the price to the individual is low, he will be more inclined to ask for additional services—but if the price is high he tends to do without them. Obviously the price to the individual is not entirely in dollar terms, and must include the time, inconvenience, and effort involved in obtaining medical attention; but the dollar cost to the individual no doubt has an important relationship to demand.

The foregoing paragraph is valid in principle if the individual has the ultimate decision as to whether health services are rendered. In practice the physician may have more influence in this decision than the patient. The physician's attitude may be colored by his perception of the patient's ability to pay, not so much because of his interest in whether his own bill will be collectible, but because he does not wish to impose a financial sacrifice on the patient incommensurate with the expected improvement resulting from the treatment. Hence induced costs can be inferred even if the physician is considered the main determiner of medical expenditure.

Health insurance, though it does not reduce (and may well raise) the aggregate cost of health services to the group of persons who collectively pay the premiums, does lead to the reduction or elimination of an individual's out-of-pocket expenditure for any particular service. When the individual pays the same premium no matter what services he obtains, the marginal cost to him of any fully insured service is close to zero. The insurance mechanism leads to extra demand—and in the absence of counteracting influences will almost certainly add to the health services rendered. This is the principle behind the concept of induced costs arising from the health insurance mechanism.

Induced services must be viewed in the light of the additional health services rendered. They may be a reflection of previously unmet needs, or they may be indicative of overuse of health services. No value judgment is intended, since an induced health service *in itself* may be considered favorable or unfavorable, depending on the contributions of the extra services to the overall health needs of the Nation.

Services induced by health insurance add to demand. In the absence of adequate increase in supply, prices per unit of service, as well as the amount of services rendered, may also increase. Thus induced cost may have two elements—induced services and induced price.

It seems unlikely that induced costs arising from transfer of cost from the individual to private insurance or to the Government, could ever be negative. There are, however, other kinds of induced costs. If a proposal contains measures for controlling utilization of health services, effective demand is affected downward—and the number of

services rendered and possibly the price per service may be actually reduced; or more likely may not rise as fast as they otherwise would.

*(2) Past studies*

The existence of induced costs has been demonstrated, and to some degree quantified, in earlier studies. No attempt is made here to summarize the literature on this subject.

The coming of Medicare in 1966 made possible "before and after" studies based on samples of those aged 65 and over. The *Social Security Bulletin* of April 1971 carries an article indicating some of these results. Some additional data, based on experience under the British Drug Act and the Saskatchewan program, and the experience of insurance companies, Blue Cross, and certain group health plans, are available. There are also a number of theoretical studies based on econometric models.

This study has made use of, to the degree that they appear to be applicable, all of the studies available. Few of them, however, bear directly on this particular problem. Since the state of knowledge with respect to induced costs is not far advanced, this study is necessarily handicapped. Several econometric studies have been published but such studies have not advanced to the point of consensus and independent verification.

*(3) Principles used in this cost study*

(*a*) The basic estimating factor for induced services used in this cost study is the additional service induced as a transfer from direct payment by individuals to a public or private insurance mechanism. Additional service is expressed as a percent of the transferred cost. The induced service percentage no doubt varies by type of service, child versus adult, family income, and many other factors; but, in the absence of data necessary for refined measurement, the induction forces are aggregated into one factor for each type of service.[1]

| | *Induced service as a percentage of transferred cost from direct individual payments* |
|---|---|
| Hospital | 25 |
| Extended care facilities | 25 |
| Professional services: | |
| Physicians | 25 |
| Dentists | 45 |
| All other | 35 |
| Drugs | 35 |
| Eyeglasses and hearing aids | 40 |

Note particularly that the induced service percentages apply only to the cost transferred from direct payment, not to the entire cost of any service. If, for example, 10 percent of the total cost of all hospital services is transferred under a proposal from direct payment to an insurance mechanism, then the induced services are estimated as 25

[1] The induced service percentages were chosen after a review of past experience, but no claim is made that any of the induced service percentages are based on solid empirical foundations. There is a range of reasonable percentages, and those chosen are thought to be within this range. If there were no limitations on supply, the percentages for institutional services and for physicians might well be higher. The higher percentages for dentists, drugs, and eye and hearing aids are based partly on more adequate and more elastic supply, and partly on the more elective nature of these types of services.

percent of the transfer, or 2.5 percent of the overall cost of hospital services.[2]

(*b*) There are certain kinds of induced services for which the above technique is not satisfactory. When the induced service percentage would appear to be very high because of the optional nature of the service, and particularly if the transferred cost is itself difficult to estimate, more direct estimation methods seem necessary. The routine physical examination specifically provided by some of the proposals is an example.

(*c*) For any national health insurance proposal which would transfer vast amounts of expenditure from direct payment by individuals to an insurance mechanism, the additional demand created is assumed to interact with supply in such a way that costs per service throughout the economy are increased. This effect is likely to take place slowly—and its ultimate accumlative effect cannot be estimated. The estimates of this cost study have included induced price changes of up to 3 percent for hospital and extended care facilities, up to 2 percent for professional services, with the actual percentage used depending on the proportion of services transferred. These may be viewed as fiscal year 1974 effects. Price effects arising after 1974 are especially difficult to estimate because of the effect of increases in supply and price control measures established by a particular proposal. For this reason the induced price change factors are considered to be applicable to fiscal year 1974 only.[3]

(*d*) Where effective utilization controls appear to be a part of a proposal, a negative induced service factor is employed to be applied in the same areas to which the controls are effective. The effect of utilization controls is thought to be largest in the area of elective surgery, and in the substitution of outpatient treatment or diagnosis for inpatient hospital care. Negative induced cost can also arise from changes in the methods for compensating institutions and physicians, or by other structural change.[4]

(*e*) Appropriate induced costs for administrative expenses are built into these estimates whenever costs of administration are expected to increase, and negative induced costs are estimated whenever cost of administration are expected to decrease.[5]

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[2] It is recognized that the transfer of the last 10 percent of the cost of any service may have a different inductive effect than the transfer of any earlier 10 percent. The linearity implied by the procedure outlined is questionable, but evidence on which to base any more sophisticated assumption is lacking.

[3] The methods described for recognizing induced price increases are admittedly rough, but no sharper tools are available. Much remains to be learned in this area, and past experience confounds various causes of price increase. There is no deliberate bias between proposals in the method used. Price changes over time which take place independent of any proposal are built into the fiscal year 1974 model, and are presumably neutral in relative comparisons.

[4] Very little recognition of structural change could be incorporated into this study due to lack of data. It is nonetheless possible that in the long run the provisions of the various proposals with respect to change in the health delivery system will be most important.

[5] Costs of administration, distribution, and any provision for stockholders or for contingency funds have been estimated as follows:

For a national health proposal operated by Federal Government—7 percent of benefits paid.
For employer-employee plans operated on group basis—10 percent of benefits paid.
For individual health insurance policies—30 percent of benefits paid.

# ANALYSIS AND RESULTS

The final step is the analysis of each proposal, in terms of its transferred costs, induced costs, and the attendant income tax effects. This analysis may involve such elements as (1) the distribution of the population by income and family composition, (2) the pricing of various benefit packages, (3) the ways in which individuals, health insurance companies, or governments react to choices they are given, and many others not easily estimated.

The results for each proposal are displayed by comparing table 4 (the fiscal year 1974 model as if no proposal were in effect) to the similar display as if the proposal were adopted. The standard format in which results are displayed includes transferred costs, induced costs, and tax adjustments for each sector, but with emphasis on the effect to the Federal taxpayer. The distribution of expenditures after a proposal is effective is shown in a final column.

Consideration was given to recognizing uncertainty with respect to induced costs by expressing them as a range, rather than the point estimates actually shown. It is felt that any of the induced costs can conceivably be wrong by as much as 100 percent, since techniques for estimating induced costs with any degree of precision do not exist. Range estimates may also imply more certainty than actually exists, by suggesting that the actual result will fall within the range. Range estimates are also confusing and badly complicate the presentation. The decision to use point estimates was pragmatic, and not intended to suggest precision.

Program cost is only determined for any proposal which has an explicit provision in it to finance the program. The program cost is shown in the supplementary cost estimate table of such proposals, and a comparison with the financing is presented.

The cost estimates which follow include, in addition to the results in the standard format, a descriptive section intended to make the results understandable. The provisions which particularly affect transferred and induced costs are highlighted, but for a real understanding of the provisions of each proposal reference should be made to Part I of this report. The descriptive section states any important assumptions or interpretations essential to the estimate, and comments very briefly on the results found.

# BYRNES BILL—H.R. 7741

*Main provisions*

1. This bill contains two programs—one requiring employers to provide health insurance coverage with specified benefits for employees and their families and the other a Federally operated program for low-income families with children. Virtually all nongovernmental employers would be required to make available through private insurance carriers a minimum standard health insurance plan covering both full and part-time employees and their dependents but employees could choose not to join. The employer would have to pay at least 65 percent of the premium initially (increasing to 75 percent within 2½ years) with the employee contributing the remainder. The Federally operated Family Health Insurance Plan would establish coverage for low-income families with children where eligibility would vary with the family's annual income ($5,000 maximum for a family of four). It would be financed from Federal general revenues but would require cost sharing from some covered families varying by family income class.

2. Present governmental health programs including Medicare would remain essentially intact, but the Medicaid program would be limited to the aged, blind, and disabled persons.

Special group plans would be developed by insurance carriers for employees of small (under 100 employees) employers. The self-employed and others not eligible for coverage under an employer plan, the Family Health Insurance Plan, or Part A of Medicare would be eligible to purchase health insurance coverage through special private insurance carrier group plans or pools.

3. The basic employer benefit plan must include inpatient hospital room and board charges with a 2-day deductible. Other hospital care (inpatient and outpatient), all physicians' services, and vision care for children are covered subject to a deductible and coinsurance on a calendar year basis. The Family Health Insurance Plan provides for 30 days of inpatient hospital care along with physicians' services and a broad range of other services. There are limits on some services and there are deductible and coinsurance provisions which vary by family income class.

4. Applicable standards and reimbursement to providers of services are similar to the Medicare approach. The proposal also includes provisions designed to encourage the formation and use of health maintenance organizations.

5. An employee would be subsidized by the Federal Government if the employer's share of the average premium cost for employees covered under a required plan exceeds 4 percent of the average wage paid to those employees. The subsidy payment would be equal to the amount of the excess multiplied by the number of employees for a maximum of 10 employees.

*Transferred costs*

1. For employees of nongovernmental employers, some costs of health insurance for themselves and their dependents would be transferred from direct payment to group insurance. Some additional takeover by employers of employee contributions could also be expected.

2. State and local governments will gain because of the Federal program for low-income families and some of the direct payments of individuals will also transfer to this Federal program.

*Induced costs*

There are some induced costs because of the expansion (compulsory on employers) of group health insurance.

*Estimation assumptions*

1. It is assumed that all of those working for employers on whom the plan is compulsory will join.

2. It is assumed that those now under Medicaid though still working will be covered by the Family Health Insurance Plan.

*Comments on results*

The total cost to the Federal Government under the Byrnes bill is estimated at $3.0 billion (see table 5). It is estimated that the provisions for subsidy payments to employers will transfer some $0.5 billion to Federal costs instead of to employer costs. The transfer results in an offsetting change of about $0.1 billion in tax adjustment, leaving a net change of $0.4 billion.

TABLE 5.—*Byrnes bill: Cost estimate*

[In billions]

| Sector | 1974 model [1] before proposal effective | Transferred costs | Induced costs | Change in tax adjustment | 1974 model after proposal effective |
|---|---|---|---|---|---|
| Total | $105.4 | [2] 0 | +$1.8 | 0 | $107.2 |
| Private sector | 62.3 | −$0.8 | +1.3 | −$0.6 | 62.2 |
| Individual direct payments | 32.0 | −4.1 | +.1 | +.3 | 28.3 |
| Health insurance | 26.4 | +3.3 | +1.2 | −.9 | 30.0 |
| Others (including voluntary givers) | 3.9 | | | | 3.9 |
| Government sector | 43.1 | +.8 | +.5 | +.6 | 45.0 |
| State and local taxpayers | 11.1 | −1.2 | +.1 | | 10.0 |
| Federal taxpayers | 32.0 | [2] [+2.0] | [3] [+.4] | [3] [+.6] | [4] 35.0 |

[1] This model, identical for all proposals, is the fiscal year 1974 model, after tax adjustment rounded to nearest $100,000,000.

[2] Transferred costs, by definition, must add to zero.

[3] Total additional cost to the Federal taxpayer is sum of figures in 3 brackets.

[4] This figure represents the total Federal cost of all health programs, after tax adjustment, and not the cost of the program proposed alone.

# GRIFFITHS-CORMAN BILL—H.R. 22

*Main provisions*

1. This bill would provide broad health care benefits for all U.S. citizen-residents and for certain alien residents.

(*a*) Professional services are provided without deductibles or cost sharing, but with a maximum on the number of psychiatric visits, and a maximum age on dental care.

(*b*) The bill also covers inpatient and outpatient hospital care without deductibles or cost sharing, but with a limit on number of days for psychiatric patients. Skilled nursing home care for up to 120 days, home health services, and other noncustodial institutional health care services are also provided. This proposal specifically excludes domiciliary and custodial institutional care.

(*c*) Inpatient drugs are generally covered. Outpatient drug coverage is limited to drugs needed in the treatment of chronic diseases or of conditions requiring especially costly drug therapy.

(*d*) Appliances and equipment (including eye and hearing aids) are covered, but with limits designed to keep these expenditures within 2 percent of expenditures for all covered services.

2. The proposal includes provisions designed to reorganize the delivery of health services and to increase the supply of health care, manpower, and facilities. Emphasis is given to the encouragement of the development of comprehensive health service organizations through grants and loans, the encouragement of health professionals to work on a salary or capitation basis, and a scheme to allow certain organizations to share the savings brought about by low utilization of institutional services. A fairly elaborate payment mechanism has been developed in order to ensure that aggregate payments do not exceed a predetermined budget.

3. The program will be financed by a (a) tax of 1 percent on wages and unearned income, (b) 2.5 percent tax on self-employment, (c) 3.5 percent tax on employers payroll and (d) contribution from Federal general revenues equal to the total receipts from taxes.

*Transferred costs*

1. The main thrust of the Griffiths-Corman proposal is to transfer the vast majority of health costs to the Federal sector from each of the other sectors.

2. The entire Medicare program for the aged would be specifically eliminated by the Griffiths-Corman proposal.

*Induced costs*

1. Positive induced costs arise from expected increase in utilization of practically all health services.

2. Some negative induced costs are due to measures to cut utilization of health services, to put limits on the increase in unit costs, and to promote more efficient use of health resources.

*Estimation assumptions*

1. Dental care was assumed to be provided for only those under age 25.

2. The Health Resources Development Fund was assumed to be 2 percent of the program income (specified in the bill for the first year), instead of the ultimate level of 5 percent of program income.

*Comments on results*

Table 6 exhibits transferred costs of $56.0 billion, the Federal share of induced cost of $8.4 billion, and an offsetting change in tax adjustments of $5.0 billion. The net additional cost to the Federal taxpayer is therefore estimated at $59.4 billion. The resulting overall cost to the Federal taxpayer if the proposal is adopted is estimated at $91.4 billion.

As the Griffiths-Corman bill is one which contains financing provisions, a program cost is computed (see table 7). The expenditure under the Griffiths-Corman program is estimated to be $81.6 billion; the financing provided by the bill is estimated to be $57.0 billion.

TABLE 6.—*Griffiths-Corman bill: Cost estimate*

[In billions]

| Sector | 1974 model [1] before proposal effective | Transferred costs | Induced costs | Change in tax adjustment | 1974 model after proposal effective |
|---|---|---|---|---|---|
| Total | $105.4 | [2] 0 | +$8.4 | 0 | $113.8 |
| Private sector | 62.3 | −$51.4 | | +$5.0 | 15.9 |
| Individual direct payments | 32.0 | −22.0 | | +1.2 | 11.2 |
| Health insurance | 26.4 | −28.3 | | +3.8 | 1.9 |
| Others (including voluntary givers) | 3.9 | −1.1 | | | 2.8 |
| Governmental sector | 43.1 | +51.4 | +8.4 | −5.0 | 97.9 |
| State and local taxpayers | 11.1 | −4.6 | | | 6.5 |
| Federal taxpayers | 32.0 | [3] [+56.0] | [3] [+8.4] | [3] [−5.0] | [4] 91.4 |

[1] This model identical for all proposals in the fiscal year 1974 model, after tax adjustment and rounded to nearest $100,000

[2] Transferred costs by definition must add to zero

[3] Total additional cost to the Federal taxpayer is sum of figures in 3 brackets

[4] This figure represents the total Federal cost of all health programs, after tax adjustment, and not the cost of the program proposed alone.

TABLE 7.—*Griffiths-Corman bill: Supplementary cost estimate—conversion to program cost and comparison with proposed financing*

| | In billions |
|---|---|
| A. Conversion to program cost, fiscal year 1974: | |
| 1. Federal taxpayer share of total health expenditures after proposal effective (from table 6) | $91.4 |
| 2. Adjustments to eliminate expenditures financed under other programs | −8.5 |
| 3. Adjustment to eliminate Federal income tax effects | −1.3 |
| 4. Program cost to Federal taxpayer | 81.6 |
| B. Comparison with proposed financing, fiscal year 1974: | |
| 1. Estimate of payroll tax—employee portion | 7.7 |
| 2. Estimate of payroll tax—employer portion | 20.8 |
| 3. Estimate of general revenue financing proposed | 28.5 |
| 4. Program financing proposed | 57.0 |
| Underfinancing of program | 24.6 |
| Underfinancing as a percent of financing provided | 43 |

# FULTON-BROYHILL BILL—H.R. 4960

*Main provisions*

1. This proposal permits a tax credit for premiums paid for qualified private health insurance policies. The tax credit is a percent of the premium for basic coverage with those with low income tax liabilities entitled to a higher credit than those with high income tax liabilities, as illustrated at sample points below:

| Tax liability: | *Tax credit as percent of premium* |
|---|---|
| None | 100 |
| $100 | 90 |
| $300 | 70 |
| $500 | 50 |
| $700 | 30 |
| $891 | 10 |

Policies must include certain catastrophic illness coverage in order to be qualified. The catastrophic portion of the premium is fully deductible as a tax credit. An employee, in computing the amount of premiums against which he may take a tax credit on his personal tax return, would count 80 percent of any contribution his employer makes to a qualified plan. Employers with qualified plans may continue to treat the premium as a business expense. Employers with a nonqualified plan will only be allowed to take 50 percent of the premium as a business expense.

2. The insurance policy must meet certain standards to be a qualified policy eligible for tax credit. In particular, it must offer specified basic benefits, and certain catastrophic illness benefits. All persons could voluntarily elect coverage under the plan except those age 65 and over.

3. If the tax would be less than the tax credit, the credit is paid to the taxpayer by voucher. Hence, the credit is never lost.

4. The special tax credit is in lieu of the right to deduct health insurance premiums as a medical expense.

*Transferred costs*

1. Much of cost of insurance in force prior to the bill's effect would presumably transfer from the private sector to the Federal Government through tax credits.

2. Presumably substantial numbers of persons not now insured (or inadequately insured) under individual policies would apply for such insurance in order to qualify for tax credits. Some of this individual insurance would insure health expenditures paid directly by the individual; but some would replace State and local government expenditures.

3. The problem of estimating transferred costs is in estimating the volume of voluntary purchase of new policies, when tax credits are the incentive, and the extent to which group policies will be upgraded to avoid the tax penalty provided by the bill.

*Induced costs*

To the extent new private insurance represents a transfer from expenditures paid directly by individuals, induced services are to be expected—but to the extent that new insurance arrangements replace present Medicaid arrangements, such induced services are not expected.

*Estimation assumptions*

1. It is assumed that not all eligible persons will be covered by a qualified plan. Many employers will find it too expensive to introduce qualified plans or upgrade existing ones. Higher income persons may find the tax credit inadequate incentive to purchase individual insurance. The table below shows the percentage of maximum credit assumed to be claimed by the individuals.

| Tax liability: | *Percent of maximum credits* |
|---|---|
| None | 98 |
| $1 to $100 | 95 |
| $101 to $300 | 92 |
| $301 to $500 | 60 |
| $501 to $700 | 53 |
| $701 to $890 | 50 |
| Over $890 | 48 |

2. Internal Revenue furnished a distribution of income tax returns by amount of tax liability using the 1973 tax levels and their most recent tabulations from tax returns. From these data and the assumptions in paragraph 1 above, we estimated the total special tax credit and new insurance premiums.

*Comments on results*

1. Overall additional cost to the Federal Government shown in table 8 is $6.3 billion. Most of the transfer to the Federal Government shows up as a change in the tax adjustment, but the effect is the same as a transferred cost.

2. The makeup of this estimate is as follows:

| | *In billions* |
|---|---|
| Individual tax credits | $9.0 |
| Employee credit for employer's premium | 1.5 |
| Tax penalty for nonqualified plans | −2.9 |
| Net additional tax deduction | 0.4 |
| Total | 8.0 |
| Induced price increase | 0.2 |
| Reduction in Federal share—Medicaid | −1.9 |
| Net additional cost to Federal Government | 6.3 |

TABLE 8.—*Fulton-Broyhill bill: Cost estimate*

[In billions]

| Sector | 1974 model[1] before proposal effective | Transferred costs | Induced costs | Change in tax adjustment | 1974 model after proposal effective |
|---|---|---|---|---|---|
| Total | $105.4 | [2] 0 | +$4.1 | 0 | $109.5 |
| Private sector | 62.3 | +$3.7 | +3.9 | −$8.0 | 61.9 |
| Individual direct payments | 32.0 | −6.0 | +.2 | +.3 | 26.5 |
| Health insurance | 26.4 | +9.7 | +3.7 | −8.3 | 31.5 |
| Others (including voluntary givers) | 3.9 | | | | 3.9 |
| Governmental sector | 43.1 | −3.7 | +.2 | +8.0 | 47.6 |
| State and local taxpayers | 11.1 | −1.8 | | | 9.3 |
| Federal taxpayers | 32.0 | [2] [−1.9] | [3] [+.2] | [3] [+8.0] | [4] 38.3 |

[1] This model, identical for all proposals, is the fiscal year 1974 model, after tax adjustment rounded to nearest $100,000,000.

[2] Transferred costs, by definition, must add to zero.

[3] Total additional cost to the Federal taxpayer is sum of figures in 3 brackets.

[4] This figure represents the total Federal cost of all health programs, after tax adjustment, and not the cost of the program proposed alone.

## BURLESON BILL—H.R. 4349

*Main provisions*

1. This proposal provides for three voluntary health care plans. Each plan would have the same benefit structure, but premiums and copayment by an individual would vary depending on whether the individual was covered under an employer plan, a State plan, or an individual plan. The basic benefits would be phased in over a period of six years, though for cost estimation purposes it is assumed that all benefits will be in effect by July 1, 1973.

2. The three population groups are:

(*a*) Workers and dependents—employer plan.
(*b*) Public assistance and low-income people—State plan.
(*c*) All others—individual plan.

3. Reimbursement for care in institutions will be based on prospectively approved rates which would be reasonably related to the cost of efficient operation. Physicians and dentists would be reimbursed on a reasonable and customary charge basis.

4. Benefits include the following:

(*a*) Hospitalization (300 days per year).
(*b*) Extended care facility (180 days per year).
(*c*) Home health agency (270 visits per year).
(*d*) Physicians' services.
(*e*) Dentists' services except orthodontia.
(*f*) Prescription drugs.
(*g*) Eyeglasses.

5. A range of copayments and a deductible are provided by the bill. Health care institutions would be required to have an active utilization review committee.

6. If an employer's plan does not meet the requirements, he suffers a tax penalty in that he loses half of the tax deductions he would otherwise enjoy.

*Transferred costs*

1. To a substantial degree health expenditures would be transferred from individual direct payments to individual premium payments, employee and employer contributions towards group premiums, and Federal and State governments.

2. For State governments, a large part of the cost of operating the State plan would be transferred to the Federal Government.

3. The Federal Government is also affected through tax adjustments. Some employers lose a part of the deductibility of group premiums; but additional group insurance is sold and adds to the employee tax subsidy.

*Induced costs*

1. Positive induced costs arise from expansion of insurance.
2. Negative induced costs are due to the emphasis on ambulatory benefits and prospectively determined reimbursement rates for institutions.
3. Increased administration costs arise from expansion of the private insurance mechanism.

*Estimation assumptions*

1. Although the State plan proposed by the Burleson bill differs considerably from the present Medicaid program in benefits, administrative procedures and financing, it has been assumed that the estimated expenditures under the Medicaid program in the absence of the Burleson program would still be spent either through the State plan or in providing supplementary benefits.
2. It is assumed that benefits for about one-third of the employees covered under existing employer group plans would be upgraded to the benefit standards provided by the bill but that employers would lose part of their tax deductions on the remaining two-thirds.
3. The members of the low income population who would be eligible for coverage under a State plan consist of two groups:

Group A—Those whose premiums are paid completely by the State.

Group B—Those who pay a portion of the premium while the State underwrites the remaining portion.

It was assumed that all the members of Group A would be covered under a State plan. Those of Group B not covered under an upgraded employer plan would be covered under a State plan.

4. The percentage of Federal reimbursement to a State for the operation of a qualified plan was assumed to be 80 (the midpoint of the 70 percent-90 percent provided for by the bill).

*Comments on results*

Table 9 shows transferred costs to the Federal taxpayer of $8.2 billion. The Federal share of induced costs is $2.1 billion and the Federal change in tax adjustment is —$3.0 billion. The net additional cost to the Federal taxpayer is therefore $7.3 billion. The resulting overall cost to the Federal taxpayer is estimated to be $39.3 billion.

## TABLE 9.—*Burleson bill: Cost estimate*

[In billions]

| Sector | 1974 model [1] before proposal effective | Transferred costs | Induced costs | Change in tax adjustment | 1974 model after proposal effective |
|---|---|---|---|---|---|
| Total | $105.4 | [2] 0 | +$4.8 | 0 | $110.2 |
| Private sector | 62.3 | −$5.6 | +2.6 | +$3.0 | 62.3 |
| Individual direct payments | 32.0 | −11.1 | +0.2 | +0.6 | 21.7 |
| Health insurance | 26.4 | +5.5 | +2.4 | +2.4 | 36.7 |
| Others (including voluntary givers) | 3.9 | | | | 3.9 |
| Governmental sector | 43.1 | +5.6 | +2.2 | −3.0 | 47.9 |
| State and local taxpayers | 11.1 | −2.6 | +0.1 | | 8.6 |
| Federal taxpayers | 32.0 | [3] [+8.2] | [3] [+2.1] | [3] [−3.0] | [4] 39.3 |

[1] This model, identical for all proposals, is the fiscal year 1974 model, after tax adjustment rounded to nearest $100,000,000.

[2] Transferred costs, by definition, must add to zero.

[3] Total additional cost to the Federal taxpayer is sum of figures in 3 brackets.

[4] This figure represents the total Federal cost of all health programs, after tax adjustment, and not the cost of the program proposed alone.

# DINGELL BILL—H.R. 48

*Main provisions*

1. This proposal would establish a national health insurance program covering nearly all residents of the United States. The medical benefits are very broad, with nursing home care the only important area excluded. There are some limitations on number of days covered in hospitals. Unusually expensive drugs are covered.

2. The program is financed by a payroll tax, and for those not employed through Federal-State general revenues. Initially Medicare would continue to exist, but it is intended that eventually it be absorbed into the national program. Medicaid and other Federal-State assistance programs would finance the cost for those for whom payroll taxes are not paid.

3. There is some attempt to control health expenditures via the financial and administrative provisions. Administration is largely at a State level.

*Transferred costs*

Nearly all health expenditures not already in the Federal Government sector would be transferred to that sector. However, health expenditures of State and local governments would not be materially affected.

*Induced costs*

Transfer of a substantial portion of health insurance expenditures from paid by individuals to paid by social insurance results in substantial induced costs.

*Estimation assumptions*

It is assumed the Medicare program will continue under its present form and will not be incorporated under the Dingell program until after fiscal year 1974.

*Comments on results*

Table 10 exhibits transferred costs of $55.2 billion to the Federal taxpayer, induced costs of $11.3 billion, all in the Federal area, and an offsetting change in tax adjustments of $5.2 billion. The net additional cost to the Federal taxpayer is, therefore, estimated at $61.3 billion, and the resulting overall cost of health expenditure to the Federal taxpayer is estimated at $93.3 billion.

As the Dingell bill is one which contains financing provisions, a program cost is computed (see table 11). The expenditure under the Dingell program is estimated to be $68.2 billion; the financing provided by the bill is estimated to be $22.7 billion plus an unspecified amount of general revenue financing.

## TABLE 10.—*Dingell bill: Cost estimate*

[In billions]

| Sector | 1974 model [1] before proposal effective | Transferred costs | Induced costs | Change in tax adjustment | 1974 model after proposal effective |
|---|---|---|---|---|---|
| Total | $105.4 | [2] 0 | +$11.4 | 0 | $116.8 |
| Private sector | 62.3 | −$53.6 | | +$5.2 | 13.9 |
| Individual direct payments | 32.0 | −26.6 | | +1.5 | 6.9 |
| Health insurance | 26.4 | −27.0 | | +3.7 | 3.1 |
| Others (including voluntary givers) | 3.9 | | | | 3.9 |
| Governmental sector | 43.1 | +53.6 | +11.4 | −5.2 | 102.9 |
| State and local taxpayers | 11.1 | −1.6 | +.1 | | 9.6 |
| Federal taxpayers | 32.0 | [3] [+55.2] | [3] [+11.3] | [3] [−5.2] | [4] 93.3 |

[1] This model, identical for all proposals, is the fiscal year 1974 model, after tax adjustment rounded to nearest $100,000,000.
[2] Transferred costs, by definition, must add to zero.
[3] Total additional cost to the Federal taxpayer is sum of figures in 3 brackets.
[4] This figure represents the total Federal cost of all health programs, after tax adjustment, and not the cost of the program proposed alone.

TABLE 11.—*Dingell bill: Supplementary cost estimate—conversion to program cost and comparison with proposed financing*

| | *In billions* |
|---|---|
| A. Conversion to program cost, fiscal year 1974: | |
| 1. Federal taxpayer share of total health expenditures after proposal effective (from table 10) | $93.3 |
| 2. Adjustments to eliminate expenditures financed under other programs | −24.0 |
| 3. Adjustment to eliminate Federal income tax effects | −1.1 |
| 4. Program cost to Federal taxpayer | 68.2 |
| B. Comparison with proposed financing, fiscal year 1974: | |
| 1. Estimate of payroll tax—employee portion | 11.7 |
| 2. Estimate of payroll tax—employer portion | 11.0 |
| 3. Estimate of general revenue financing proposed | (1) |
| 4. Program financing proposed | [1] 22.7 |
| Underfinancing of program | 45.5 |
| Underfinancing as a percent of financing provided | 200 |

[1] Intention of bill seems to be that general revenue financing is to be provided, although the amount thereof is difficult to interpret. Any general revenue financing would tend to reduce underfinancing illustrated.

## HALL BILL—H.R. 177

*Main provisions*

The types of benefits provided under this program include all health expenditures which are eligible under present Federal income tax laws as medical expense deductions.

The Hall bill consists of two separate but related programs:

Part A—a program for the medically indigent replacing Medicaid financed jointly by State and local governments and the Federal Government through general revenues.

Part B—a catastrophic health insurance program covering all other persons, financed by a payroll tax. This program covers 90 percent of health care costs above a specified annual deductible, defined as the larger of (1) $5,000 for persons or families under age 65, or $1,000 for persons age 65 or over, and (2) 25 percent of individual or family gross income.

*Transferred costs*

1. Part A results in a small transfer from individual direct payments to State or local governments and to the Federal Government.

2. Part B is essentially a transfer from individual direct payments to Federal social insurance. With the high deductible established, a relatively small amount of transfer comes from the private insurance sector.

*Induced costs*

1. Some induced cost arises from Part B, as services previously paid from individual resources are transferred to a social insurance arrangement.

*Estimation assumptions*

1. The cost estimate assumes, with respect to Part A, that the level of medical indigence is set at the poverty level, and the "average cost of adequate care" which would be covered under the bill is set so that one-half of the cost of the coverage provided is below such coverage. If so, the States are required to pay 57.5 percent of the cost of the basic coverage of the medically indigent. It is assumed that all States will have programs that insure all those who are medically indigent.

2. It is assumed that the States will provide coverage to the medically indigent for all health expenses which are defined under the Federal income tax law as eligible medical expense deductions. This coverage is broader than the benefit coverages under the existing Medicaid programs.

*Comments on results*

Table 12 shows transferred and induced costs, to the Federal Government, of $3.2 billion.

The program cost for Part A, ignoring the offsetting release of expenditure from the Medicaid program, is estimated at $12.8 billion. It is assumed 57.5 percent will be paid by State and local governments while the Federal Government pays the remainder.

The program cost for Part B, ignoring the offsetting transfers arising from tax adjustments, is estimated at $3.2 billion, completely financed by the Federal Government.

TABLE 12.—*Hall bill: Cost estimate*

[In billions]

| Sector | 1974 model [1] before proposal effective | Transferred costs | Induced costs | Change in tax adjustment | 1974 model after proposal effective |
|---|---|---|---|---|---|
| Total | $105.4 | [2] 0 | +$2.2 | 0 | $107.6 |
| Private sector | 62.3 | −$4.1 | +0.6 | +$0.2 | 59.0 |
| Individual direct payments | 32.0 | −4.0 | +0.3 | +0.2 | 28.5 |
| Health insurance | 26.4 | −0.1 | +0.3 | | 26.6 |
| Others (including voluntary givers) | 3.9 | | | | 3.9 |
| Governmental sector | 43.1 | +4.1 | +1.6 | −0.2 | 48.6 |
| State and local taxpayers | 11.1 | +1.7 | +0.6 | | 13.4 |
| Federal taxpayers | 32.0 | [3] [+2.4] | [3] [+1.0] | [3] [−0.2] | [4] 35.2 |

[1] This model, identical for all proposals, is the fiscal year 1974 model, after tax adjustment rounded to nearest $100,000,000.

[2] Transferred costs, by definition, must add to zero.

[3] Total additional cost to the Federal taxpayer is sum of figures in 3 brackets.

[4] This figure represents the total Federal cost of all health programs, after tax adjustment, and not the cost of the program proposed alone.

# HOGAN BILL—H.R. 817

*Main provisions*

1. This proposal endeavors to encourage the voluntary purchase of private health insurance to cover the expenses of catastrophic illness. The insurance policies contemplated would have a family calendar year deductible, the amount of which is determined by family income and number of family members. For a family of four, in fiscal year 1974 the amount of the deductible would be as follows:

| Annual family income | Calendar year deductible | |
|---|---|---|
| | In dollar amount | As percent of income |
| $4,000 or below | None | None |
| $5,000 | $500 | 10 |
| $6,000 | 1, 500 | 25 |
| $8,000 | 3, 500 | 44 |
| $10,000 | 5, 500 | 55 |
| $15,000 | 10, 500 | 70 |
| $25,000 | 22, 500 | 90 |

2. Other provisions of the coverage would be worked out by the private health insurance industry, under regulation by both State insurance departments and the Federal regulatory officials.

3. The Federal Government would subsidize the premium cost in an undetermined amount in order that all risks could acquire insurance at reasonable rates, and that a high percentage of individuals would join.

*Transferred costs*

1. To the extent that catastrophic health policies are paid for by the private sector, no transfer to the Federal Government takes place.

2. However, it seems clear that the purposes of the bill can be met only if a substantial Federal subsidy of the premium cost is involved. Otherwise, low income families are not likely to purchase insurance because the premium rate, for a policy with little or no deductible, will be too high. High income families are likewise unlikely to purchase coverage, because the substantial deductible makes the coverage unattractive. Any Federal subsidy involves a transfer from the private sector, or from State and local taxpayers, to the Federal taxpayer.

*Induced costs*

To the extent the contemplated insurance is sold, induced costs can be expected in accordance with the general principles of induced costs arising from the health insurance mechanism.

*Estimation assumptions*

1. The key element to the cost estimate for this bill is the amount of any Federal Government subsidy of the catastrophic health insurance

premium. The transferred and induced costs can be anything that the Federal Government chooses to make them, since the bill is silent with respect to the level of Federal subsidy. Therefore, this bill cannot be estimated except by means of an assumption as to the subsidy level.

2. This estimate is based on the arbitrary assumption that the subsidy from Federal funds will be 50 percent of premiums, uniformly over all income levels. This means that low income families would get a 50 percent Federal subsidy of a large premium insurance policy (due to the low deductible); high income families would get the same 50 percent Federal subsidy of a small premium insurance policy (due to the high deductible).

3. It is further assumed that, for low income families now eligible for Medicaid, the nonfederalized 50 percent cost would be paid from State or local government resources. The net effect would be not too different, with respect to the lowest income group, from the situation today, where Federal and State governments share the cost of medical care.

4. For relatively low income families above the Medicaid level, it is assumed that only 70 percent will join. The premium cost for those who join would be borne 50 percent by the Federal Government, 24 percent by employers, 24 percent by State or local governments, and 2 percent by the individuals covered.

5. For middle and high income families, 80 percent participation is assumed. The Federal Government will subsidize 50 percent of the premium cost and the remainder would be paid 30 percent and 20 percent by employer and individual, respectively.

*Comments on results*

The overall cost of this proposal to the Federal taxpayer, under the definitions of this study, is estimated to be $3.3 billion as shown in table 13. This estimate is not very meaningful, however, since the bill is incomplete with respect to the level of Federal subsidy intended. If a higher level than the 50 percent subsidy is assumed, the cost estimate would be more than proportionately higher, since more voluntary (and subsidized) insurance would come into existence. With a lower level of subsidy the cost estimate would be more than proportionately lower, and very little catastrophic insurance would be purchased.

TABLE 13.—*Hogan bill: Cost estimate*

[In billions]

| Sector | 1974 model [1] before proposal effective | Transferred costs | Induced costs | Change in tax adjustment | 1974 model after proposal effective |
|---|---|---|---|---|---|
| Total | $105.4 | [2] 0 | +$2.3 | 0 | $107.7 |
| Private sector | 62.3 | −$4.2 | +.7 | +$0.2 | 59.0 |
| Individual direct payments | 32.0 | −4.7 | +.3 | +.2 | 27.8 |
| Health insurance | 26.4 | +.5 | +.4 | | 27.3 |
| Others (including voluntary givers) | 3.9 | | | | 3.9 |
| Governmental sector | 43.1 | +4.2 | +1.6 | −.2 | 48.7 |
| State and local taxpayers | 11.1 | +1.7 | +.6 | | 13.4 |
| Federal taxpayers | 32.0 | [3] [+2.5] | [3] [+1.0] | [3] [−0.2] | [4] 35.3 |

[1] This model, identical for all proposals, is the fiscal year 1974 model, after tax adjustment rounded to nearest $100,000,000.

[2] Transferred costs, by definition, must add to zero.

[3] Total additional cost to the Federal taxpayer is sum of figures in 3 brackets.

[4] This figure represents the total Federal cost of all health programs, after tax adjustment, and not the cost of the program proposed alone

# FISHER BILL—H.R. 1283

*Main provisions*

1. This proposal permits a tax credit for premiums paid for qualified private health insurance policies. The tax credit is a percent of the premium, with those with low income tax liabilities entitled to a higher credit than those with high income tax liabilities, as illustrated at sample points below:

| Tax liability: | *Tax credit as percent of premium* |
|---|---|
| $500 or under | 100 |
| $500 | 73 |
| $700 | 45 |
| $900 | 22 |
| $1,100 | 20 |
| $1,300 | 12 |
| Over $1,300 | 10 |

2. The insurance policy must meet certain standards to be a qualified policy eligible for tax credit. In particular it must offer specified basic benefits, and one or more specified supplemental benefits. Coverage under Parts A and B of Medicare meets the requirements of the basic benefits. Hence, enrollee premium for SMI can count for purposes of computing tax credits.

3. If the tax would be less than the tax credit, the credit is paid to the taxpayer by voucher. Hence, the credit is never lost.

4. The special tax credit is in lieu of the right to deduct health insurance premiums as a medical expense.

5. A Peer Review Organization would be established as a utilization control mechanism for Medicaid, Part B of Medicare, and for qualified policies under the proposal.

*Transferred costs*

1. Some of the cost of individual insurance and of the employee contribution to group health insurance premiums (and SMI enrollee premium) in force prior to bill's effect would presumably transfer from the private sector to the Federal Government through tax credits.

2. Presumably substantial numbers of persons not now insured (or inadequately insured) would apply for individual insurance in order to qualify for tax credits. Some of this insurance would insure health expenditures currently paid directly by the individual; but some would replace payments by government and some would replace group insurance premiums paid.

3. The problem of estimating transferred costs is in estimating the volume of voluntary purchase of new individual policies, when tax credits are the incentive, and the extent to which group policies will be upgraded due to employee pressures. It is assumed that 30 percent of workers will be covered by qualified group plans.

*Induced costs*

To the extent new insurance represents a transfer from expenditures paid directly by individuals, induced services are to be expected—but to the extent that new individual insurance replaces other insured or Medicaid arrangements, the only costs induced by this bill are in the area of cost of administration.

*Estimation assumptions*

1. It is assumed that not all eligible persons will be covered by a qualified plan. Many employers will find it too expensive to introduce qualified plans or upgrade existing ones. Higher income persons may find the tax credit inadequate incentive to purchase individual insurance. The table below shows the percentage of maximum credit assumed to be claimed by the individuals.

| Tax liability: | *Percent* |
|---|---|
| Less than $300 | 95 |
| $300 to $449 | 50 |
| $450 to $574 | 40 |
| $575 to $724 | 38 |
| $725 to $1,199 | 35 |
| $1,200 to $1,299 | 33 |
| More than $1,300 | 33 |

2. Internal Revenue furnished a distribution of income tax returns by amount of tax liability using the 1973 tax levels and their most recent tabulations from tax returns. From these data and the assumptions in paragraph 1 above, we estimated the total special tax credit and new insurance premiums.

*Comments on results*

1. Overall additional cost to the Federal Government shown in table 14 is $10.3 billion. This increase to the Federal Government shows up as a change in the tax adjustment, but the effect is the same as a transferred cost.

2. The makeup of this estimate is as follows:

| | *In billions* |
|---|---|
| Tax credits | $12.3 |
| Net additional tax | 0.2 |
| Total | 12.5 |
| Induced price increase | 0.2 |
| Reduction in Federal share—Medicaid | −2.4 |
| Net additional cost to Federal Government | 10.3 |

## TABLE 14.—*Fisher bill: Cost estimate*

[In billions]

| Sector | 1974 model [1] before proposal effective | Transferred costs | Induced costs | Change in tax adjustment | 1974 model after proposal effective |
|---|---|---|---|---|---|
| Total | $105.4 | [2] 0 | +$3.7 | 0 | $109.1 |
| Private sector | 62.3 | +$4.8 | +3.5 | −$12.5 | 58.1 |
| Individual direct payments | 32.0 | −4.9 | +.2 | +.2 | 27.5 |
| Health insurance | 26.4 | +9.7 | +3.3 | −12.7 | 26.7 |
| Others (including voluntary givers) | 3.9 | | | | 3.9 |
| Governmental sector | 43.1 | −4.8 | +.2 | +12.5 | 51.0 |
| State and local taxpayers | 11.1 | −2.4 | | | 8.7 |
| Federal taxpayers | 32.0 | [3] [−2.4] | [3] [+.2] | [3] [+12.5] | [4] 42.3 |

[1] This model, identical for all proposals, is the fiscal year 1974 model, after tax adjustment rounded to nearest $100,000,000

[2] Transferred costs, by definition, must add to zero

[3] Total additional cost to the Federal taxpayer is sum of figures in 3 brackets

[4] This figure represents the total Federal cost of all health programs, after tax adjustment, and not the cost of the progam proposed alone.

# BENNETT BILL—S. 1623

*Main provisions*

This proposal has provisions which are identical with the Byrnes bill, except that the Bennett bill does not include the provisions for subsidy payments to employers by the Federal Government which are contained in the Byrnes bill.

The net change in cost to the Federal taxpayer because of the Bennett bill is estimated to be $2.6 billion and one-quarter of this is the change in tax adjustment (see table 15).

TABLE 15.—*Bennett bill: Cost estimate*

[In billions]

| Sector | 1974 model [1] before proposal effective | Transferred costs | Induced costs | Change in tax adjustment | 1974 model after proposal effective |
|---|---|---|---|---|---|
| Total | $105.4 | [2] 0 | +$1.8 | 0 | $107.2 |
| Private sector | 62.3 | −$0.4 | +1.4 | −$0.7 | 62.6 |
| Individual direct payments | 32.0 | −4.1 | +.1 | +.3 | 28.3 |
| Health insurance | 26.4 | +3.7 | +1.3 | −1.0 | 30.4 |
| Others (including voluntary givers) | 3.9 | | | | 3.9 |
| Governmental sector | 43.1 | +.4 | +.4 | +.7 | 44.6 |
| State and local taxpayers | 11.1 | −1.2 | +.1 | | 10.0 |
| Federal taxpayers | 32.0 | [3] [+1.6] | [3] [+.3] | [3] [+.7] | [4] 34.6 |

[1] This model, identical for all proposals, is the fiscal year 1974 model, after tax adjustment rounded to nearest $100,000,000.

[2] Transferred costs, by definition, must add to zero.

[3] Total additional cost to the Federal taxpayers in sum of figures in 3 brackets.

[4] This figure represents the total cost of all health programs, after tax adjustment, and not the cost of the program proposed alone.

## LONG BILL—S. 1376

*Main provisions*

1. This proposal provides, under the Medicare program, a package of catastrophic insurance benefits for those under age 65 who are currently or fully insured under the Social Security program, including the ones who are currently receiving cash benefits.

(*a*) In the area of institutional services, covered services are generally the same as Part A of Medicare, and consist of hospital inpatient services and extended care services following hospitalization. The first 60 days of hospitalization in any calendar year are not covered (but with a carryover provision) and thereafter program pays approximately 75 percent. For those transferred to an extended care facility after 60 or more days of hospitalization, the program pays approximately 75 percent of the cost of extended care facility services. There is a 190-day lifetime limit with respect to psychiatric hospitals.

(*b*) In the area of physicians' services and related medical expense, covered services are generally the same as Part B of Medicare. For these services, there is a $2,000 dynamic calendar year family deductible, and a 20 percent coinsurance requirement.

(*c*) Benefits not covered are generally those excluded under Medicare—prescription drugs, eye and hearing aids, dental care, and private duty nurses.

2. This proposal incorporates the cost and utilization controls of the Medicare program.

*Transferred costs*

1. The important transfer is the transfer to a Federal social insurance system of the expenditures within the defined catastrophic insurance benefits, from individual direct payments. A small portion is the transfer from the private health insurance mechanism, and from State and local governments.

2. A much less important transfer is the elimination of certain income tax deductions for major health expenditures incurred.

*Induced costs*

1. Induced services are particularly likely when insurance steps in after a person's health expenditure has already exceeded the individual's ability to pay.

2. Control measures incorporated are helpful in reducing induced costs.

*Estimation assumptions*

1. It is assumed that the dollar amount of the dynamic family deductible would be approximately $2,150 over fiscal year 1974.

2. To the extent that program expenditures replace expenditures by other parties, such transfer is assumed to be entirely the replacement by Federal expenditures of payments by individuals. It is assumed that the coverage under individual and group policies will be broadened rather than the premiums reduced. Expenditures by Federal or State or local governments for services that will be paid by the new catastrophic illness program are assumed to be diverted to pay for the types of services not covered under this program.

*Comments on results*

Table 16 shows a total additional cost to the Federal taxpayer of $3.1 billion.

Table 17 recasts the above results to eliminate the income tax effects, and indicates a program cost of $3.1 billion. It also indicates that the proposed financing for the bill is approximately equal to the program cost.

## TABLE 16.—*Long bill: Cost estimate*

[In billions]

| Sector | 1974 model [1] before proposal effective | Transferred costs | Induced costs | Change in tax adjustment | 1974 model after proposal effective |
|---|---|---|---|---|---|
| Total | $105.4 | [2] 0 | +$1.1 | 0 | $106.5 |
| Private sector | 62.3 | −$2.4 | +.3 | +$.1 | 60.3 |
| Individual direct payments | 32.0 | −2.2 | +.1 | +.1 | 30.0 |
| Health insurance | 26.4 | −.2 | +.2 | ---------- | 26.4 |
| Others (including voluntary givers) | 3.9 | ---------- | ---------- | ---------- | 3.9 |
| Governmental sector | 43.1 | +2.4 | +.8 | −.1 | 46.2 |
| State and local taxpayers | 11.1 | ---------- | ---------- | ---------- | 11.1 |
| Federal taxpayers | 32.0 | [3] [+2.4] | [3] [+.8] | [3] [−.1] | [4] 35.1 |

[1] This model, identical for all proposals, is the fiscal year 1974 model, after tax adjustment rounded to nearest $100,000,000.
[2] Transferred costs, by definition, must add to zero.
[3] Total additional cost to the Federal taxpayer is sum of figures in 3 brackets.
[4] This figure represents the total Federal cost of all health programs, after tax adjustment, and not the cost of the program proposed alone.

TABLE 17.—*Long bill: Supplementary cost estimate—conversion to program cost and comparison with proposed financing*

| | *In billions* |
|---|---|
| A. Conversion to program cost, fiscal year 1974: | |
| 1. Federal taxpayer share of total health expenditures after proposal effective (from table 16) | $35.1 |
| 2. Adjustments to eliminate expenditures financed under other programs | −25.8 |
| 3. Adjustment to eliminate Federal income tax effects | −6.2 |
| 4. Program cost to Federal taxpayer | 3.1 |
| B. Comparison with proposed financing, fiscal year 1974: | |
| 1. Estimate of payroll tax—employee portion | 1.6 |
| 2. Estimate of payroll tax—employer portion | 1.6 |
| 3. Estimate of general revenue financing proposed | ------ |
| 4. Program financing proposed | 3.2 |
| Overfinancing of program | .1 |
| Overfinancing as a percent of financing provided | 3.0 |

## JAVITS BILL—S. 836

*Main provisions*

1. This bill extends the present Medicare benefits now available only to those age 65 and over to the general population. The initial extension is to those eligible for disability insurance benefits under the present Social Security system; but 2 years later the benefits are extended to all persons not previously covered who are resident U.S. citizens or resident aliens admitted for permanent residence.

2. In addition to the Part A and Part B Medicare benefits, certain other benefits are added. These are annual physical checkups, dental care for children under 8, and a limited drug benefit for persons with chronic diseases.

3. Financing is roughly one-third from employees, one-third from employers, and one-third from Federal general revenue. There are, however, provisions whereby an employer can "opt-out" of the social insurance system by providing equal or better benefits with an employee contribution of no more than 25 percent.

4. The cost control provisions already associated with the Medicare program (including the copayment areas) are included. There is also a provision for a special study of reimbursement methods. There is encouragement of the formation of comprehensive health care organizations through grants and loans.

*Transferred costs*

1. Most health expenditures can be expected to transfer to the Federal area. Some expenditures will remain in the private sector, and copayment areas for the medically indigent will presumably be financed by State or local governments.

*Induced costs*

1. Induced costs arise from the transfer of health expenditures from direct payments by individuals to the social insurance arrangement.

2. The copayment features in the benefits provided might be expected to act as a brake on induced costs, if private insurance does not, in its adjustment of its coverage, insure most of these areas.

*Estimation assumptions*

1. It is assumed that the right of an employer to "opt-out" (by providing as good or better benefits) is not, from his viewpoint, a practical alternative, and hence the option will seldom be elected. To so elect, the employer must assume three-fourths of the cost of the benefits for his employees, whereas under the social insurance arrangements, he pays approximately one-third. Employees and employer together must pay all of the benefits under the option, but only two-thirds under the social insurance arrangements.

2. It is, on the other hand, assumed that employers, especially those who now provide higher levels of benefits than the proposal, will tend to enrich their employee plan by providing through private insurance some of the benefits not provided by the Javits program. Hospital benefits beyond 90 days, copayment areas, and catastrophic illness benefits are obvious targets. It is assumed that 50 percent of all employees will benefit from additional employer-sponsored health insurance.

*Comments on results*

Table 18 exhibits transferred costs of $37.8 billion to Federal taxpayers, a Federal share of induced cost of $6.9 billion, and an offsetting change in tax adjustments of $3.1 billion. The net additional costs to the Federal taxpayer is therefore estimated at $41.6 billion, and the resulting overall cost of health expenditures to the Federal taxpayer, if the proposal is adopted, is estimated at $73.6 billion.

As the Javits bill is one which contains financing provisions, a program cost is computed (see table 19).

## TABLE 18.—*Javits bill: Cost estimate*

[In billions]

| Sector | 1974 model [1] before proposal effective | Transferred costs | Induced costs | Change in tax adjustment | 1974 model after proposal effective |
|---|---|---|---|---|---|
| Total | $105.4 | [2] 0 | +$7.6 | 0 | $113.0 |
| Private sector | 62.3 | −$34.6 | +.5 | +$3.1 | 31.3 |
| Individual direct payments | 32.0 | −13.1 | +.3 | +.7 | 19.9 |
| Health insurance | 26.4 | −20.8 | +.2 | +2.4 | 8.2 |
| Others (including voluntary givers) | 3.9 | −.7 | | | 3.2 |
| Governmental sector | 43.1 | +34.6 | +7.1 | −3.1 | 81.7 |
| State and local taxpayers | 11.1 | −3.2 | +.2 | | 8.1 |
| Federal taxpayers | 32.0 | [3] [+37.8] | [3] [+6.9] | [3] [−3.1] | [4] 73.6 |

[1] This model, identical for all proposals, is the fiscal year 1974 model, after tax adjustment rounded to nearest $100,000,000.

[2] Transferred costs, by definition, must add to zero.

[3] Total additional cost to the Federal taxpayer is sum of figures in 3 brackets.

[4] This figure represents the total Federal cost of all health programs, after tax adjustment, and not the cost of the program proposed alone.

TABLE 19.—*Javits bill: Supplementary cost estimate—conversion to program cost and comparison with proposed financing*

| A. Conversion to program cost, fiscal year 1974: | *In billions* |
|---|---|
| 1. Federal taxpayer share of total health expenditures after proposal effective (from table 18) | $73.6 |
| 2. Adjustments to eliminate expenditures financed under other programs | −11.4 |
| 3. Adjustment to eliminate Federal income tax effects | −3.2 |
| 4. Program cost to Federal taxpayer | 59.0 |

NOTE.—The Javits bill proposes a gradual phasing-in of benefits and of the population covered under the program. The $59.0 billion program cost shown above assumes all benefit provisions of the proposal are in full effect for fiscal year 1974, and all resident U.S. citizens are being covered. These assumptions are not in accordance with the actual provisions of the proposal. When the financing provisions of the bill are compared with the benefit provisions, the proposal contains adequate financing for the program at least through fiscal year 1974.

# PELL-MONDALE BILL—S. 703

*Main provisions*

1. This proposal requires most employers to provide, without cost to employees, a package of health benefits for employees and their families.

(*a*) In the areas of professional services and drugs, there are no copayment areas, and special provision is made for one diagnostic examination per year, optometrist services, and some services of podiatrists and chiropractors. Dental services are not covered.

(*b*) Hospital stays are covered for 12 days per calendar year, after the first 2 days. Skilled nursing home stays up to 10 days are covered, as are all hospital outpatient services.

(*c*) The package also includes catastrophic insurance without coinsurance, but with a calendar-year family deductible equal to 25 percent of family income.

2. This proposal attempts to avoid overutilization of health services by:

(*a*) Regulations issued by DHEW to insure that services are medically needed or are for a preventive purpose.

(*b*) Encouraging the formation of health service corporations, one of whose requirements would be that they monitor and review utilization of health services.

*Transferred costs*

1. For employed persons and their families, most costs of health services not already paid through health insurance would be transferred to this category, and much of the cost paid by employees would be transferred to employers.

2. The Federal Government would be affected through tax adjustments, and through transfer of a part of the Federal share of Medicaid to the employer.

*Induced costs*

1. Positive induced costs arise from expansion (compulsory on employers) of private insurance.

2. Some negative induced costs are due to utilization control measures.



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*Estimation assumptions*

1. It is assumed that 85 percent of all workers (and their dependents) will be covered under the mandated employer plan.
2. It is assumed that Medicaid will continue to provide the existing benefits to the unemployed, and to those who are not covered under the mandated employer plan and whose income will make them eligible for the Medicaid program.

*Comments on results*

The net additional cost of this proposal to the Federal taxpayer, under the definitions of this study, is relatively small ($4.9 billion) because the burden is put on employers rather than on the Federal taxpayer. The Federal Government share is largely confined to the extra tax effect of expanded employer contributions for employee health benefits.

Induced costs, on the entire economy, are estimated at $9.5 billion, and the bulk of these induced costs fall on the employer (see table 20).

## TABLE 20. - *Pell-Mondale bill: Cost estimate*

[In billions]

| Sector | 1974 model[1] before proposal effective | Transferred costs | Induced costs | Change in tax adjustment | 1974 model after proposal effective |
|---|---|---|---|---|---|
| Total | $105.4 | [2] 0 | +$0.5 | 0 | $114.9 |
| Private sector | 62.3 | +$1.0 | +0.1 | +$5.1 | 67.3 |
| Individual direct payments | 32.0 | −15.7 | +.2 | +.8 | 17.3 |
| Health insurance | 26.4 | +16.7 | +8.9 | −5.9 | 46.1 |
| Others (including voluntary givers) | 3.9 | | | | 3.9 |
| Governmental sector | 43.1 | −1.0 | +.4 | +5.1 | 47.6 |
| State and local taxpayers | 11.1 | −.5 | +.1 | | 10.7 |
| Federal taxpayers | 32.0 | [2] [−.5] | [2] [+.3] | [2] [+5.1] | [4] 36.9 |

[1] This model, identical for all proposals, is the fiscal year 1974 model, after tax adjustment rounded to nearest $100,000,000

[2] Transferred costs, by definition, must add to zero.

[3] Total additional cost to the Federal taxpayer is sum of figures in 3 brackets

[4] This figure represents the total Federal cost of all health programs, after tax adjustment, and not the cost of the program proposed alone.

# APPENDIX A

## NATIONAL HEALTH EXPENDITURES—FISCAL YEAR 1970

The first table in this appendix breaks down the total national health expenditures in fiscal year 1970 into four major categories of services. The numbers presented are taken from the National Health Expenditures series, compiled by the Office of Research and Statistics (ORS) of the Social Security Administration and the cost estimates in this report start with these ORS studies. The latest estimates for fiscal year 1970 were published in considerable detail in the January 1971 issue of the *Social Security Bulletin.*

For purposes of this report on the estimated comparative costs of the various national health insurance proposals, the amounts given in the ORS estimates for each type of expenditure—hospital care, professional services, drugs and appliances, and all other were used without change. The ORS model, however, was recast to identify the ultimate payer for health care services. Certain expenditures, classified as payments under public programs by ORS, were shifted to the private sector in this analysis because they are not borne by taxpayers. The second table in this appendix shows the amounts shifted and a reconciliation with the ORS totals.

## APPENDIX A

### TABLE 1.—*National health expenditures, fiscal year 1970: Analysis by type of service*

[In millions]

| Financing channels | Total | Hospital care [1] | Professional services [2] | Drugs and appliances [3] | All other [4] |
|---|---|---|---|---|---|
| Total | $67,240 | $25,616 | $18,511 | $8,543 | $14,570 |
| Private sector | 44,277 | 13,716 | 16,175 | 8,079 | 6,307 |
| Individual direct payments | 22,909 | 4,099 | 10,166 | 7,666 | 978 |
| Health insurance | 17,499 | 9,251 | 5,072 | 413 | 1,863 |
| Individual policies | 3,483 | 2,436 | 639 | 30 | 378 |
| SMI premiums | 989 | 40 | 821 | ---- | 128 |
| Employees, group plans | 3,630 | 1,941 | 1,179 | 104 | 406 |
| Employers, group plans | 9,397 | 4,834 | 3,333 | 279 | 951 |
| Others (including voluntary givers) | 3,869 | 366 | 37 | ---- | 3,466 |
| Governmental sector | 22,963 | 11,900 | 2,336 | 464 | 8,263 |
| State and local taxpayers | 7,304 | 3,933 | 471 | 211 | 2,689 |
| Federal taxpayers | 15,659 | 7,967 | 1,865 | 253 | 5,574 |
| Social insurance: | | | | | |
| Payroll tax, HI | 4,378 | 3,924 | 62 | ---- | 392 |
| General revenue, HI and SMI | 1,781 | 563 | 1,011 | ---- | 207 |
| General revenue | 9,500 | 3,480 | 792 | 253 | 4,975 |

[1] Short-term and long-term hospitals.
[2] Physicians, dentists, and other self-employed professionals.
[3] Drugs, drug sundries, eyeglasses, hearing aids, and appliances.
[4] Public health services, nursing homes, research, construction, expenses of administration, and miscellaneous.

## APPENDIX A

TABLE 2.—*National health expenditures—fiscal year 1970: Reconciliation with analysis published by ORS*

[In millions]

| Financing channels | Analysis | |
|---|---|---|
| | ORS | This study |
| Total | $67,240 | $67,240 |
| Private sector | 42,258 | 44,277 |
| Individual direct payments | 22,909 | 22,909 |
| Health insurance | 15,480 | 17,499 |
| Health insurance | 15,480 | 15,480 |
| SMI premiums | (1) | 989 |
| Workmen's compensation | (1) | 970 |
| TDI | (1) | 60 |
| Others (including voluntary givers) | 3,869 | 3,869 |
| Governmental sector | 24,982 | 22,963 |
| Federal | 16,667 | 15,659 |
| State and local | 8,315 | 7,304 |

[1] Classified by ORS as payments under public programs as follows:

| | Federal | State and local |
|---|---|---|
| Total | $1,008 | $1,011 |
| Medicare part B premium payments (SMI) | 989 | ..... |
| Medical benefits under workmen's compensation programs | 19 | 951 |
| Medical benefits under temporary disability insurance programs | ..... | 60 |

# APPENDIX B

## NATIONAL HEALTH EXPENDITURES—FISCAL YEAR 1974

The first table in this appendix shows a breakdown of the estimated total national health expenditures for fiscal year 1974 in the same form as the table in appendix A for fiscal year 1970. In constructing the fiscal year 1974 model from the fiscal year 1970 model the expenditure for each type of health service was projected from fiscal year 1970 to fiscal year 1974 using the projection factors shown in the second table in this appendix for unit prices and for changes in utilization rates per capita. These projection factors are based largely on recent past trends and, in addition, it is assumed that the population will increase at an annual rate of 1.5 percent.

There are certain items of health expenditures which cannot be projected using the above approach (e.g., expenses of administration, government public health activities, other health services). In such cases, each is projected in the aggregate using the most appropriate method. For example, the expenses of administration for private health insurance is estimated by first forecasting the amount of health expenditures which will be paid by private health insurance in fiscal year 1974 and then a percentage of that amount, based on current experience, is taken as administrative expenses.

The fiscal year 1974 model portrays the national health expenditures in two dimensions—by type of health service and by ultimate payer. The estimated amounts of payments by State, local and Federal Governments have been based, whenever possible, on the information contained in the latest available programming, planning and budgeting documents. Otherwise the estimates have been largely based on the trends during the past 5 years. The projected amounts of payments through private insurance have been estimated by projecting the fiscal year 1970 private insurance coverage using the increases in unit prices and average utilization rates and with some allowance for relatively greater coverage of health expenditures through insurance, based on recent trends.

The amount paid for any one type of service was estimated in total and then by each ultimate payer (except direct payments by individuals); the balance was used as the estimate of the amount paid directly by individuals.

## APPENDIX B

TABLE 1.—*National health expenditures, fiscal year 1974: Analysis by type of service*

[In millions]

| Financing channels | Total | Hospital care [1] | Professional services [2] | Drugs and appliances [3] | All other [4] |
|---|---|---|---|---|---|
| Total | $105,400 | $43,865 | $27,923 | $11,640 | $21,972 |
| Private sector | 68,633 | 25,255 | 23,818 | 10,807 | 8,753 |
| Individual direct payments | 33,846 | 9,002 | 13,386 | 10,014 | 1,444 |
| Health insurance | 30,344 | 15,460 | 10,241 | 793 | 3,850 |
| Individual policies | 4,911 | 2,690 | 704 | 33 | 1,484 |
| SMI premiums | 1,613 | 64 | 1,339 | ---------- | 210 |
| Employees, group plans | 6,743 | 3,599 | 2,202 | 211 | 641 |
| Employers, group plans | 17,077 | 9,107 | 5,906 | 549 | 1,515 |
| Others (including voluntary givers) | 4,443 | 793 | 191 | ---------- | 3,459 |
| Governmental sector | 36,767 | 18,610 | 4,105 | 833 | 13,219 |
| State and local taxpayers | 11,108 | 5,272 | 964 | 374 | 4,498 |
| Federal taxpayers | 25,659 | 13,338 | 3,141 | 459 | 8,721 |
| Social insurance: | | | | | |
| Payroll tax, HI | 8,600 | 7,400 | 233 | ---------- | 967 |
| General revenue, HI and SMI | 2,297 | 629 | 1,368 | ---------- | 300 |
| General revenue | 14,762 | 5,309 | 1,540 | 459 | 7,454 |

[1] Short-term and long-term hospitals.
[2] Physicians, dentists, and other self-employed professionals.
[3] Drugs, drug sundries, eyeglasses, hearing aids, and appliances.
[4] Public health services, nursing homes, research, construction, expenses of administration, and miscellaneous.

## APPENDIX B

TABLE 2.—*Factors used in projecting the 1970 fiscal year model to 1974*

| Type of service | Percent increase | | | |
|---|---|---|---|---|
| | 1971/1970 | 1972/1971 | 1973/1972 | 1974/1973 |
| | Increase in unit price | | | |
| Hospital care: | | | | |
| Long-term | 10.0 | 10.0 | 9.2 | 8.0 |
| Short-term | 13.0 | 13.0 | 12.0 | 11.0 |
| Physicians' services | 7.0 | 6.5 | 6.5 | 6.1 |
| Dentists' services | 7.0 | 6.5 | 6.5 | 6.1 |
| Other professional services | 7.0 | 6.5 | 6.5 | 6.1 |
| Drugs and drug sundries | 2.5 | 2.5 | 2.0 | 2.0 |
| Eyeglasses and appliances | 6.0 | 6.0 | 5.0 | 5.0 |
| Nursing home care | 12.0 | 12.0 | 11.0 | 10.0 |
| | Increase in average utilization per capita | | | |
| Hospital care: | | | | |
| Long-term | 1.5 | 1.5 | 1.5 | 1.5 |
| Short-term | 1.5 | 1.5 | 1.5 | 1.5 |
| Physicians' services | 2.5 | 2.5 | 2.5 | 2.5 |
| Dentists' services | 2.5 | 2.5 | 2.5 | 2.5 |
| Other professional services | 2.5 | 2.5 | 2.5 | 2.5 |
| Drugs and drug sundries | 4.0 | 4.0 | 3.0 | 3.0 |
| Eyeglasses and appliances | 3.0 | 3.0 | 3.0 | 3.0 |
| Nursing home care | 5.0 | 5.0 | 5.0 | 5.0 |

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# III. COMPARISON OF PROF

*Comparison of proposals for*

| Subject | Byrnes bill—H.R. 7741 |
|---|---|
| General concept and approach | 2-part national health insurance plan covering most of the population under age 65: (1) required employer plan under private insurance for employees and their families and (2) federally operated family health insurance plan (FHIP) for low-income families with children. Provisions to encourage use of health maintenance organizations. |
| Coverage of the population | Employer plan.—Employers required to provide coverage for his employees and their families. Special group plans for small employers, self-employed and other individuals.<br>FHIP.—Low-income families with children who meet specified income levels could voluntarily enroll. Mandatory coverage for families under (proposed) Family Assistance Plan. |
| Benefit structure | Employer plan: Broad benefits, with cost sharing of $100 annual deductible per person and 25 percent coinsurance for most services.<br>Hospital: 2-day deductible and 25 percent coinsurance for room and board per year. Other services subject to annual deductible and coinsurance.<br>Physicians: Annual deductible and coinsurance. Well-baby care up to age 5 without cost sharing.<br>Laboratory and X-ray: Annual deductible and coinsurance.<br>Medical appliances: Annual deductible and coinsurance.<br>FHIP: Broad benefits. Some cost sharing depending on annual income, but none for lowest income group. Benefits include 30 days of hospital care; nursing home care (3-day substitution for 1 day of hospital care); all physicians' services while receiving hospital, nursing home, or home health services; 8 home or office physician visits; well-baby care up to age 5; home health services (7-day substitution for 1 day of hospital care). |
| Administration | Employer plan.—Private insurance carriers under Federal supervision.<br>FHIP.—Administered by DHEW, similar to Medicare program. |
| Relationship to other Government programs | Medicare: Continues to operate.<br>Medicaid: Limited to aged, blind, and disabled.<br>Other programs: Most not affected. |
| Financing | Employer plan.—Financed by employee-employer premium payments. Employer pays 75 percent (65 percent for 1st 2½ years of program).<br>FHIP.—Financed in part by premiums paid by enrollees, graduated according to income; no premium for lowest income group. Balance of costs paid from Federal general revenues. Also employers with high premium costs get subsidy payments for up to 10 employees. (Not included in Bennett bill, S. 1623.) |
| Standards for providers of services | Same as Medicare. Also Professional Standards Review Organizations (PSRO) would review services provided under all plans, if PSRO is made applicable to Medicare and Medicaid. |
| Reimbursement of providers of services | Hospitals and other institutions: Reasonable cost of services (same as Medicare).<br>Physicians: Reasonable charges (same as Medicare).<br>Health maintenance organizations: Per capita rate. |
| Delivery and resources | Health maintenance organizations: Would be available as an option under all plans. Must provide comprehensive services efficiently and economically. Under related bill (S. 1182), grants and loans for development, construction and payment to meet initial operating costs.<br>Health education: Under S. 1183, grants and loans to schools for education of health professionals in short supply and improvement of health delivery. |

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# ON OF PROPOSALS FOR NATIONAL HEALTH INSURANCE

*of proposals for national health insurance: Mixed public-private approach*

| | Bennett bill—S. 1623 | Scott-Pe |
|---|---|---|
| population under ance for employees alth insurance plan to encourage use | 2-part national health insurance plan covering most of the population under age 65: (1) required employer plan under private insurance for employees and their families and (2) federally operated family health insurance plan (FHIP) for low-income families with children. Provisions to encourage use of health maintenance organizations. Endorsed by Nixon administration. | 2-part health insurance program: ( by Federal Government and fina (2) voluntary outpatient care p ernment subsidizing premiums f |
| for his employees yers, self-employed cified income levels under (proposed) | Employer plan.—Employer required to provide coverage for his employees and their families. Special group plans for small employers, self-employed and other individuals.<br>FHIP.—Low-income families with children who meet specified income levels could voluntarily enroll. Mandatory coverage for families under (proposed) Family Assistance Plan. | Inpatient plan.—All U.S. residents<br>Outpatient plan.—All U.S. resident |
| annual deductible ance for room and deductible and co- ll-baby care up to urance. ce. annual income, but vs of hospital care; ital care); all physi- home health serv- up to age 5; home care). | Employer plan: Broad benefits, with cost sharing of $100 annual deductible per person and 25 percent coinsurance for most services.<br>Hospital: 2-day deductible and 25 percent coinsurance for room and board per year. Other services subject to annual deductible and coinsurance.<br>Physicians: Annual deductible and coinsurance. Well-baby care up to age 5 without cost sharing.<br>Laboratory and X-ray: Annual deductible and coinsurance.<br>Medical appliances: Annual deductible and coinsurance.<br>FHIP: Broad benefits. Some cost sharing depending on annual income, but none for lowest income group. Benefits include 30 days of hospital care; nursing home care (3-day substitution for 1 day of hospital care); all physicians' services while receiving hospital, nursing home, or home health services; 8 home or office physician visits; well-baby care up to age 5; home health services (7-day substitution for 1 day of hospital care). | Inpatient plan: Hospital, nursing payments begin after family ha ing), varying according to family<br>Outpatient plan: Subject to annual on family income and size. (Adc benefits.)<br>Physicians and hospital outpat<br>Dentists: For children under 1:<br>Other health professional: Opt<br>Laboratory and X-ray.<br>Medical appliances.<br>Prescription drugs: For chroni |
| supervision. ogram. | Employer plan.—Private insurance carriers under Federal supervision.<br>FHIP.—Administered by DHEW, similar to Medicare program. | Inpatient plan.—Administered by<br>Outpatient plan.—Private insuranc |
| | Medicare: Continues to operate.<br>Medicaid: Limited to aged, blind, and disabled.<br>Other programs: Most not affected. | Medicare: Abolished.<br>Medicaid: Would not pay for servi<br>Other programs: Most not affected |
| um payments. Em- rogram). raduated according lance of costs paid igh premium costs ncluded in Bennett | Employer plan.—Financed by employee-employer premium payments. Employer pays 75 percent (65 percent for 1st 2½ years of program).<br>FHIP.—Financed in part by premiums paid by enrollees, graduated according to income; no premium for lowest income group. Balance of costs paid from Federal general revenues. | Inpatient plan.—Medicare (hospit program, plus Federal general re<br>Outpatient plan.—Premium paym sidized by Government for low-i and size. |
| ganizations (PSRO) is made applicable | Same as Medicare. Also Professional Standards Review Organizations (PSRO) would review services provided under all plans, if PSRO is made applicable to Medicare and Medicaid. | Similar to Medicare with additiona personnel must meet standards se Health maintenance organizatio can be federally incorporated if regional and national boards to r |
| (same as Medicare). | Hospitals and other institutions: Reasonable cost of services (same as Medicare).<br>Physicians: Reasonable charges, same as Medicare.<br>Health maintenance organizations: Per capita rate. | Inpatient plan.—To be determined<br>Outpatient plan.—Reasonable cost |
| an option under all and economically. oment, construction ols for education of health delivery. | Health maintenance organizations: Would be made available as an option for all plans. Must provide comprehensive services efficiently and economically. Under related bill (S. 1182), grants and loans for development, construction and payment to meet initial operating costs.<br>Health education: Under S. 1183, grants and loans to schools for education of health professionals in short supply and improvement of health delivery. | Health delivery committee: Com recommendations.<br>Health maintenance organizations construction.<br>Health manpower: Liberalize PHS students and special grants to m |

# H INSURANCE

*e approach*

| | Scott-Percy bill—S. 1598 |
|---|---|
| he population under age ance for employees and health insurance plan isions to encourage use Nixon administration. | 2-part health insurance program: (1) inpatient health care plan administered by Federal Government and financed by payroll taxes and general revenues, (2) voluntary outpatient care plan through private insurance, with Government subsidizing premiums for low-income families. |
| rage for his employees mployers, self-employed<br>specified income levels milies under (proposed) | Inpatient plan.—All U.S. residents.<br>Outpatient plan.—All U.S. residents on voluntary enrollment basis. |
| $100 annual deductible vices.<br>nsurance for room and annual deductible and<br>. Well-baby care up to<br>insurance.<br>urance.<br>on annual income, but days of hospital care; hospital care); all physime, or home health servcare up to age 5; home spital care). | Inpatient plan: Hospital, nursing home, and home health services. Benefit payments begin after family has paid a deductible (family health cost ceiling), varying according to family income and size.<br>Outpatient plan: Subject to annual deductible of $10 to $50 a year, depending on family income and size. (Additional deductible of $10 to $25 for dental benefits.)<br>Physicians and hospital outpatient.<br>Dentists: For children under 12.<br>Other health professional: Optometrists and podiatrists.<br>Laboratory and X-ray.<br>Medical appliances.<br>Prescription drugs: For chronic illnesses. |
| deral supervision.<br>e program. | Inpatient plan.—Administered by DHEW through regional offices.<br>Outpatient plan.—Private insurance carriers under supervision of DHEW. |
| | Medicare: Abolished.<br>Medicaid: Would not pay for services under program.<br>Other programs: Most not affected. |
| remium payments. Em- of program).<br>es, graduated according . Balance of costs paid | Inpatient plan.—Medicare (hospital insurance) payroll taxes diverted to new program, plus Federal general revenues if needed.<br>Outpatient plan.—Premium payments by enrolled family, with premium subsidized by Government for low-income families, depending on family income and size. |
| Organizations (PSRO) PSRO is made applicable | Similar to Medicare with additional requirements: Physicians and other health personnel must meet standards set by DHEW and may practice in any State. Health maintenance organizations must meet standards set by DHEW; can be federally incorporated if incorporation prohibited by State. Local, regional and national boards to review and study utilization. |
| vices (same as Medicare). | Inpatient plan.—To be determined by regulation.<br>Outpatient plan.—Reasonable cost as under Medicare. |
| vailable as an option for iently and economically, evelopment, construction<br>to schools for education ement of health delivery. | Health delivery committee: Committee to study health needs and make recommendations.<br>Health maintenance organizations: Grants and loans for development and construction.<br>Health manpower: Liberalize PHS programs for loans to medical and nursing students and special grants to medical schools. |

| Subject | Javits bill—S. 836 | |
|---|---|---|
| General concept and approach | National health insurance program, based on expansion of Medicare program to general population. Administered by Federal Government and financed by payroll taxes and Federal general revenues. Includes option for alternative coverage under private insurance plans. | 3- |
| Coverage of the population | All U.S. residents | P<br>St |
| Benefit structure | Benefits same as Medicare, plus dental care and drugs. Most services subject to present Medicare part B cost sharing of $50 annual deductible per person and 20 percent coinsurance.<br>Hospital: 90 days of care; $60 deductible, $15 copayment per day after 60th day.<br>Nursing home: 100 days of care; $7.50 copayment per day after 20th day.<br>Physicians: Part B cost sharing.<br>Dentists: For children under 8; 20 percent coinsurance.<br>Home health services: 100 post-hospital visits, plus 100 additional visits subject to part B cost sharing.<br>Laboratory and X-ray; Part B cost shring.<br>Other health professionals: Podiatrists, psychologists, physical therapy; part B cost sharing.<br>Medical appliances: Part B cost sharing.<br>Prescription drugs: For chronic conditions, $1 charge per prescription. | Bi<br>H<br>N<br>D<br>H<br>I<br>C<br>M<br>E<br>P<br>P<br>St |
| Administration | Federal Government: Similar to Medicare. DHEW would have general administrative responsibility. Private insurance carriers (or quasi-governmental corporations) would handle claims and pay providers.<br>Employer-employee plans: Employers may elect out of the Government program by establishing an approved private insurance plan providing superior benefits.<br>Carrier plans: Individuals may elect out by purchasing approved private insurance providing equivalent benefits. | P<br>St |
| Relationship to other Government programs | Medicare: Absorbed by program.<br>Medicaid and other assistance programs: Would not pay for services under program.<br>Other programs: Most not affected. | C |
| Financing | Tax on payroll and self-employment income, and Federal general revenues.<br>Tax rates: (a) 3.3 percent of earnings for employers, employees, and self-employed, (b) general revenue contribution equal to ⅓ of total tax receipts.<br>Earnings subject to tax: 1st $15,000 of earnings for employee and self-employed; total payroll for employers.<br>Employment subject to tax: Workers under social security, plus Federal, State, and local government employees.<br>Employer-employee plans: Employers and employees exempt from regular insurance tax. Employer pays at least 75 percent of cost of private plan. | P<br>St |
| Standards for providers of services | Same as Medicare. Additional standards may be established for physicians concerning continuing education, national licensing, and qualifications for major surgery and other specialists' services. | Sa |
| Reimbursement of providers of services | Similar to Medicare for 1st 2 years of program. Afterward, new payment methods may be established, based on a study required under bill. In interim, hospitals and nursing homes receive reasonable costs of services; physicians, dentists, and suppliers receive appropriate and reasonable charges. Comprehensive health service system gets reasonable cost or per capita rate for enrolled members. | H<br>P |
| Delivery and resources | Comprehensive health service systems: DHEW can contract with comprehensive systems to provide health care to enrolled population. System must provide preventive services and health education and must train paramedical health personnel. Loans, grants, and technical assistance provided for the development, operation, and construction of comprehensive systems. | H<br>H<br>A<br>P |

*ison of proposals for national health insurance: Mixed public-private approach—Continued.*

| | Burleson bill—H.R. 4349 | P |
|---|---|---|
| of Medicare program overnment and financed udes option for alterna- | 3-part voluntary health insurance plan: (1) an employee-employer plan, (2) plan for individuals, and (3) a State plan for the poor. All plans administered through private insurance and provide same benefits. Endorsed by Health Insurance Association of America. | Employers required to provic families, at no cost to the corporations to furnish com |
| ---------- | Private plans.—Employee-employer plan includes employees (and their families) of employers who voluntarily elect coverage. Individual plan includes persons who voluntarily elect.<br>State plans.—Voluntary enrollment for poor and uninsuranble persons. | Employees (and their families ment agencies. |
| . Most services subject ial deductible per person<br>ment per day after 60th<br>· day after 20th day.<br>00 additional visits sub-<br>physical therapy; part<br>per prescription. | Broad range of benefits, with cost sharing. Benefits phased-in over 6-year period for private plans and 4 years for State plan.<br>Hospital: 300 days of care; $10 copayment for 1st day, then $5 per day.<br>Nursing home: 180 days of care; $2.50 copayment per day.<br>Physicians: $2 copayment per visit.<br>Dentists: 1 examination each year; most other services 20 percent coinsurance.<br>Home health services: 270 days of care; $2.50 copayment per day.<br>Laboratory and X-ray: No cost sharing.<br>Other health professionals: 20 percent coinsurance.<br>Medical appliances: 20 percent coinsurance.<br>Eyeglasses: 50 percent coinsurance.<br>Prescription drugs: $1 copayment per prescription.<br>Private plans.—For employee-employer plan, annual limit for all cost sharing of $1,000 per family.<br>State plan.—Amount of cost sharing limited, according to family income. | Required benefits, with limit<br>Hospital: 12 days a year after<br>Nursing home: 10 days a year<br>Physicians.<br>Laboratory and X-ray.<br>Other health professionals: P<br>Medical appliances.<br>Prescription drugs.<br>Catastrophic: Coverage of me income. |
| would have general ad- riers (or quasi-govern- providers.<br>the Government pro- plan providing superior<br>asing approved private | Private plans.—Administered by private insurance carriers, under State supervision. Treasury Department determines tax status of plan.<br>State plan.—Administered by private carrier under State supervision. Regulations for program established by DHEW. | Benefits administered throug tions, or other approved me<br>DHEW establish standards a |
| pay for services under | Medicare: Continues to operate.<br>Medicaid and other assistance programs: Would not pay for services under program.<br>Other programs: Most not affected. | Medicare and Medicaid: Cont<br>Other programs: Most not affe |
| eral general revenues. , employees, and self- ½ of total tax receipts. employee and self-em- security, plus Federal, exempt from regular cost of private plan. | Private plans.—For employee-employer plan premium paid by employers and employees, as arranged between them. Individual plan, policyholder pays entire premium. Employees and individuals who itemize deductions can take entire premium contribution as deduction on income tax return. Employers can take their entire contribution as business expense.<br>State plan.—No premium contribution required for lowest income group; for others, part of premium paid by enrollees, with amount varying according to family income. Federal and State Governments pay balance of costs from their general revenues. | Employers pay for health be employees. |
| ablished for physicians and qualifications for | Same as Medicare---------- | DHEW establishes regulation necessity of services. |
| terward, new payment equired under bill. In nable costs of services; priate and reasonable reasonable cost or per | Hospitals and other institutions: Reasonable cost of services, based on prospectively approved rates. Hospitals prepare budgets and schedule of charges which are reviewed by a State Commission responsible for establishing charges, subject to DHEW approval.<br>Physicians and dentists: Reasonable charges, based on customary and prevailing rates. | As arranged by employers wit |
| contract with compre- opulation. System must must train paramedical tance provided for the hensive systems. | Health planning: Increased funding and authority given to State and local planning agencies. Approval of planning agency required before projects can receive funds under Federal programs. Also, Presidential advisory council on health is created.<br>Health maintenance organizations: Must be made available as an option to persons enrolled in State plan and employee-employer plans.<br>Ambulatory health centers: Grants, loans, and loan guarantees for construction and operation of centers.<br>Health manpower: Loans and grants for students and educational institutions, with priority given to shortage areas. | Health services corporations: area to provide comprehensi and operate health facilitie facilities and/or make arra mainly by sale of stock to tions and personnel affiliat staff must meet national st available for construction, s<br>Regional planning councils: D Would approve the budgets involving Federal funds. |

*e approach—Continued.*

| | Pell-Mondale bill—S. 703 |
|---|---|
| yee-employer plan, (2) All plans administered . Endorsed by Health | Employers required to provide specified health benefits for their employees and families, at no cost to the employee. Authorizes creation of health services corporations to furnish comprehensive health care and operate facilities. |
| employees (and their ge. Individual plan in- uranble persons. | Employees (and their families) of businesses in interstate commerce, and government agencies. |
| phased-in over 6-year then $5 per day. day. 20 percent coinsurance. nt per day. mit for all cost sharing to family income. | Required benefits, with limitations, as noted.<br>Hospital: 12 days a year after 1st 2 days.<br>Nursing home: 10 days a year.<br>Physicians.<br>Laboratory and X-ray.<br>Other health professionals: Podiatrists and chiropractors.<br>Medical appliances.<br>Prescription drugs.<br>Catastrophic: Coverage of medical costs, if they exceed 25 percent of family income. |
| carriers, under State atus of plan. ate supervision. Regu- | Benefits administered through prepaid health plans, health services corporations, or other approved methods.<br>DHEW establish standards and regulations for program. |
| pay for services under | Medicare and Medicaid: Continue to operate.<br>Other programs: Most not affected. |
| paid by employers and lan, policyholder pays ze deductions can take tax return. Employers est income group; for unt varying according balance of costs from | Employers pay for health benefits as cost of doing business. No charge to employees. |
| ---------- | DHEW establishes regulations regarding facilities, quality standards, and necessity of services. |
| ervices, based on pros- nd schedule of charges nsible for establishing customary and pre- | As arranged by employers with providers. |
| en to State and local quired before projects idential advisory coun- ailable as an option to plans. uarantees for construc- ducational institutions, | Health services corporations: For profit organizations to be established in an area to provide comprehensive health services (including required benefits), and operate health facilities and medical schools. Would purchase health facilities and/or make arrangements with providers of services. Funded mainly by sale of stock to State and local government, and health organizations and personnel affiliated with corporation. Corporation facilities and staff must meet national standards. Federal grants, loans and guarantees available for construction, staffing and operation.<br>Regional planning councils: Develop plans for comprehensive health services. Would approve the budgets of health service corporations and all projects involving Federal funds. |

| Subject | Dingell bill—H.R. 48 | |
|---|---|---|
| General concept and approach | National health insurance program providing broad benefits, administered at Federal, State, and local levels, and financed by payroll taxes. | Natio<br>Fed<br>rev<br>AF |
| Coverage of the population | All U.S. residents | All U |
| Benefit structure | Broad benefits with no cost sharing or limitations, except as noted.<br>Hospital: 60 days of care.<br>Nursing home: No benefit.<br>Physicians.<br>Dentists.<br>Home health services.<br>Laboratory and X-ray.<br>Other health professionals.<br>Medical appliances and eyeglasses.<br>Prescription drugs: Unusally expensive drugs.<br>Specified benefits may be delayed in a State if resources are inadequate. | Broad<br>Hospi<br>Nursi<br>Physi<br>Denti<br>Other<br>Labor<br>Medic<br>Prescr |
| Administration | Federal Government: Special board in DHEW with overall supervision of program.<br>State: Under contract with Federal Government, would establish State plan and arrange to operate program at the local level. | Feder<br>to o |
| Relationship to other Government programs | Medicare: Continues to operate, but study to be made of methods of incorporating it into the national plan.<br>Medicaid and other assistance programs: Would not pay for services under the national plan.<br>Other programs: Most not affected. | Medic<br>Medic<br>Other |
| Financing | Tax on wage and self-employment income similar to social security tax. Total tax for employers and employees combined would be 4 percent. | Tax o<br>reve<br>T<br>E<br>E |
| Standards for providers of services | Must meet State standards. If no State standards, they would be established by National Board. | Same<br>staff<br>whic<br>natio<br>All<br>direc<br>provi |
| Reimbursement of providers of services | Hospitals and other institutions: Reasonable cost of services, but subject to a maximum rate.<br>Physicians and other professionals: Fee for service (based on fee schedule), per capita (for persons enrolled with a practitioner), or salary. | Nation<br>to re<br>Hospita<br>based<br>Physici<br>based<br>agree<br>reduc<br>Compre<br>Per c<br>Can |
| Delivery and resources | Grants to students and educational institutions for training in health occupations. | Health<br>State<br>care<br>Health<br>total<br>and<br>Compre<br>loans<br>Manpow<br>of ph<br>occup |

## *osals for national health insurance: Mainly public approach*

| Dingell bill—H.R. 43 | Griffiths-Corman bill—H.R. 22 |
|---|---|
| ogram providing broad benefits, administered evels, and financed by payroll taxes. | National health insurance program providing broad benefits, administered by Federal Government and financed by payroll taxes and Federal general revenues. Endorsed by Committee for National Health Insurance and AFL–CIO. |
| | All U.S. residents. |
| ring or limitations, except as noted.<br><br><br><br><br>ises.<br>xpensive drugs.<br>ed in a State if resources are inadequate. | Broad benefits with no cost sharing or limitations, except as noted.<br>Hospital.<br>Nursing home: 120 days of care.<br>Physicians.<br>Dentists: For children under age 15; later extended to age 25.<br>Other health professionals.<br>Laboratory and X-ray.<br>Medical appliances and eyeglasses.<br>Prescription drugs: For chronic and other specified illness. |
| oard in DHEW with overall supervision of pro-<br><br>deral Government, would establish State plan am at the local level. | Federal Government: Special board in DHEW, with regional and local offices to operate program. |
| , but study to be made of methods of incor-<br>plan.<br>ograms: Would not pay for services under the<br><br>cted. | Medicare: Abolished.<br>Medicaid and other assistance programs: Would not pay for covered services.<br>Other programs: Most not affected. |
| ent income similar to social security tax. Total ees combined would be 4 percent. | Tax on payroll, self-employed, and unearned income, and Federal general revenues.<br>Tax rates: (a) 1.0 percent on employee wages and unearned income, (b) 3.5 percent for employers, (c) 2.5 percent for self-employed, and (d) Federal general revenues equal to total receipts from taxes.<br>Earnings subject to tax: 1st $15,000 of earnings and income of individuals; total payroll for employers.<br>Employment subject to tax: Workers under social security, plus Federal, State, and local government employment. State and local governments do not pay employer tax. |
| State standards, they would be established | Same as Medicare, with additional requirements: Hospitals cannot refuse staff privileges to physicians. Nursing homes must be affiliated with hospital which is responsible for medical services in home. Physicians must meet national standards; major surgery performed only by qualified specialists. All providers: Records subject to review by regional office. Also, can be directed to add or reduce services, and to establish linkages with other providers. |
| : Reasonable cost of services, but subject to a<br><br>als: Fee for service (based on fee schedule), with a practitioner), or salary. | National health budget established and funds allocated, by type of service, to regions and local areas.<br>Hospitals and nursing homes: Would receive annual predetermined budget based on reasonable cost.<br>Physicians, dentists, and professionals: Methods available are fee-for-service based on fee schedule, per capita payment for persons enrolled, and (by agreement) full- or part-time salary. Payments for fee-for-service may be reduced if payments exceed estimates.<br>Comprehensive health service organizations and medical society foundations: Per capita payment for all services (or budget for institutional services). Can retain all or part of savings. |
| nal institutions for training in health occupa- | Health planning: DHEW responsible for health planning, in cooperation with State planning agencies. Priority to be given to development of comprehensive care on ambulatory basis.<br>Health resources development fund: Will receive, ultimately, 5 percent of total income of programs, to be used for improving delivery of health care and increasing health resources.<br>Comprehensive health service system: Could receive grants for development, loans for construction, and payments to offset operating deficit.<br>Manpower training: Grants to schools and allowances to students for training of physicians for general practice and shortage specialties, other health occupations, and development of new kinds of health personnel. |

| Subject | Fisher bill—H.R. 1283 | |
|---|---|---|
| General concept and approach | Credits against personal income taxes would be granted to offset the premium cost of qualified private health insurance providing specified benefits. | Cre<br>do |
| Coverage of the population | All U.S. residents, on voluntary basis | All U |
| Benefit structure | Tax credits of 10 to 100 percent of cost of qualified health insurance policy, depending on annual tax payments. Voucher certificates issued to persons with little or no tax liability. Policy must provide basic coverage and one or more supplemental benefits. Low-income families exempt from cost sharing; for others, limited to $100 annually per person.<br>Hospital: 60 days of care; $50 deductible per stay.<br>Nursing home: Substituted for hospital days on 2 for 1 basis; $50 deductible per stay.<br>Physicians: 20 percent coinsurance.<br>Dentists: No benefit.<br>Laboratory and X-ray: 20 percent coinsurance.<br>Other health professionals: 20 percent coinsurance.<br>Medical appliances: No benefit.<br>Prescription drugs: 20 percent coinsurance.<br>Catastrophic coverage: $300 deductible per family.<br>Other health professionals, prescription drugs, additional hospital days (beyond 60) and catastrophic coverage are the supplemental benefits available at an additional premium. | Tax<br>Hosp<br>Nurs<br>per<br>Phy<br>Dent<br>Lab<br>Presc<br>Cata<br>aft<br>inc<br>Tota<br>fan |
| Administration | Private insurance carriers issue policies. State insurance departments certify carriers and qualified policies. Federal board establishes standard for program. Treasury Department processes tax credits. DHEW issues voucher certificates. | Priv<br>car<br>pro<br>cer |
| Relationship to other Government programs | Medicare: Continues to operate.<br>Medicaid and other assistance programs: Would not pay for services under program.<br>Other programs: Most not affected. | Medi<br>Medi<br>pro<br>Other |
| Financing | Financed from Federal general revenues | Finan |
| Standards for providers of services | By contract between DHEW and State medical societies, review boards (PRO) established to review charges, utilization, and quality of services for this program and other Federal programs; provisions for hearings and appeals, disciplinary action, and recourse to courts. DHEW reviews and implements decisions. | No |
| Reimbursement of providers of services | PRO boards review charges (see above) | No |
| Delivery and resources | The Federal board is directed to develop programs for effective use of manpower and resources. | The |

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*proposals for national health insurance: Tax credit approach*

| Fisher bill—H.R. 1283 | Fulton-Broyhill bill—H.R. 4960 |
|---|---|
| ome taxes would be granted to offset the premium<br>ıealth insurance providing specified benefits. | Credits against personal income taxes would be granted to offset the premium cost of qualified private health insurance providing specified benefits. Endorsed by American Medical Association. |
| ;ary basis | All U.S. residents, on voluntary basis. |
| 'cent of cost of qualified health insurance policy,<br>payments. Voucher certificates issued to persons<br>y. Policy must provide basic coverage and one or<br>. Low-income families exempt from cost sharing;<br>annually per person.<br>deductible per stay.<br>or hospital days on 2 for 1 basis; $50 deductible<br><br>urance.<br><br>ercent coinsurance.<br>percent coinsurance.<br>ıfit.<br>coinsurance.<br>deductible per family.<br>prescription drugs, additional hospital days<br>hic coverage are the supplemental benefits availa-<br>um. | Tax credits of 10 to 100 percent of cost of qualified health insurance policy, depending on annual tax payments. Voucher certificates issued to persons with little or no tax liability. Policy provides basic and catastrophic benefits.<br>Hospital: 60 days of care; $50 deductible per stay.<br>Nursing home: Substituted for hospital days on 2 for 1 basis; $50 deductible per stay.<br>Physicians: 20 percent coinsurance.<br>Dentists: No benefits.<br>Laboratory and X-ray: 20 percent coinsurance.<br>Prescription drugs: 20 percent coinsurance.<br>Catastrophic coverage: Additional hospital days and medical appliances covered after corridor deductible (out-of-pocket payment) which varies according to income.<br>Total coinsurance (for physicians, laboratory and X-ray) limited to $100 per family. |
| sue policies. State insurance departments certify<br>olicies. Federal board establishes standard for<br>ment processes tax credits. DHEW issues voucher | Private insurance carriers issue policies. State insurance departments certify carriers and qualified policies. Federal board establishes standards for program. Treasury Department processes tax credits. DHEW issues voucher certificates. |
| te.<br>programs: Would not pay for services under<br><br>fected. | Medicare: Continues to operate.<br>Medicaid and other assistance programs: Would not pay for services under program.<br>Other programs: Most not affected. |
| al revenues | Financed from Federal general revenues. |
| W and State medical societies, review boards<br>w charges, utilization, and quality of services for<br>'ederal programs; provisions for hearings and<br>n, and recourse to courts. DHEW reviews and | No provision. |
| see above) | No provision. |
| to develop programs for effective use of man- | The Federal board is directed to develop programs for effective use of manpower and resources. |

| Subject | Hogan bill—H.R. 817 | |
|---|---|---|
| General concept and approach | Program for coverage of catastrophic illness which would pay medical expenses above a specified amount, depending on family income. Administered by private insurance companies under State supervision and financed by premium payments and Federal subsidy. | 2-part national hea plan of health basic and catastr program of catas the population. |
| Coverage of the population | All U.S. residents, on voluntary basis | Poor.—All medicall General populatio indigent. |
| Benefit structure | All services eligible as medical expense deductions under the income tax law may be covered after family expenses exceed a specified amount (deductible), which varies according to family income and size. There is no deductible for low income families but the deductible rises rapidly as income increases. Expenses paid by other private insurance or government programs can be counted toward the deductible. | All services eligible under the income Poor.—Insurance cal care, with val costs, and catast costs. No cost sha General population family health car expenses ($1,000 private insurance counted toward |
| Administration | Private insurance carriers would issue and administer the catastrophic insurance policies.<br>State insurance department would design and establish the plan.<br>Federal Government: DHEW would establish regulations for program. | Poor.—Private ins insurance policies would establish General populatio using same proce care, if possible. |
| Relationship to other Government programs. | Medicare: Continues to operate.<br>Medicaid and other assistance programs: Would not pay for services covered under the program.<br>Other programs: Most not affected. | Poor.—Would repla General population.- to report on laws |
| Financing | Policyholders would pay premium for insurance with subsidy from Federal general revenues.<br>Premium rate: DHEW would determine actuarial value of policies and could establish a premium rate lower than the actuarial value, to encourage widespread enrollment. Federal Government would pay carriers (from general revenues) the difference between the actuarial value and the premium rate.<br>Reinsurance: Federal Government would arrange to reinsure the insurance risk; carriers would pay the reinsurance premiums. | Poor.—Federal and pays 85 percent pays remaining protection.<br>General population.- wages, self-employ of individuals.<br>Tax rate: 0.4<br>Earnings subjec wages, self-em earned or unea a maximum of<br>Employment security. |
| Standards for providers of services | No provision | Poor.—No provision General population.— feasible. |
| Reimbursement of providers of services | No provision | Poor.—No provision General population.— feasible. |
| Delivery and resources | No provision | No provision |

*posals for national health insurance: Catastrophic illness approach*

| | Hall bill—H.R. 177 | Long bill—S. 1376 |
|---|---|---|
| ophic illness which above a specified income. Adminis- panies under State remium payments | 2-part national health insurance program: (1) State plan of health insurance for the poor providing basic and catastrophic coverage and (2) Federal program of catastrophic protection for the rest of the population. | Federal program for coverage of catastrophic illness which would pay expenses for hospital and medical care above a specified amount. Program would be administered through Medicare program and financed by special payroll taxes. |
| basis | Poor.—All medically indigent persons.<br>General population.—All persons not medically indigent. | Persons under age 65 insured under social security and their families. State and local governments may cover their employees under special arrangements. |
| xpense deductions be covered after ified amount (de- g to family income le for low income rapidly as income other private in- ns can be counted | All services eligible as medical expense deductions under the income tax law may be covered.<br>Poor.—Insurance providing basic coverage of medical care, with value equal to average health care costs, and catastrophic protection of additional costs. No cost sharing.<br>General population.—Coverage of 90 percent of family health care costs after the 1st $5,000 of expenses ($1,000 for the aged). Expenses paid by private insurance or public programs can be counted toward this deductible amount. | Covers same types of benefits as Medicare. Hospital and nursing-home expenses covered after 60 days of hospital care; subject to copayment of $15 per day for hospital and $7.50 for nursing home. Other medical expenses covered after 1st $2,000 incurred by family, subject to 20 percent coinsurance. |
| issue and admin- policies. design and estab- uld establish reg- | Poor.—Private insurance companies would issue insurance policies and administer claims. DHEW would establish plan if State does not.<br>General population.—Administered by DHEW, using same procedures and requirements as Medicare, if possible. | Administered through Medicare program (by DHEW) under which private carriers handle claims and pay providers of services. |
| grams: Would not he program. d. | Poor.—Would replace Medicaid program.<br>General population.—No specific reference. DHEW to report on laws that need to be changed. | Medicare: Continues to operate.<br>Medicaid and other assistance programs: Would not pay for services under program.<br>Other programs: Most not affected. |
| for insurance with venues. termine actuarial ablish a premium alue, to encourage eral Government eral revenues) the al value and the nt would arrange carriers would pay | Poor.—Federal and State general revenues. Federal pays 85 percent of cost of basic coverage. State pays remaining costs and cost of catastrophic protection.<br>General population.—Financed by special tax on wages, self-employment income, and other income of individuals.<br>Tax rate: 0.4 percent.<br>Earnings subject to tax: Sum of an individual's wages, self-employment income, and other earned or unearned income over $2,000, up to a maximum of $7,800.<br>Employment subject to tax: Same as social security. | Financed by payroll taxes, similar to Medicare.<br>Tax rates for employers, employees, and self-employed: 0.3 percent initially rising to 0.4 percent ultimately.<br>Earnings subject to tax: 1st $9,000 of earnings.<br>Employment subject to tax: Workers under social security. |
| | Poor.—No provision.<br>General population.—Same as Medicare, as much as feasible. | Same requirements and standards as Medicare. |
| | Poor.—No provision.<br>General population.—Same as Medicare, as much as feasible. | Same provisions as Medicare.<br>Hospitals and other institutions: Reasonable costs of services.<br>Physicians and suppliers: Reasonable charges. |
| | No provision. | No provision. |