NATIONAL HEALTH INSURANCE PROPOSALS

HEARINGS

BEFORE THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-SECOND CONGRESS

FIRST SESSION

ON THE

SUBJECT OF NATIONAL HEALTH INSURANCE PROPOSALS

OCTOBER 19, 20, 26, 27, 28, 29; NOVEMBER 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18 AND 19, 1971

Part 1 of 13 Parts
(October 19 and 20, 1971)

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MATERIAL SUBMITTED FOR THE RECORD BY THE PUBLIC

NATIONAL HEALTH INSURANCE PROPOSALS

TUESDAY, OCTOBER 19, 1971

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in the committee room, Longworth House Office Building, Hon. Wilbur D. Mills (chairman) presiding.

The CHAIRMAN. The committee will please be in order.

The committee today begins extensive hearings on the various national health insurance and related bills which have been introduced in the House of Representatives and referred to the Committee on Ways and Means. Most of the major bills before us would make substantial and far-reaching changes in the present organization and financing of health care.

At this point, without objection, let me place in the record the press releases which were issued relating to and establishing this hearing. Is there objection? None is heard.

(The press releases referred to follow:)

[Press release of Tuesday, Sept. 14, 1971]

CHAIRMAN MILLS, HOUSE COMMITTEE ON WAYS AND MEANS, ANNOUNCES THAT PUBLIC HEARINGS ON NATIONAL HEALTH INSURANCE WILL BE THE NEXT MAJOR ORDER OF BUSINESS AFTER COMPLETION OF THE CURRENT TAX PROPOSALS

Chairman Wilbur D. Mills (D., Ark.), Committee on Ways and Means, U.S. House of Representatives, today announced that the next major order of business of the Committee on Ways and Means would be public hearings on the subject of national health insurance. The Chairman stated that this announcement is being made at this time in order that all interested individuals and organizations might be making their plans and preparing their statements so that when the announcement of specific dates is made all such interested organizations and individuals will be prepared to testify.

The Chairman stated that the public hearings on national health insurance will begin after the Committee on Ways and Means has completed its consideration and action on the tax proposals recently made by the President and now under consideration by the Committee. The Chairman further advised that it is his hope that action on the President's tax proposals can be completed and legislation passed by the House by the first of October, which would mean that the hearings on national health insurance would begin shortly thereafer. It was further explained by the Chairman that there obviously would not be time for executive consideration of national health insurance during this Session of Congress, but the Committee does hope to complete the public hearing phase of that subject prior to adjournment of the First Session.

The hearings will encompass not only the proposal of the Administration, but all of the other proposals on national health insurance which are presently pending before the Committee on Ways and Means.

All individuals and organizations interested in presenting testimony should advise the Chief Counsel of the Committee, John M. Martin, Jr., Room 1102,

Longworth House Office Building, Washington, D.C. 20515, of such fact so that preliminary assessment may be made as to the number of witnesses who may appear. The Chief Counsel should also be advised as to the estimated time which the witness desires for his direct testimony. As usual, it will be necessary for those with similar interests to consolidate their testimony.

As indicated, a further announcement as to specific details will be issued as soon as possible.

[Press release of Thursday, Sept. 30, 1971]

CHAIRMAN WILBUR D. MILLS (D., ARK.), COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES THAT PUBLIC HEARINGS ON NATIONAL HEALTH INSURANCE WILL BEGIN ON MONDAY, OCTOBER 18, 1971

Chairman Wilbur D. Mills (D., Ark.), Committee on Ways and Means, U.S. House of Representatives, today issued a followup to his previous announcement of September 14, 1971, with respect to the public hearings to be held by the Committee on the subject of national health insurance.

The hearings will begin on Monday, October 18, 1971, at 10 a.m. The Chairman stated that on October 18 and 19, officials of the Administration will be heard, and that beginning on Tuesday, October 26, testimony will be received by the Committee from the interested public.

As indicated by the Chairman in his earlier press release, the hearings will encompass not only the proposal of the Administration, but all of the other proposals on national health insurance which are presently pending before the Committee on Ways and Means.

Requests to be heard must be received by the Committee by the close of business Thursday, October 14, 1971, addressed to John M. Martin, Jr., Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Room 1102, Longworth House Office Building, Washington, D.C. 20515 (telephone: 202/225-3625). If, pursuant to the earlier press release, the Committee has been notified of intention to appear and testify, it will be necessary at this time to furnish certain additional information to the Committee, as indicated below, and otherwise conform to the rules set forth in conducting this hearing. Notification will be made as promptly as possible after the cutoff date as to when witnesses have been scheduled to appear. It will be necessary for the witness to appear on the date designated or else file a written statement for the record.

It is requested that all persons and organizations with the same general interest designate one spokesman to represent them so as to conserve the time of the Committee and the other witnesses, prevent repetition and assure that all aspects of the proposals can be given appropriate attention.

The request to be heard must contain the following information, otherwise delay may result in the proper processing of a request:

(1) The name, address and capacity in which the witness will appear;

(2) The list of persons or organizations the witness represents and in the case of associations and organizations their total membership and where possible a membership list;

(3) The amount of time the witness desires in which to present his direct oral testimony (not including answers to questions of Committee Members);

(4) An indication of whether or not the witness is supporting or opposing any specific proposal or proposals on which he desires to testify; and

(5) A topical outline or summary of the comments and recommendations which the witness proposes to make.

With respect to oral testimony, the rules of the Committee require that written statements be submitted to the Committee office no later than 48 hours prior to the scheduled appearance of the witness. Seventy-five copies of the written statement would be required in this instance; an additional 75 copies may be submitted for distribution to the press and the interested public on the witness' date of appearance.

Any interested organization or person may submit a written statement in lieu of a personal appearance for consideration for inclusion in the printed record of the hearing. Such statements should be submitted in triplicate. The cutoff date for submission of such written statements will be announced later. An additional 75 copies of written statements for the printed record will be accepted for distribution to the press and the interested public if submitted before the final day of the public hearing.

It would be most helpful for all prepared written statements to contain a summary of testimony and recommendations and that throughout the statement itself pertinent subject headings be used.

[Press release of Monday, Oct. 4, 1971]

CHAIRMAN WILBUR D. MILLS (D., ARK.), COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES THAT THE NATIONAL HEALTH INSURANCE PUBLIC HEARINGS WILL BEGIN ON TUESDAY, OCTOBER 19, INSTEAD OF MONDAY, OCTOBER 18, 1971

Chairman Wilbur D. Mills (D., Ark.), Committee on Ways and Means, U.S. House of Representatives, today announced that the public hearings on national health insurance would begin on Tuesday, October 19, instead of Monday, October 18, 1971, because of a conflict in Committee schedule. Thus, testimony will be received from Administration witnesses on Tuesday and Wednesday, October 19 and 20, 1971, to be followed, as previously announced, by testimony from the interested public beginning on Tuesday, October 26, 1971.

The CHAIRMAN. The purpose of these hearings is to obtain the information and advice which will enable the committee to evaluate and judge all these proposals and to receive suggestions for additions, changes, alterations, eliminations, and so forth.

The public hearing process continues to be a very vital element in the process of developing sound legislation on matters particularly as large as this. We are in the process of scheduling some 200 or more witnesses to appear, and we will have the benefit of statements for the record by many more. The committee will need the best possible information and advice it can obtain in this very complex area.

Based upon information presently available, there seems to be widespread agreement that the Nation's health industry which these bills would affect so greatly, is beset by many problems. Many serious grievances have been raised from time to time. We must examine these issues carefully. One could conclude that the health industry, as it has developed in this country, is marked—

(1) by the ability to produce the highest quality care—but with services so unevenly available that the United States lags well behind many other nations in major health indices;

(2) by the capacity to consume more than 7 percent of our gross national product—but almost one-half of the increased health care expenditures in the last decade went for higher prices, not more services;

(3) by rapid growth in the number of hospital and nursing home beds—but so lacking in planning as to create costly surpluses in many areas and shortages in others;

(4) by a medical education system which responds to increased demand for physicians' services largely by importing thousands of less-well-trained foreign medical graduates, aggravating, we are told, the already serious maldistribution of physicians;

(5) by a largely nonprofit hospital system which actually makes "profits" from a cost-plus payment system lacking incentives for efficient provision of services; and

(6) by a clientele which is increasingly resentful of trying to find the way through a maze of referring practitioners to find services for which a higher and higher part of the family budget must be used, and this without confidence that the care finally obtained is appropriate or of high quality.

The hearings that are about to commence should give us the basic data necessary to evaluate these charges and to develop appropriate solutions, if needed.

There is, of course, widespread disagreement on what the solutions to the problems in the health field should be and what role government should assume in carrying them out. The various proponents and sponsors of these bills will be appearing before us to advocate their particular proposals and formulae.

Today, we have as the first of these witnesses, the Secretary of Health, Education, and Welfare, the Honorable Elliot Richardson, who will present the case of the administration proposal. We will, of course, have other witnesses later on who will make the case for the other bills pending before us.

Mr. Secretary, it is good to have you with us again. I would ask members to withhold questions until the end of your statement so that we may hear your statement without interruption and then interrogate you. If you will identify those with you at the table for the record, we would be glad to recognize you, sir.

STATEMENT OF HON. ELLIOT L. RICHARDSON, SECRETARY OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY HON. JOHN G. VENEMAN, UNDER SECRETARY; HON. MERLIN K. DUVAL, JR., ASSISTANT SECRETARY OF HEALTH AND SCIENTIFIC AFFAIRS; HON. STEPHEN KURZMAN, ASSISTANT SECRETARY FOR LEGISLATION; HON. LAURENCE E. LYNN, JR., ASSISTANT SECRETARY FOR PLANNING AND EVALUATION; HON. ROBERT M. BALL, COMMISSIONER, SOCIAL SECURITY ADMINISTRATION; AND HON. HOWARD N. NEWMAN, COMMISSIONER, MEDICAL SERVICES ADMINISTRATION, SOCIAL AND REHABILITATION SERVICES ADMINISTRATION

Secretary RICHARDSON. Thank you, very much, Mr. Chairman and members of the committee.

I am accompanied by the Under Secretary Mr. John G. Vensman on my immediate right, who is, of course, very well known to this committee. On his right is the Assistant Secretary for Health and Scientific affairs, Dr. Merlin K. DuVal and on my far right, Mr. Howard N. Newman, Commissioner of the Medical Services Administration of the Social and Rehabilitation Services Administration. On my immediate left is Stephen Kurzman, Assistant Secretary for Legislation; on his left, Laurence E. Lynn, Jr., Assistant Secretary for Planning and Evaluation; and on my far left another individual very well known to this committee, Commissioner of Social Security, Mr. Robert M. Ball.

The CHAIRMAN. Mr. Secretary, don't be under any false impression. All of you are very well known to the committee and we consider all of you very able in your fields. We appreciate having you here and you are recognized, sir.

Secretary RICHARDSON. Thank you, sir.

I appreciate the opportunity to read this statement in full, Mr. Chairman. It is a rather long statement and yet the subject is a com-

plex one and widely ramified and we have tried to be as succinct as we can.

Today this distinguished committee will begin a major debate that I am certain will culminate in a national health insurance program. None of us can fail to be aware of the historic importance of this dialog—not only with respect to the pervasive effects of legislation that will be felt in every American home in the years ahead, but also with respect to the organic architecture of social legislation that has helped define the growth and undergirds the greatness of this Nation.

For more than 35 years now, the Nation has been building the impressive structure of Federal health programs we have today. The foundation were laid with the maternal and child health legislation, the emergency relief and public assistance programs, and the birth of the National Cancer Institute—all in the thirties. We have gone on from there to develop hospitals where there were none, to shift the center of importance in the development of biomedical knowledge from Europe to this country, and, in recent years, to increase the supply of health manpower faster than the growth of population, while relieving the financial distress of most of the aged and many of the poor who face medical costs. Many other steps have been taken, far too numerous to mention here, which, along with those I have noted, demonstrate in retrospect a national leadership that has been responsible and responsive to national needs.

In reviewing this history, the members of this committee, who have played a major role in its making, must have a sense of accomplishment that is large indeed—and deservedly so.

But now the future of health care in the United States is before us, and the agenda is full.

National health insurance is our subject today, but I should like to emphasize here, as I have elsewhere, that health care financing is only part of the complex arrangements we call health care. The problems besetting health care in this Nation require a coherent and comprehensive strategy in which financing—or demand—is intelligently related to the supply of services, to the manner in which those services are organized and delivered, and to their costs, recognizing that change in each of these occupies a different and complex time frame of leads and lags.

The administration, after extensive studies and analysis of almost innumerable alternatives, has evolved the strategy set forth in our White Paper, "Towards a Comprehensive Health Policy for the 1970's," copies of which are in this committee's hands.

Through a comprehensive and coordinated set of proposals, we have been seeking to improve the health care of all citizens in the Nation by improving the quantity, quality, and distribution of services, by containing the costs of care, and by insuring that no citizen is denied access to care for financial reasons. Our legislative initiatives include proposals we have sent to the Congress on Health Manpower and Health Maintenance Organizations and the National Health Insurance Partnership Act, which was introduced in amended form as H.R. 7741 by Congressman Byrnes. Certain cost control measures in H.R. 1 which contains improvements in Medicare and Medicaid are also integral parts of our national health strategy.

In planning any such major strategy, there are underlying questions on the balance between health objects and other social objectives, on public and private roles, on the capacity of the system to satisfy needs within a given time frame, and on the degree to which the existing structure of public and private programs must be changed.

The basis of the administration's proposals can be summarized as follows:

First, resources for social goals are not unlimited, so that other national priorities must be weighed along with health care programs. Programs related to these other goals may have, in fact, as great an impact on health status as health programs. Seen in this light, the welfare reform bill is also an integral part of our national health strategy.

Second, since the 1930's the Nation has evolved a basic division of public and private health care roles. Over the last 35 years Government has taken responsibility in health care for the poor, the disabled, and the aged, while the private sector has provided ever-increasing protection for those in the labor force through diversity, free choice, and competition. We firmly believe that this fundamental division of responsibilities between the two sectors is desirable, workable, and can serve as a basis for improvement.

Finally, we believe that comprehensive health care services should be provided as rapidly as possible for the entire population. However, it will take time to develop sufficient manpower, facilities, and managerial skills to fulfill this goal.

THE PROBLEMS

As we seek to deal with today's urgent problem in health care and the health care industry, we should not forget the health of Americans has been improving steadily and that financial access has been extended so that only a small portion of the Nation is without some health protection. There is much evidence that progress is continually being made, but we cannot be complacent and ignore the problems remaining.

The existence of these health problems has been amply documented, most comprehensively in your committee print, Basic Facts on the Health Industry.

As we analyze these data, the problems fall into four major categories:

SHORTAGES AND MALDISTRIBUTION OF MANPOWER AND FACILITIES

First, there are severe shortages of supply and widespread maldistribution of health care resources, particularly certain types of manpower and facilities. For example, the number of physicians providing primary patient care declined from 103 to 90 per 100,000 persons between 1950 and 1969, although the total number of physicians actually increased from 134 to 146 per 100,000 persons during the same period.

INEFFECTIVE ORGANIZATION AND DELIVERY OF SERVICES.

There is considerable evidence that the current methods of organizing and delivering health services exacerbate the problems of supply by tolerating or encouraging inefficiencies and dis-economies. For example, studies of the Federal employees health benefits program indicate markedly lower rates of hospitalization and surgery under the group practice plans than under the more traditional health insurance plans.

INEQUITABLE FINANCIAL ACCESS

We have not yet achieved equal access to health care, primarily for the poor, the near poor and the catastrophically ill, and those who live in remote rural areas. Your committee print shows that lower income groups and racial minorities have far poorer health, but at the same time receive far less health service than other groups. Similarly, lower income groups have far less health insurance protection and children in low-income families are the least protected of any population group. Although private and public programs have grown, there are still too many people who do not have adequate health care because they cannot afford it or cannot meet the cost of a catastrophic illness.

INFLATION OF HEALTH CARE COSTS

Finally, sharply rising costs have been the most visible health care problem, particularly since 1966. The cost of medical services increased nearly twice as rapidly as the cost of living index during the 1960's. In part, medical care cost inflation is a function of the imbalance between supply and demand and the rigidities and inefficiencies in the organization and delivery of services, but it is also a function of technological and other advances. Intangibles also affect costs: the prestige to a hospital of the open heart team or the desire of the patient and physican to use the "best" facility even for routine care.

Stated all too briefly here, these are the problems we must resolve.

I would appreciate, Mr. Chairman, having inserted at the end of my statement more detailed descriptions of these problems.

The CHAIRMAN. Without objection that material will be included, Mr. Secretary.

Secretary RICHARDSON. Thank you, Mr. Chairman.

(The information referred to follows:)

Appendix

SOME DETAILS ON FOUR IMPORTANT TYPES OF PROBLEMS IN THE U.S. HEALTH SYSTEM

1. Manpower and Facilities
2. Organization and Delivery
3. Financial Access
4. Costs

(Based Upon Exhibits in "Facts on The Health Industry," the June 28, 1971 Committee Print Prepared for the House Committee on Ways and Means by the Committee Staff.)

Medical Care in the United States
A Summary of Current Problems

MANPOWER AND FACILITIES

The problems relating to the adequacy of medical manpower and facilities include problems of supply, distribution, or both simultaneously.

The number of community (non-Federal, short-term) hospital beds, relative to the population, has increased about one-fifth since 1946, due in large part to the financial assistance under the Hill-Burton program. Yet, the geographical distribution of hospitals is uneven, with some communities having a surplus of hospital beds and others a shortage. A related problem concerns the unnecessary duplication of expensive facilities (such as cobalt machines and open-heart surgical facilities) among hospitals in some communities. The strengthening of areawide planning could help alleviate these problems of supply and distribution.

The supply of physicians has also increased faster than population growth in recent years. However, the number providing direct patient care has not increased relatively, as more physicians have assumed positions in research, administration, and similar activities. Further, physicians tend to locate in large metropolitan areas, especially near the university medical centers and in suburban locations, and many rural and inner-city areas have inadequate physicians services.

Further, increasing specialization of physicians, especially among new medical graduates, has greatly reduced the supply of physicians in

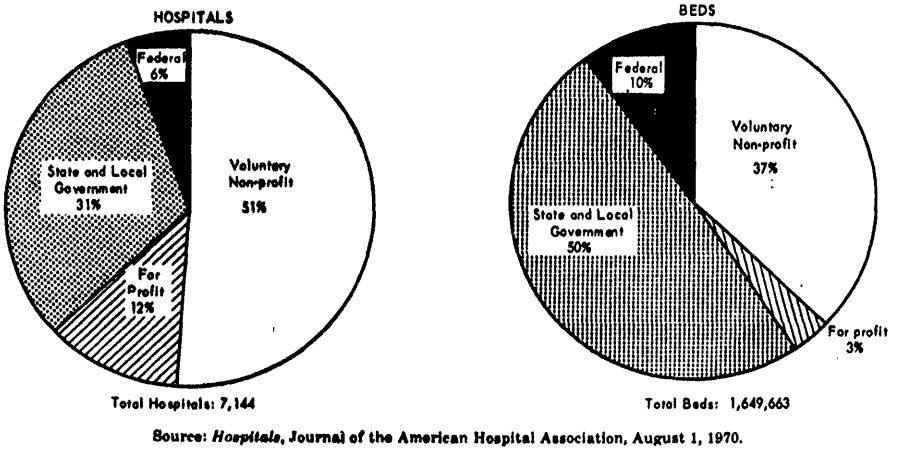
general and family practice. The experience of the American Medical Association's placement service indicates that the demand for such primary care physicians greatly exceeds the supply, while the reverse is true for surgeons and many specialties.

Simply increasing the supply of physicians may not represent the most appropriate approach to the physician shortage. By using trained paramedical assistants, the productivity of physicians could be greatly increased. For example, three-quarters of pediatric services could be performed by a trained child health assistant, according to the Joint Council of National Pediatric Societies. The use of paramedical assistants is facilitated when they are part of a health maintenance or related organization.

COMMUNITY HOSPITAL BEDS HAVE INCREASED LARGELY DUE TO THE HILL-BURTON PROGRAM

Source: *Hospitals*, Journal of the American Hospital Association, August 1, 1970.

THE HOSPITAL INDUSTRY IS VERY LARGE AND REPRESENTS A MIX OF THE PUBLIC AND PRIVATE SECTORS



Source: *Hospitals*, Journal of the American Hospital Association, August 1, 1970.

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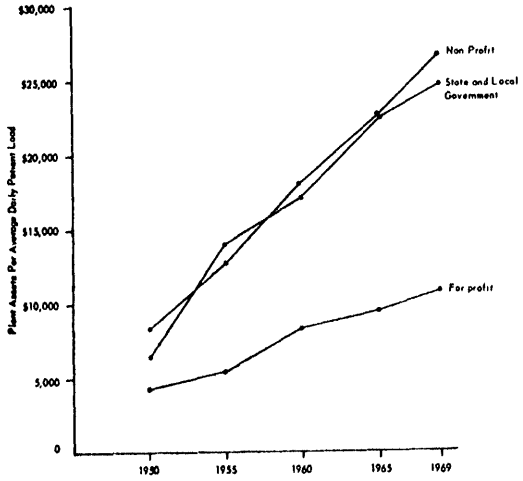
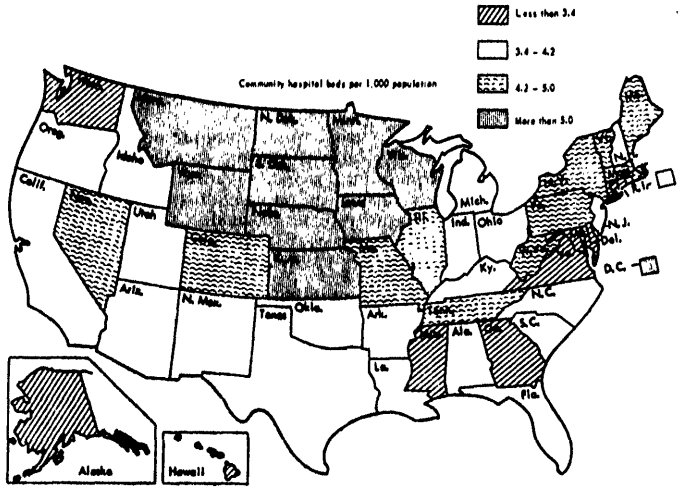
TOTAL INVESTMENT IN COMMUNITY HOSPITALS AMOUNTED TO $16.5 BILLION IN 1969



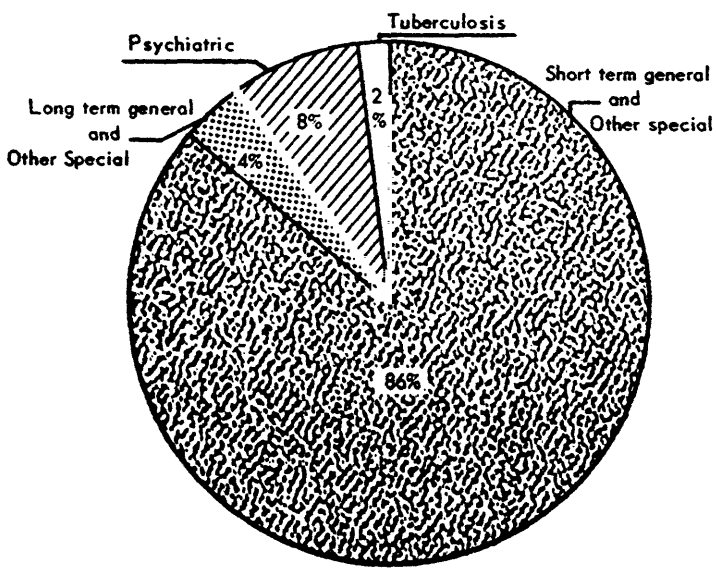
Source: *Hospitals*, Journal of the American Hospital Association, August 1, 1970.

CONSIDERABLE VARIATION EXISTS IN THE DISTRIBUTION OF COMMUNITY HOSPITAL BEDS

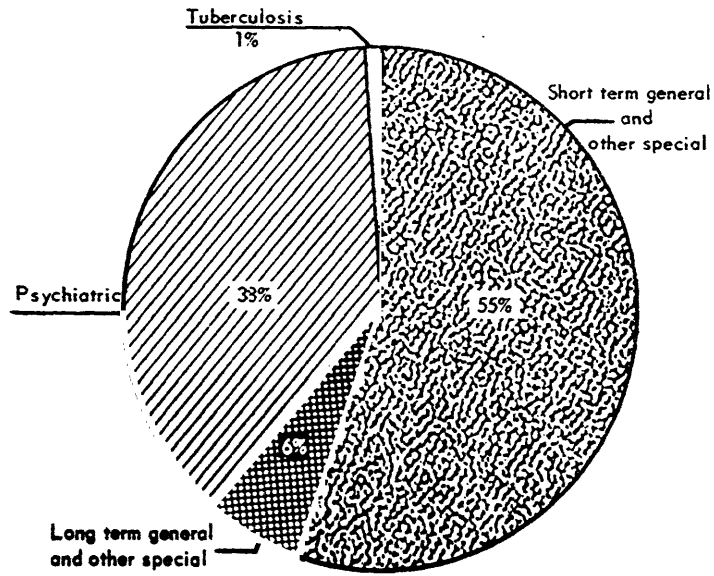


Sources: Beds; *Hospitals*, Journal of the American Hospital Association, August 1, 1970.
Population; *Statistical Abstract of the United States, 1970.*

HOSPITALS SPECIALIZE IN THE TYPE OF CARE PROVIDED



HOSPITALS: 7,144



BEDS: 1,649,663

Source: ***Hospitals,*** **Journal of the American Hospital Association, August 1, 1970.**

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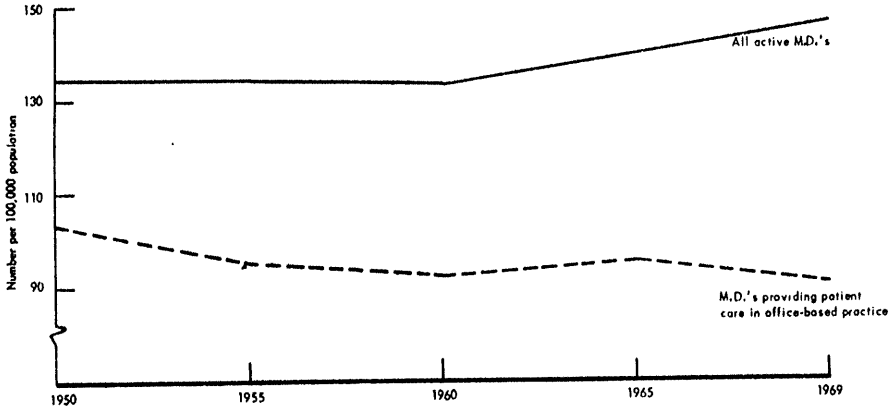
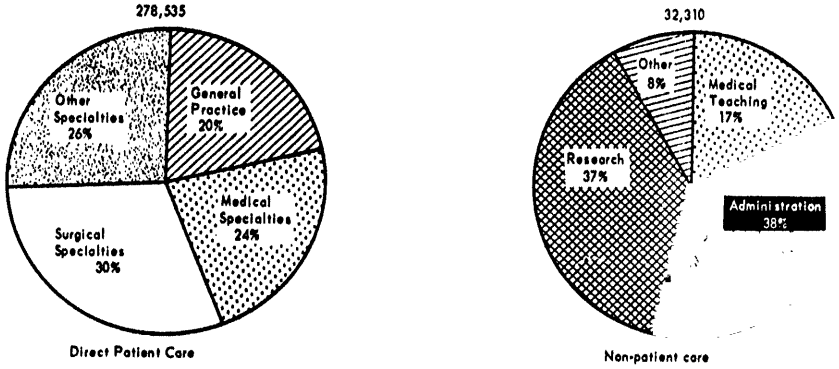
THE NUMBER OF PHYSICIANS PER 100,000 POPULATION HAS RISEN, BUT THOSE PROVIDING PATIENT CARE HAVE NOT KEPT PACE WITH POPULATION INCREASES



Source: *Health Resources Statistics, 1969*. Public Health Service Publication No. 1509. U.S. Department of Health, Education, and Welfare.

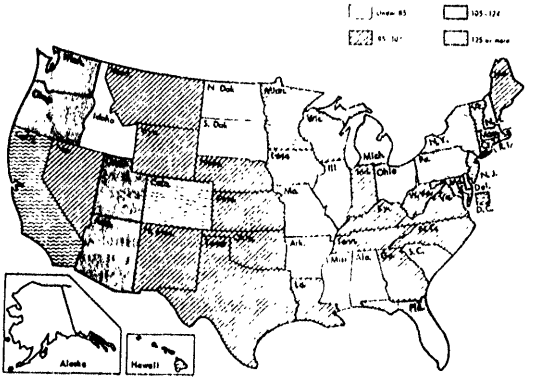
310,845 ACTIVE PHYSICIANS, OR 153 PER 100,000 POPULATION, PROVIDE MEDICAL SERVICES FOR THE NATION



1970

Source: *Reference Data on Socioeconomic Issues of Health*, 1971 Revised Edition, American Medical Association.

THE NUMBER OF PHYSICIANS PER 100,000 PERSONS VARIES FROM 63 IN ALASKA TO 160 IN CALIFORNIA



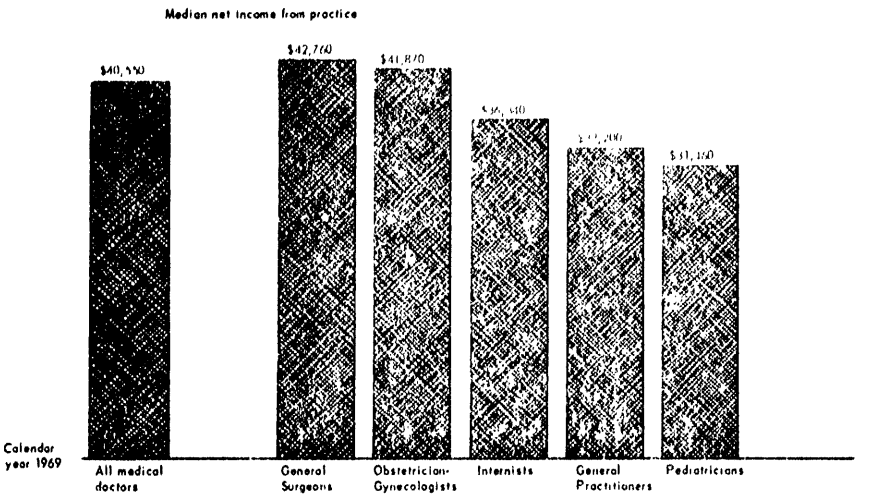
Source: *Reference Data on Socioeconomic Issues of Health*, 1971 Revised Edition, American Medical Association.

IN 1969, NEARLY 500,000 PERSONS LIVED IN COUNTIES WITH NO PRACTICING PHYSICIAN

State	Number of counties	Population	State	Number of counties	Population
United States	134	477,800	Nebraska	13	15,800
			Nevada	3	3,300
Alaska	1	18,800	New Mexico	3	24,900
California	1	400	North Carolina	1	8,600
Colorado	5	7,800	North Dakota	5	12,400
Florida	4	15,000	Oklahoma	1	6,100
Georgia	12	53,200	Oregon	3	7,500
Idaho	4	11,500	South Dakota	15	46,700
Indiana	1	6,200	Tennessee	1	5,000
Kansas	2	7,200	Texas	24	60,500
Michigan	2	6,600	Utah	4	5,100
Minnesota	1	6,200	Vermont	1	2,900
Mississippi	1	2,600	Virginia	3	33,700
Missouri	15	96,300	Wisconsin	1	2,700
Montana	6	10,400	Wyoming	1	400

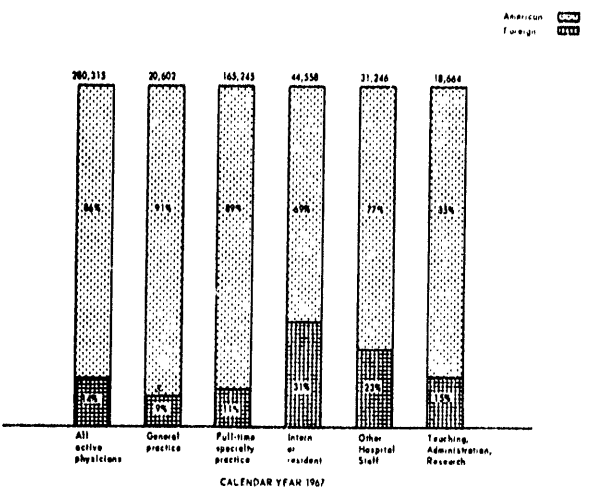
Source: *Distribution of Physicians, Hospitals, and Hospital Beds in the United States, 1969.* American Medical Association.

SURGEONS' INCOMES ARE THE HIGHEST



Source: *Medical Economics*, December 21, 1970.

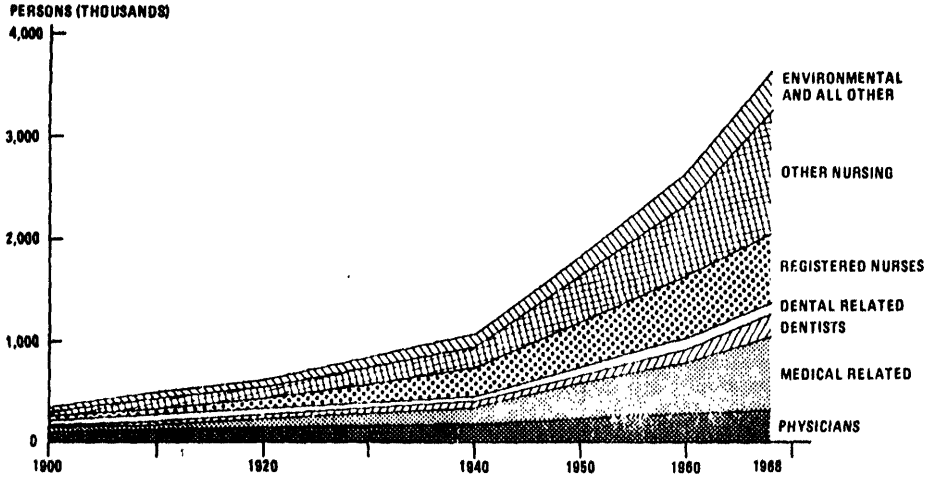
ONE OUT OF EVERY SEVEN ACTIVE PHYSICIANS IS A GRADUATE OF A FOREIGN MEDICAL SCHOOL; FOR INTERNS THE PROPORTION IS CONSIDERABLY HIGHER



Source: *Report of the National Advisory Commission on Health Manpower, Vol. II, November 1967.*

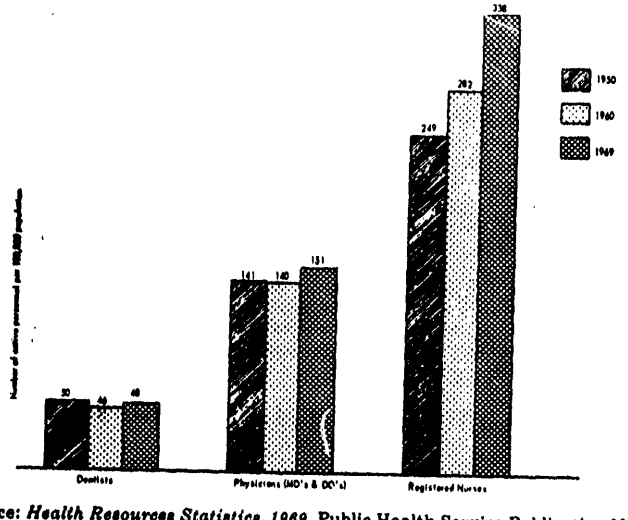
9

HEALTH IS THE 3D LARGEST INDUSTRY IN THE UNITED STATES, EMPLOYING 3.7 MILLION PEOPLE—ABOUT ONE OUT OF EVERY TWENTY WORKERS HAS A JOB IN THE HEALTH INDUSTRY



Source: Pennell, Maryland Y. and Hoover, David B. *Health Manpower Source Book*, Sec. 21, Public Health Service Publication No. 263. U.S. Department of Health, Education, and Welfare.

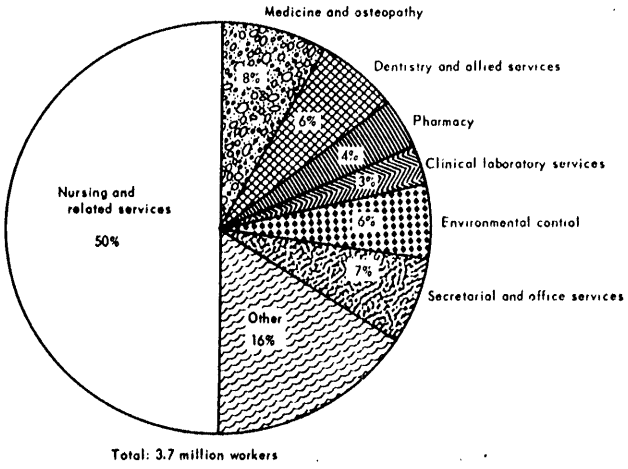
NURSING IS THE FASTEST-GROWING MEDICAL PROFESSION



Source: *Health Resources Statistics, 1969*. Public Health Service Publication No. 1509. U.S. Department of Health, Education, and Welfare.

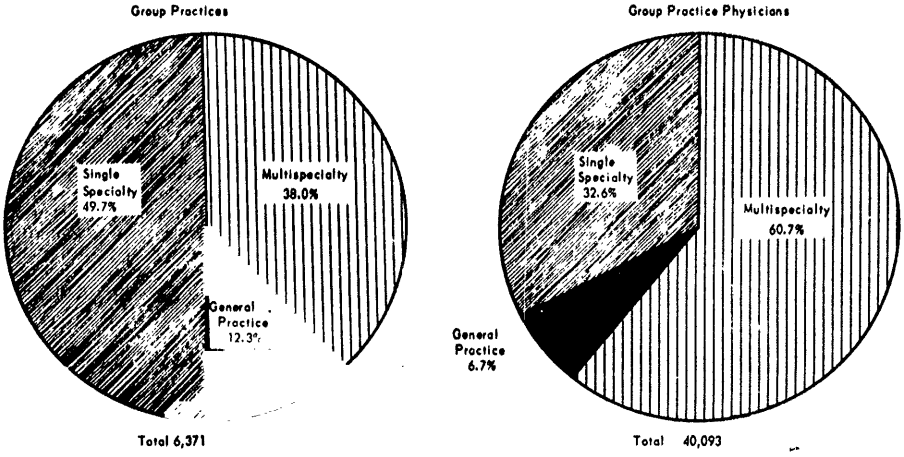
10

HALF OF ALL HEALTH CARE PERSONNEL PROVIDE NURSE-RELATED SERVICES



Source: *Health Resources Statistics, 1969.* Public Health Service Publication No. 1509. U.S. Department of Health, Education, and Welfare.

IN 1969 THERE WERE MORE THAN 6,000 GROUP PRACTICES EMPLOYING MORE THAN 40,000 PHYSICIANS



ORGANIZATION AND DELIVERY

The delivery of medical care is only one factor among the many affecting the health of the Nation's population. Environmental factors, public health activities, nutrition, and personal health education are other important factors. Yet, there is evidence that improvement is needed in many aspects of the delivery of medical care.

While life expectancy and infant mortality are improving in the United States, our experience lags behind that of many other Western countries. Further, among our population groups, the poor and non-white groups experience considerably higher rates of illness, disability and infant and maternal deaths, but receive less medical care than other groups.

Medical care in the United States is rendered mainly by private physicians, in solo practice or small partnerships. Most short-term hospitals are operated by voluntary organizations or local governments and patients are usually placed in the hospital and treated there by private attending physicians. Other medical goods and services are, in most cases, supplied by independent practitioners, organizations or firms. The various types of services are generally paid for separately, directly by the patient or by third-party payors.

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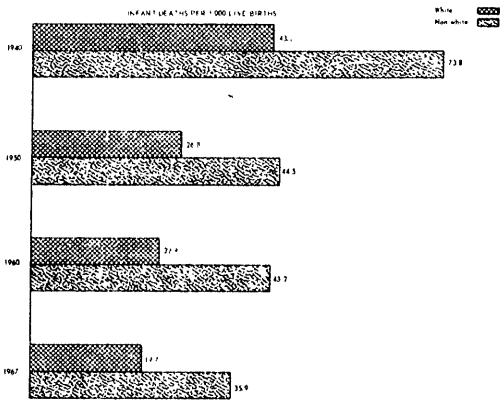
There is considerable evidence that these methods of organizing and delivering and financing health services has resulted in considerable inefficiency in the delivery of services, fragmentation and poor quality of care, overuse of certain services and failure to use appropriate facilities. The system of delivering care is sometimes described as a "non-system." Medical costs continue to rise rapidly, yet complaints are increasingly heard of the difficulty of obtaining access to medical care and of obtaining appropriate and quality care.

These problems may arise in part because of the failure of any one component of the health care delivery system to take responsibility for providing and financing quality health care services. By assigning responsibility to deliver quality care on a prepaid per capita basis to a health maintenance organization, we would give the organization an incentive to be efficient, make optimum use of paramedical personnel and avoid unnecessary use of services. For example, experience under the Federal employees health program and the Medicare program for the aged, indicates that enrollees of prepaid group practice plans used less hospital care than comparable groups in the general population.

THE INFANT MORTALITY RATE OF NONWHITES IS DOUBLE THAT OF WHITES



Source: *Vital Statistics of the U.S., 1967.* National Center for Health Statistics, U.S. Department of Health Education, and Welfare.

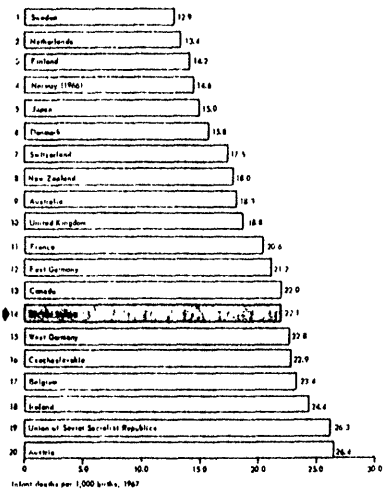
HEART DISEASE, CANCER, AND STROKE NOW CAUSE NEARLY 7/10 OF ALL U.S. DEATHS

1900			1967		
Cause of death	Deaths per 100,000 persons	Percent of all deaths	Cause of death	Deaths per 100,000 persons	Percent of all deaths
All causes	1,719.1	100.0	All causes	935.7	100.0
Influenza and pneumonia	202.2	11.8	Diseases of the heart	364.5	39.0
Tuberculosis (all forms)	194.4	11.3	Malignant neoplasms (cancer)	157.2	16.8
Gastritis, etc	142.7	8.3	Vascular lesions affecting central nervous system	102.2	10.9
Diseases of the heart	137.4	8.0	Accidents	57.2	6.1
Vascular lesions affecting central nervous system	106.9	6.2	Influenza and pneumonia	28.8	3.1
Chronic nephritis	81.0	4.7	Certain diseases of early infancy	24.4	2.6
All accidents	72.3	4.2	General arteriosclerosis	19.0	2.0
Malignant neoplasms (cancer)	64.0	3.7	Diabetes mellitus	17.7	1.9
Certain diseases of early infancy	62.6	3.6	Other diseases of the circulatory system	15.1	1.6
Diphtheria	40.3	2.3	Other bronchopulmonic diseases	14.8	1.6

Source: 1900: *Progress in Health Services*, vol. 10, No. 2, February 1961. 1967: *Statistical Abstract of the United States*, 1970. Bureau of the Census, U.S. Department of Commerce.

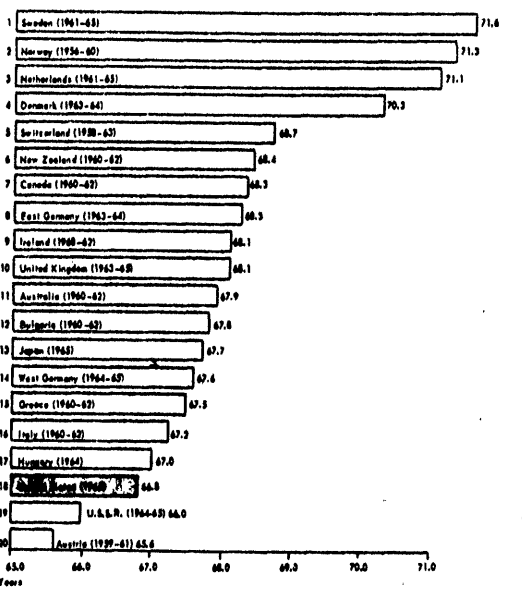
14

THE UNITED STATES RANKS 14TH IN INFANT MORTALITY



Source: *Population and Vital Statistics Report.* Series A, Volume XXI, No. 1, January 1, 1969 and No. 2, April 1, 1969. United Nations.

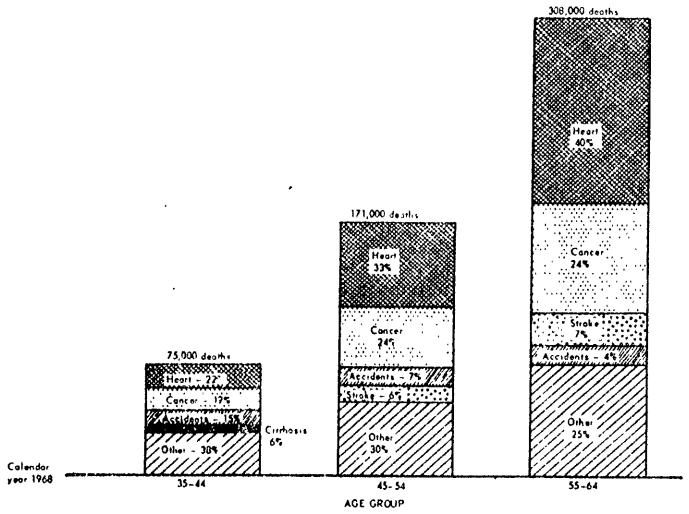
THE UNITED STATES RANKS 18TH IN MALE LIFE EXPECTANCY



Source: U.S. Department of Health, Education, and Welfare.

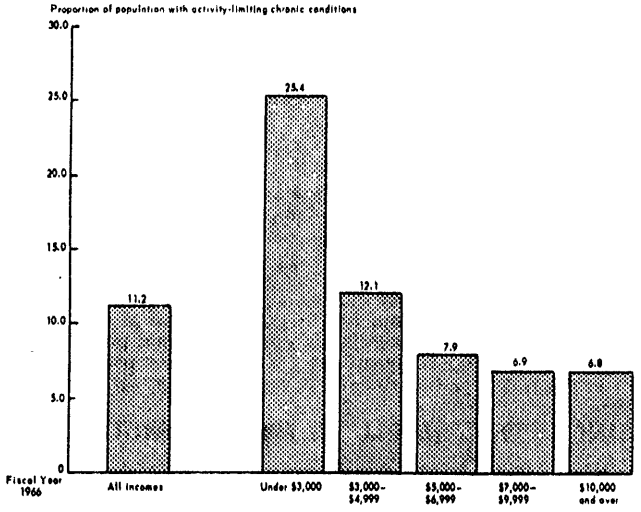
15

HEART DISEASE AND CANCER ACCOUNT FOR THREE-FIFTHS OF ALL DEATHS IN THE MIDDLE YEARS



Source: *Vital Statistics of the U.S., 1968.* National Center for Health Statistics, U.S. Department of Health, Education, and Welfare.

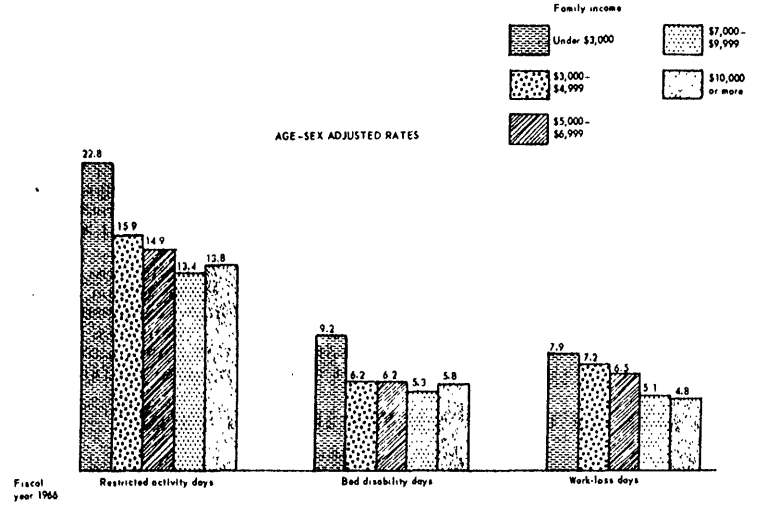
PERSONS WITH HIGHER INCOMES ARE HEALTHIER THAN THE POOR



Source: *Limitation of Activity and Mobility Due to Chronic Conditions, U.S., July 1965-June 1966.* Vital and Health Statistics, Series 10, No. 45. National Center for Health Statistics, U.S. Department of Health, Education, and Welfare.

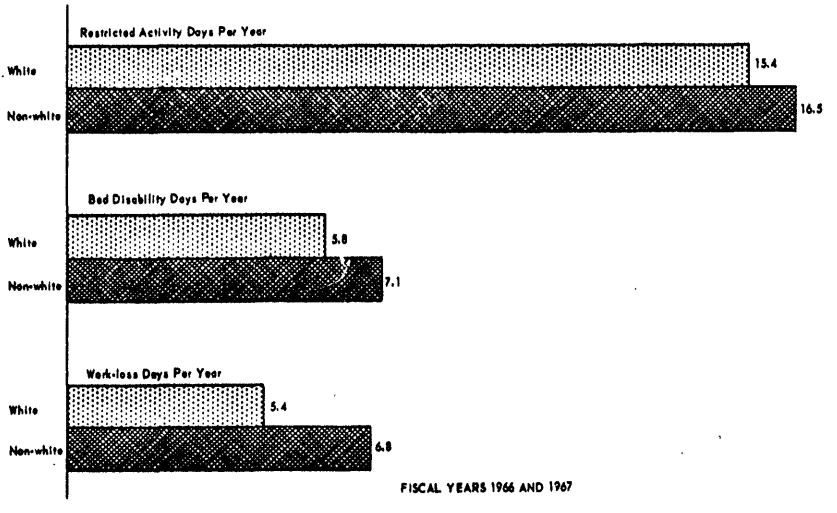
16

THE POOR HAVE A 50 PERCENT HIGHER RATE OF DISABILITY DAYS



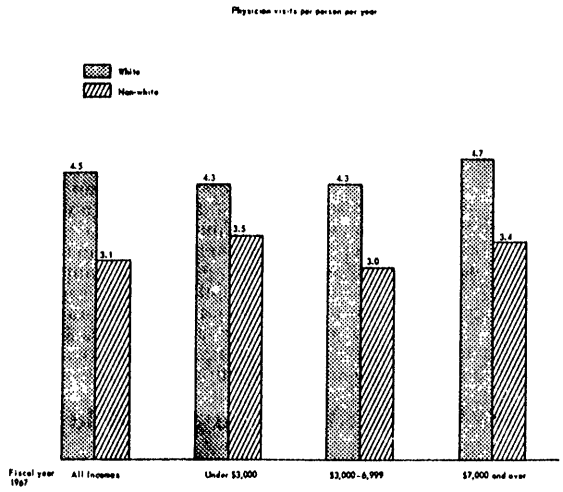
Source: *Disability Days, U.S., July 1965–June 1966.* Vital and Health Statistics, Series 10, No. 47. National Center for Health Statistics, U.S. Department of Health, Education, and Welfare.

NONWHITES HAVE MORE DISABILITY DAYS THAN WHITES



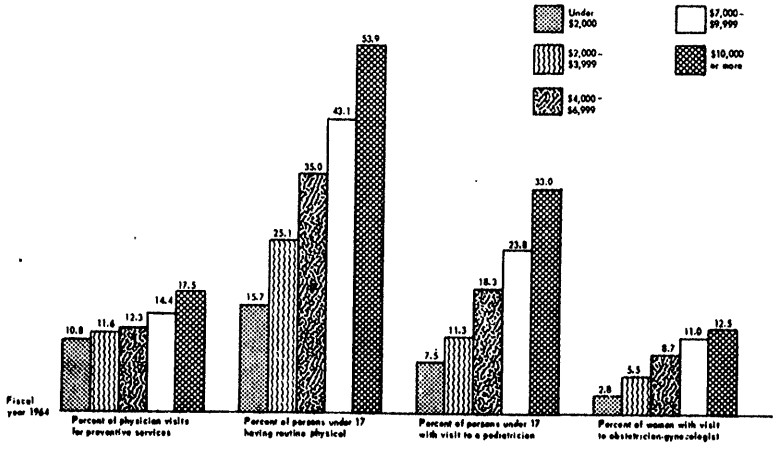
Source: *Differentials in Health Characteristics by Color, U.S., July 1965–June 1967.* Vital and Health Statistics, Series 10, No. 56, National Center for Health Statistics, U.S. Department of Health, Education, and Welfare.

NONWHITES SEE PHYSICIANS LESS OFTEN THAN WHITES



Source: *Differentials in Health Characteristics by Color, U.S., July 1965–June 1967.* Vital and Health Statistics, Series 10, No. 56, National Center for Health Statistics, U.S. Department of Health, Education. and Welfare.

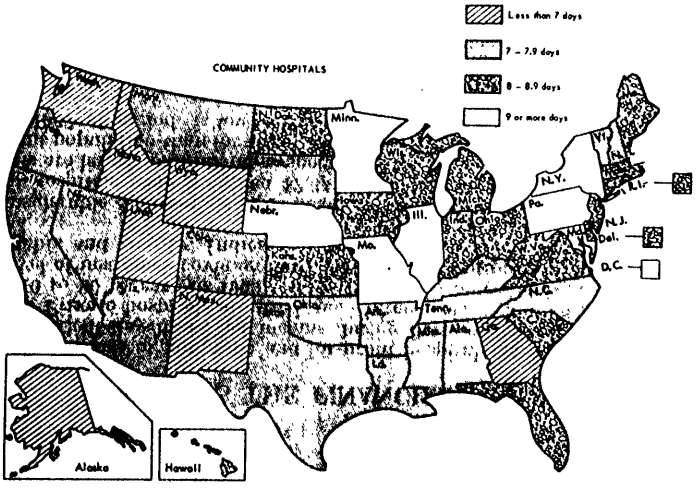
PHYSICIAN USE FOR PREVENTIVE AND ROUTINE SERVICES INCREASES WITH INCOME



Sources: White, E. L. "A Graphic Presentation on Age and Income Differentials in Selected Aspects of Morbidity, Disability, and Utilization of Health Services," *Inquiry*, Blue Cross Association, Vol. 5, No. 1, March 1968.

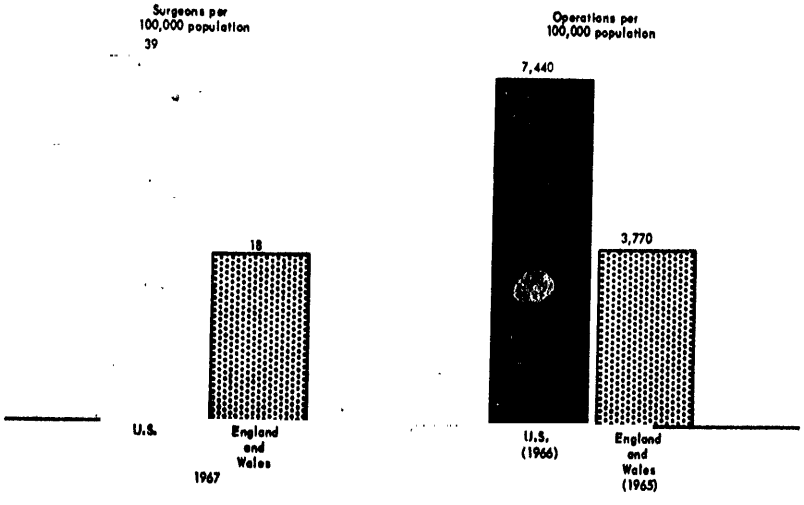
Characteristics of Patients of Selected Types of Medical Specialists and Practitioners, U.S., July 1963–June 1964. Vital and Health Statistics, Series 10, No. 28, National Center for Health Statistics, U.S. Department of Health, Education, and Welfare.

AVERAGE LENGTH OF STAY VARIES SUBSTANTIALLY



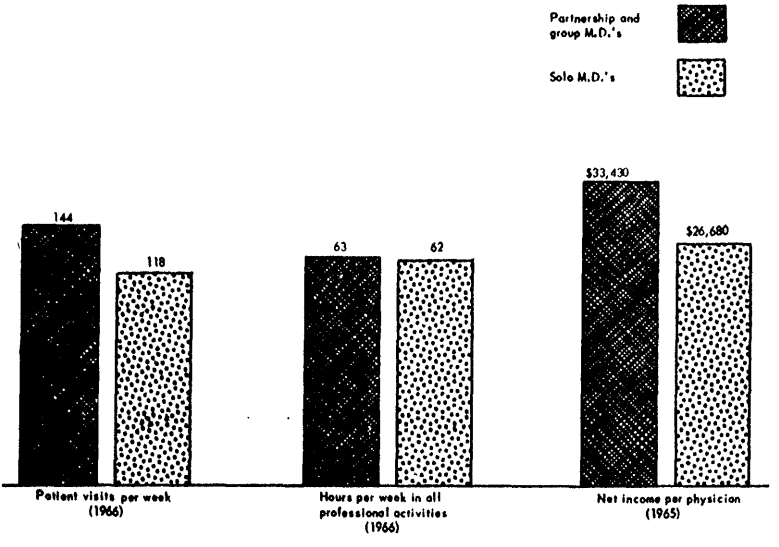
Source: *Hospitals*, Journal of the American Hospital Association, August 1, 1970.

THE UNITED STATES HAS TWICE THE NUMBER OF SURGEONS AND TWICE THE NUMBER OF OPERATIONS PER PERSON COMPARED WITH ENGLAND



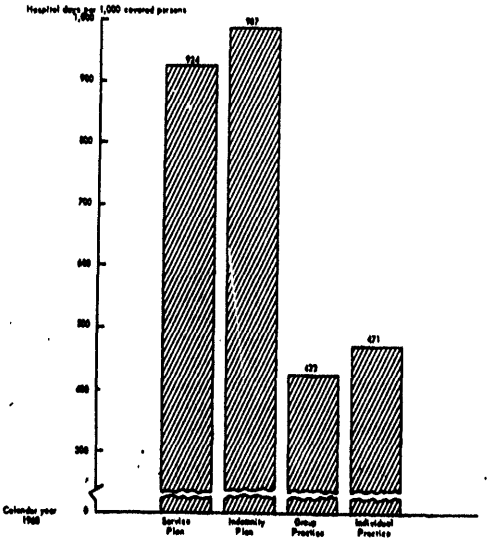
Source: Bunker, John P., M.D. "Surgical Manpower—A Comparison of Operations and Surgeons in the United States and England and Wales." *New England Journal of Medicine*, January 15, 1970.

PARTNERSHIP AND GROUP PRACTICE PHYSICIANS SEE MORE PATIENTS AND HAVE HIGHER INCOMES THAN THOSE IN SOLO PRACTICE



Source: *Medical Economics*, June 12, 1967.

PERSONS ENROLLED IN PREPAID GROUP PRACTICE USE HOSPITALS LESS



Source: Perrott, George S. *The Federal Employees Health Benefits Program.* Public Health Service, Health Services and Mental Health Administration. U.S. Department of Health, Education, and Welfare.

FINANCIAL ACCESS

Since World War II, private health insurance has expanded so that four-fifths of the population under age 65 now have some insurance protection against health care costs. Much of this insurance is provided as a fringe benefit at places of employment.

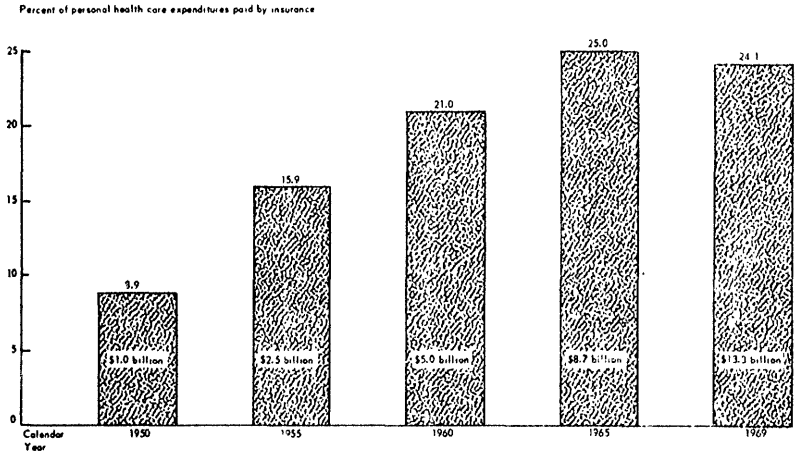
Persons not protected by employment-related insurance, such as workers in firms without health insurance, the self-employed and the nonemployed can obtain insurance only by purchasing an individual policy. These policies are typically expensive because they pay relatively little in benefits compared to their premium cost.

For those with private health insurance, the scope and type of protection is quite uneven. Most health insurance offers protection against hospital care costs and inhospital surgical and medical services. The extent of coverage for ambulatory services--such as home and office visits, hospital outpatient care and diagnostic services--is relatively low. As a result, the insurance encourages use of expensive inpatient hospital care when ambulatory care would be more economical and suitable. Further, major medical insurance policies (which generally provide both hospital and ambulatory coverage) often establish unrealistically low lifetime maximums on benefits, often $10,000 to $25,000.

The poor generally have little health insurance protection, so that only one-fourth of poor children are protected. This is especially

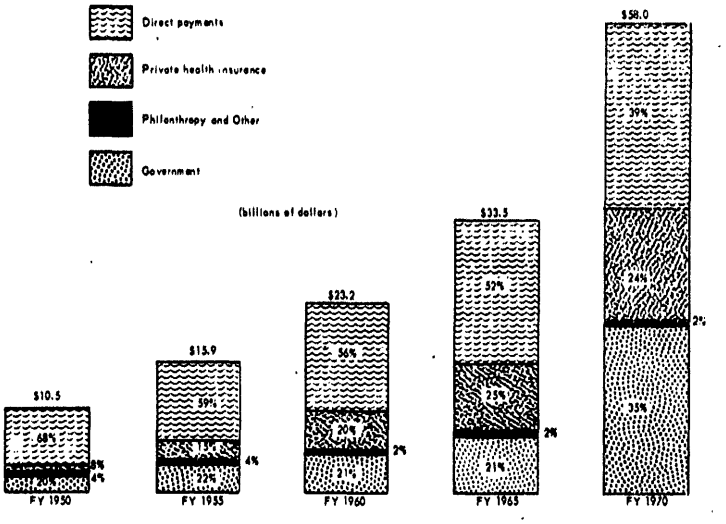
true for the nonworking poor who do not have access to employment-related health insurance and must rely on available government medical care programs. The Federal-State Medicaid program, the most important program for the poor, offers uneven and sometimes inadequate protection. Eligibility for benefits vary considerably among the States, as does the type and amount of medical services available. Since its inception, the program has been beset with a multitude of financial and administrative problems and some States have cut back on eligibility for benefits and the amount of benefits available under the programs.

FROM 1950 TO 1969 HEALTH INSURANCE COVERAGE OF HEALTH EXPENDITURES ROSE FROM LESS THAN ONE-TENTH TO NEARLY ONE-QUARTER



Source: Cooper, Barbara S. and McGee, Mary. "National Health Expenditures, Fiscal Years 1929–70 and Calendar Years 1929–69." *Research and Statistics Note No. 25*, December 14, 1970, Social Security Administration, U.S. Department of Health, Education, and Welfare.

THE PROPORTION PAID DIRECTLY FOR PERSONAL HEALTH CARE HAS DECLINED SIGNIFICANTLY SINCE 1950



Source: Rice, Dorothy P. and Cooper, Barbara S. "National Health Expenditures, 1929–70," *Social Security Bulletin*, January 1971. U.S. Department of Health, Education, and Welfare.

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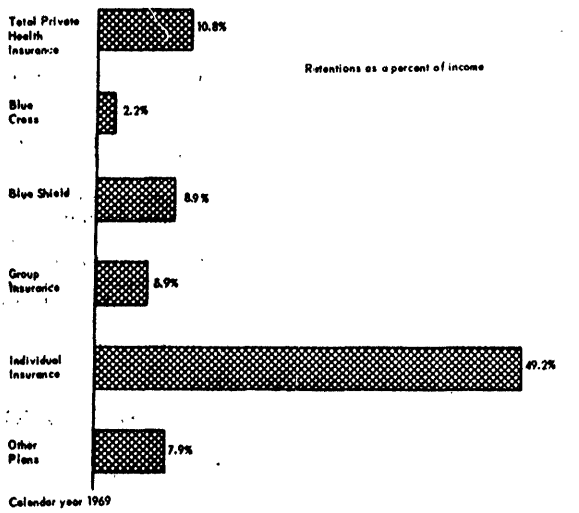
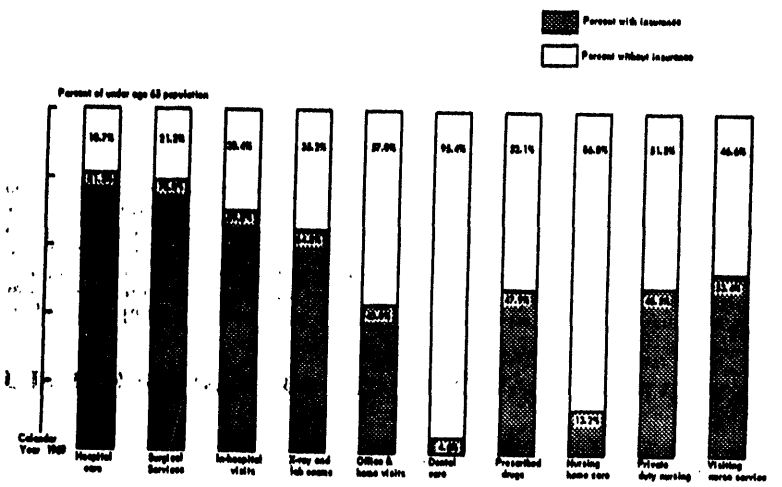
HEALTH INSURANCE ORGANIZATIONS RETAIN ONE-TENTH OF THEIR INCOME, BUT THE PROPORTION VARIES BY TYPE OF ORGANIZATION



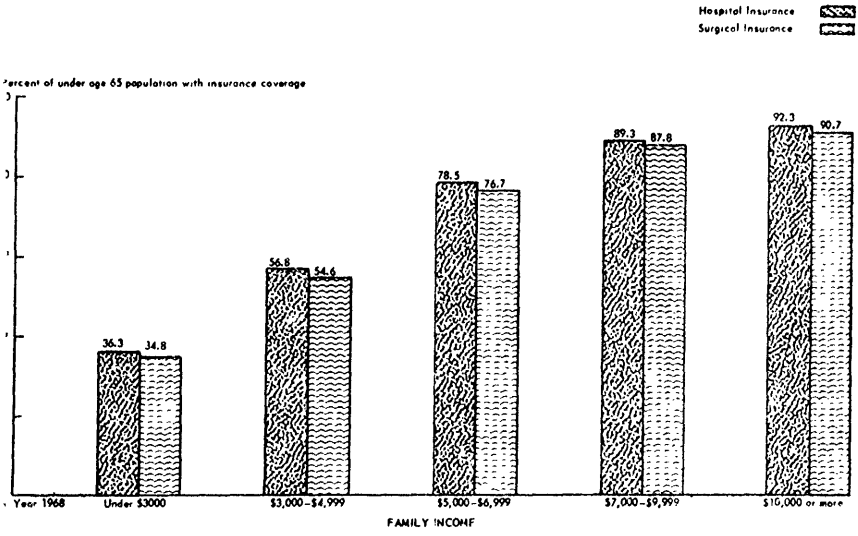
Source: Mueller, Marjorie Smith. "Private Health Insurance in 1969: A Review." *Social Security Bulletin*, February 1971, U.S. Department of Health, Education, and Welfare.

ABOUT FOUR-FIFTHS OF THE UNDER AGE 65 POPULATION HAS HOSPITAL AND SURGICAL INSURANCE, BUT FOR MANY OTHER HEALTH SERVICES INSURANCE IS SCANTY



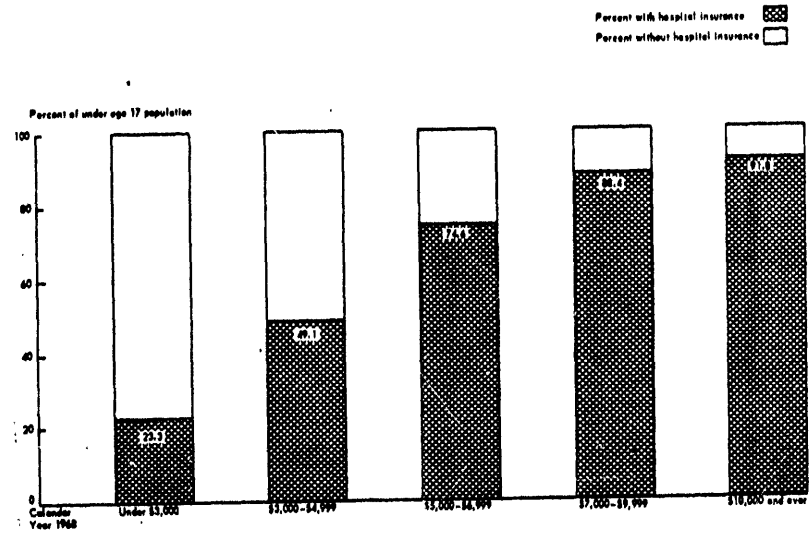
Source: Mueller, Marjorie Smith. "Private Health Insurance in 1969: A Review." *Social Security Bulletin*, February 1971, U.S. Department of Health, Education, and Welfare.

THE POORER A PERSON THE LESS LIKELY HE IS TO HAVE HEALTH INSURANCE



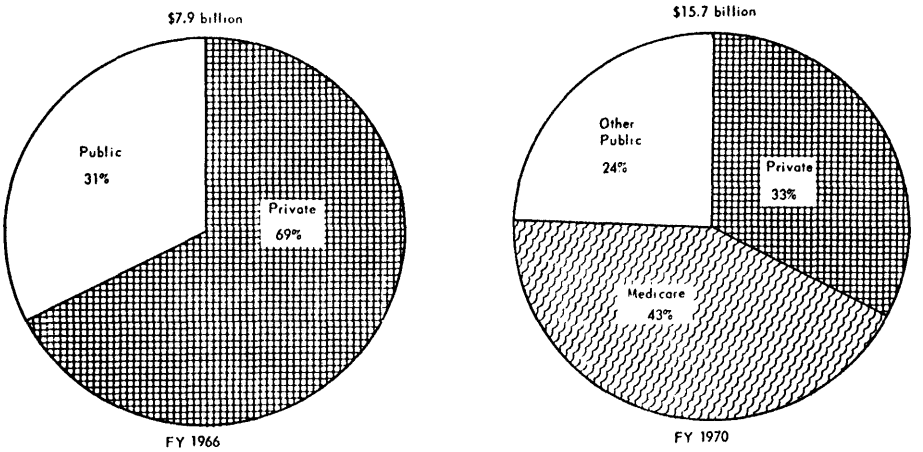
Source: *Monthly Vital Statistics Report*, February 2, 1970. National Center for Health Statistics, U.S. Department of Health, Education, and Welfare.

LESS THAN ONE-FOURTH OF CHILDREN WHO ARE POOR HAVE HOSPITAL INSURANCE



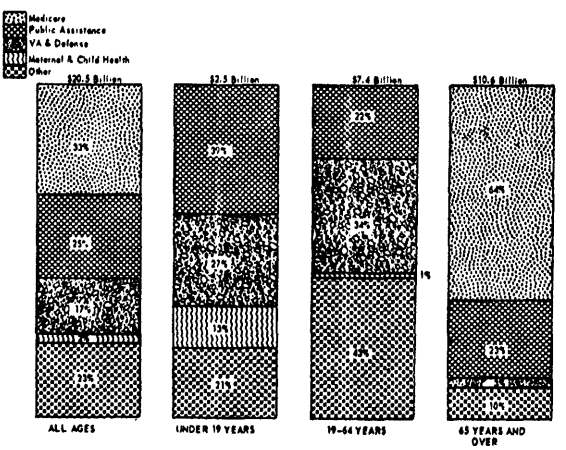
Source: *Health Interview Survey*, 1968. National Center for Health Statistics. U.S. Department of Health, Education, and Welfare.

MEDICARE AND MEDICAID CONTRIBUTE NEARLY THREE-FIFTHS OF ALL GOVERNMENT HEALTH SPENDING



Source: Cooper, Barbara S. and McGee, Mary F. "Medical Care Outlays for Three Age Groups: Young, Intermediate and Aged." *Social Security Bulletin*, May 1971. U.S. Department of Health, Education, and Welfare.

BEFORE MEDICARE, PRIVATE FUNDS PAID 69 CENTS OUT OF EVERY HEALTH CARE DOLLAR FOR THE AGED; TODAY THEY PAY 33 CENTS



COSTS

The cost of medical care services has been rising at a rapid pace for many years--both in dollars and as a proportion of the gross national product. About one-half of the increase in medical costs in the last 20 years resulted from the rise in prices and about one-third from increased use of services and introduction of new medical techniques, drugs and treatment procedures. (The balance of the increase is due to the rise in population.) The rate of increase in cost has greatly accelerated since 1966 when the Medicare and Medicaid programs first went into effect.

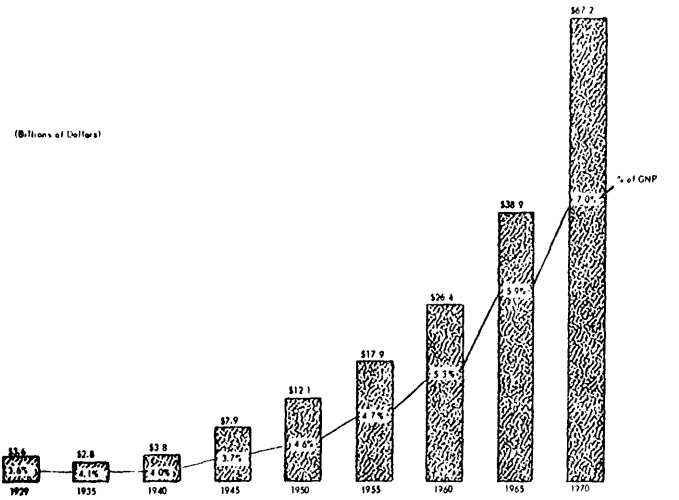
The large increase in hospital costs in recent years is in part attributable to the substantial pay raises given hospital employees, whose wages had long lagged behind those of other workers. The pay increases were given in response to demands from organizations of hospital workers and the extension (in 1967) of the minimum wage to hospital employees. Other expenditures of hospitals--for supplies, equipment and advanced medical technology--have also increased substantially during this period, and the net income of hospitals has also risen. Increases in hospital expenditures have been made possible, in part, by the flow of additional revenue to hospitals from payments under the Medicare and Medicaid programs.

Hospital and other institutional providers are reimbursed on a cost basis for services under the Medicare, Medicaid, and some private insurance plans. Payment on this basis provides little incentive for

improving efficiency and productivity of hospital operations. Development of other methods of payment, for example, payment on a prospective basis (rather than retroactively on a cost basis) might provide such incentives. Further, the actions of areawide planning could be strengthened if government programs and other third-party payors would withhold payment of costs (interest and depreciation) for hospital expansion not approved by the local planning agencies.

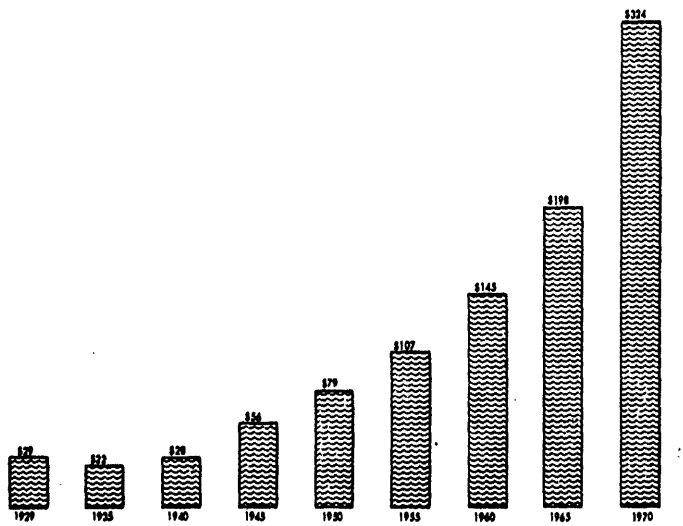
The rise in physicians' fees have also accelerated since 1966. Part of this increase was in anticipation of the Medicare program. The increased demand for physicians services resulting from the new government programs and additional private coverage--an increase not met by a rise in the availability of these services--is largely responsible for the increase in fee levels. Improvements in the availability and productivity of physicians services, as well as appropriate limits on physicians' fees, are necessary to deal with this problem.

HEALTH SPENDING TODAY—$67.2 BILLION—IS FIVE TIMES THE SPENDING OF 20 YEARS AGO



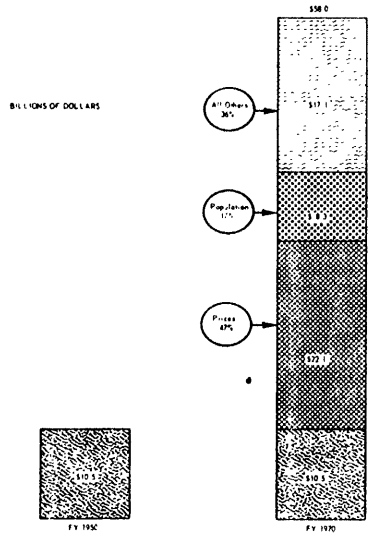
Source: Rice, Dorothy P. and Cooper, Barbara S. "National Health Expenditures, 1929-70" *Social Security Bulletin*, January 1971, U.S. Department of Health, Education, and Welfare.

IN THE LAST 20 YEARS, EACH PERSON'S AVERAGE HEALTH BILL HAS GROWN FROM $79 TO $324



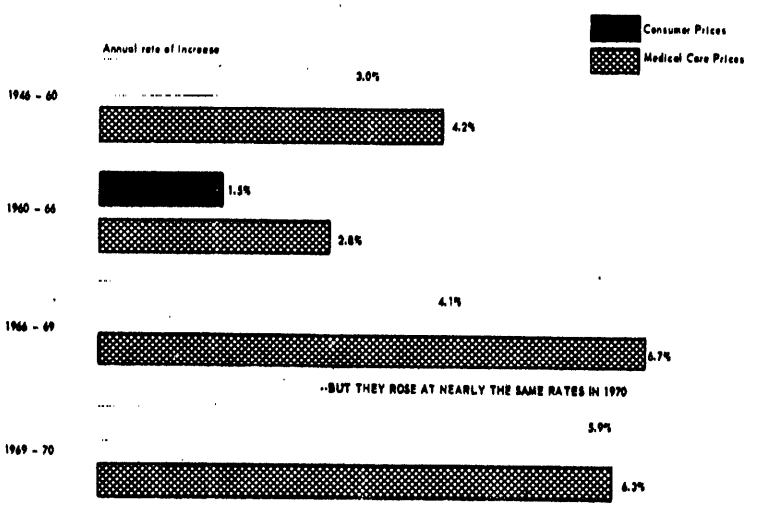
Source: Rice, Dorothy P. and Cooper, Barbara S. "National Health Expenditures, 1929-70," *Social Security Bulletin*, January 1971, U.S. Department of Health, Education, and Welfare.

HIGHER PRICES CAUSED NEARLY HALF THE 20-YEAR GROWTH



Source: Rice, Dorothy P. and Cooper, Barbara S. "National Health Expenditures, 1929-70," *Social Security Bulletin*, January 1971, U.S. Department of Health, Education, and Welfare.

IN THE 1960's MEDICAL PRICES JUMPED ALMOST TWICE AS FAST AS PRICES FOR ALL CONSUMER ITEMS



Source: ***Consumer Price Index*****, Bureau of Labor Statistics, U.S. Department of Labor.**

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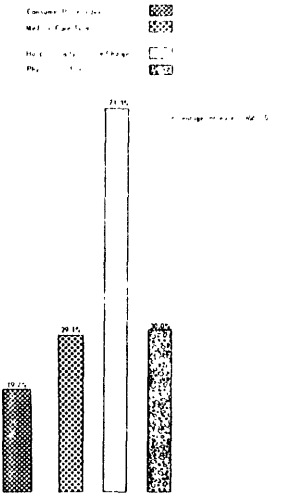
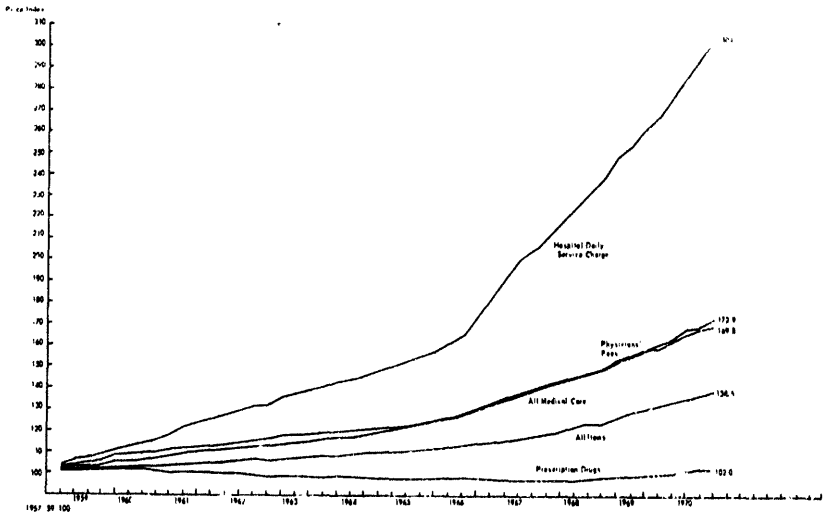
MEDICAL CARE PRICES HAVE JUMPED 29 PERCENT IN 4 YEARS



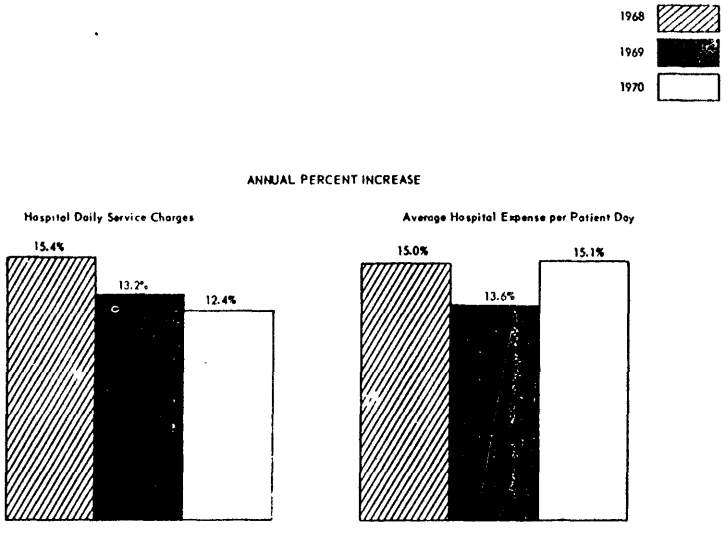
Source: *Consumer Price Index*, Bureau of Labor Statistics, U.S. Department of Labor.

HOSPITAL DAILY SERVICE CHARGES HAVE MOVED FASTEST



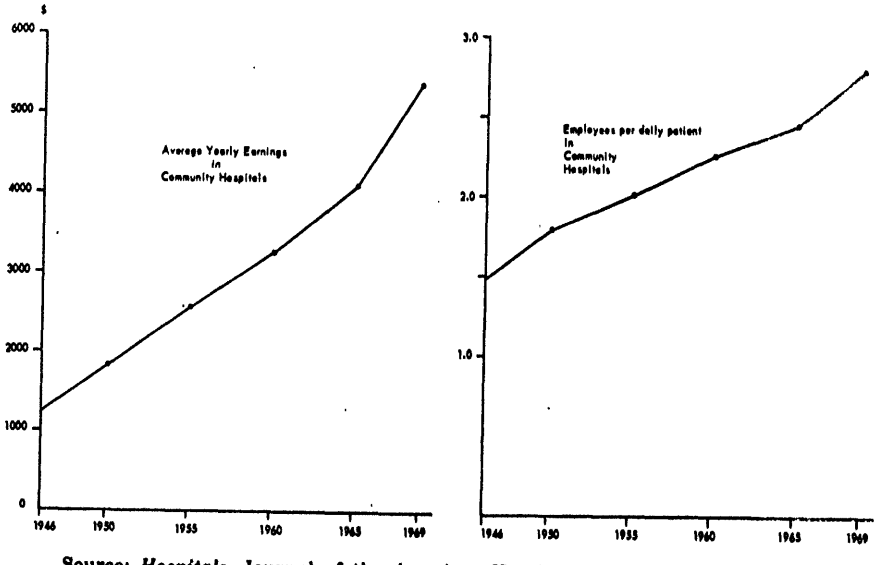
Source: *Consumer Price Index*, Bureau of Labor Statistics, U.S. Department of Labor.

HOSPITAL COSTS HAVE INCREASED SUBSTANTIALLY REGARDLESS OF MEASURE USED



Sources: *Consumer Price Index*, Bureau of Labor Statistics, U.S. Department of Labor.
Hospitals, Journal of the American Hospital Association.

BOTH AVERAGE EARNINGS AND EMPLOYMENT PER PATIENT HAVE INCREASED SUBSTANTIALLY



Source: *Hospitals*, Journal of the American Hospital Association, August 1, 1970.

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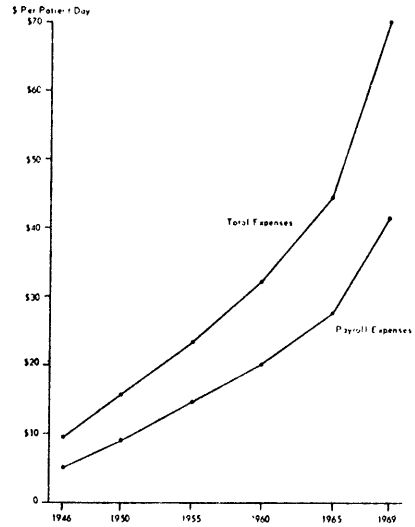
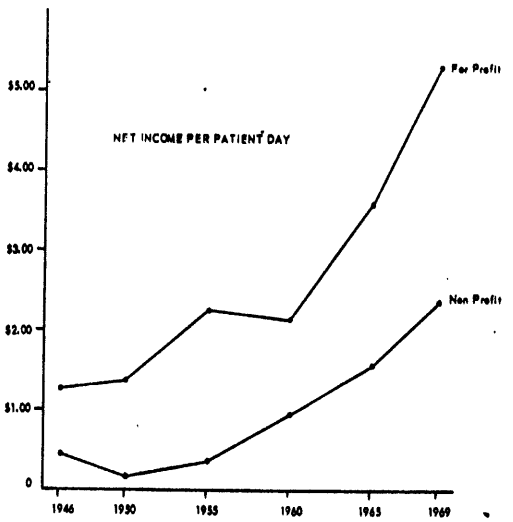
PAYROLL AND NONWAGE EXPENSES HAVE BEEN RISING AT ABOUT THE SAME RATE



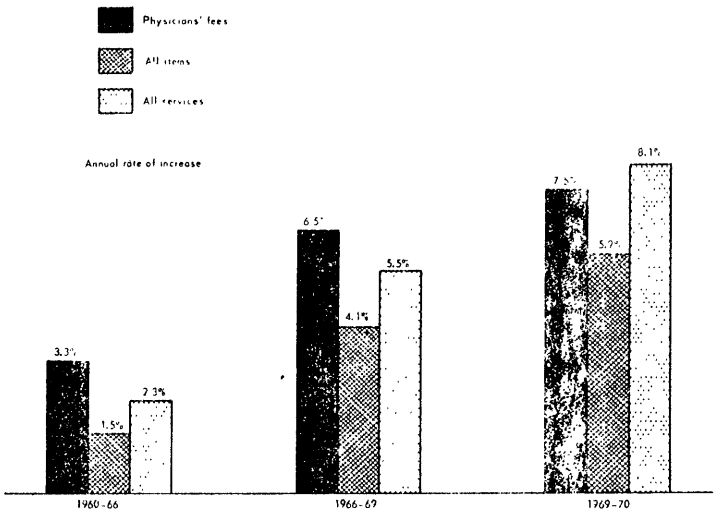
Source. *Hospitals*, Journal of the American Hospital Association, August 1, 1970.

THE FINANCIAL POSITION OF HOSPITALS HAS IMPROVED IN RECENT YEARS



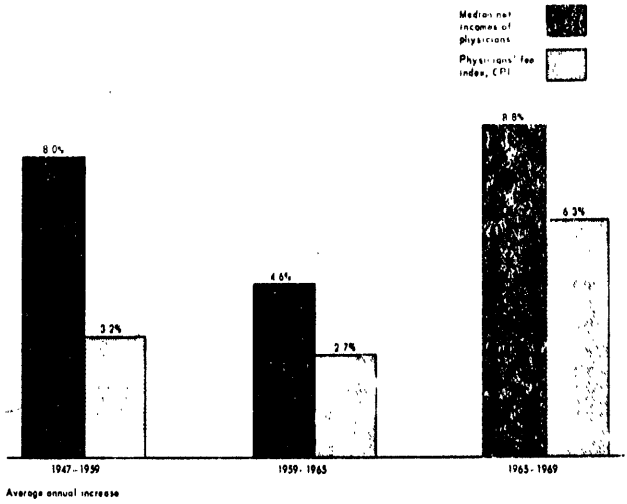
Source: *Hospitals*, Journal of the American Hospital Association.

PHYSICIANS' FEES ACCELERATED BEGINNING IN 1966



Source: *Consumer Price Index*, Bureau of Labor Statistics, U.S. Department of Labor.

PHYSICIANS' INCOMES HAVE RISEN MORE RAPIDLY THAN FEES



Sources: Income; *Medical Economics*.
Fees; *Consumer Price Index*, Bureau of Labor Statistics, U.S. Department of Labor.

Secretary RICHARDSON. I shall turn to the administration's proposals for addressing these problems; I will then examine other health care proposals now pending before the Congress and will compare their capacity for dealing with the same problems.

OUR PROPOSED SOLUTIONS

SUPPLY AND DISTRIBUTION STRATEGY

Turning first to the impact of our solutions to meet the problems of shortage and maldistribution of resources, we have proposed health manpower legislation. Under that bill the current Federal support of medical and dental training would be broadened to increase the supply of doctors and paramedical personnel, to shorten training time, and to increase the number of doctors and nurses in medically underserved rural and inner-city areas.

ORGANIZATION AND DELIVERY STRATEGY

As you will recall, during your committee's deliberations on H.R. 1, the Welfare Reform bill, we worked with your committee to develop a Health Maintenance Organization option for Medicare and Medicaid to ensure that prepaid health groups and other capitation plans would be eligible for reimbursement under these programs on a prospective basis. To insure that this option exists, in fact, for an increasing proportion of the population, we have also recommended major new legislation to stimulate the development and expansion of Health Maintenance Organizations. Our proposal, pending before the Interstate and Foreign Commerce Committee, provides for planning grants and contracts, grants for operating HMO's serving predominantly underserved areas, loan guarantees for HMO capital costs and for working capital for private organizations, and direct loans for public HMO's.

FINANCING STRATEGY

Through the National Health Insurance Partnership Act, the administration seeks to improve health care by building upon the existing public-private health financing arrangements, while simultaneously correcting their shortcomings.

Our bill is designed to insure that every family in America will have access to health insurance, at reasonable cost and with improved protection, through enforcement of standards for participating insurers, and controls on cost and quality for providers. Our bill consists of two major elements: National Health Insurance Standards (title I), covering the employed, and the Family Health Insurance Plan (title II), covering families with children not covered by title I.

1. National Health Insurance Standards Act

The National Health Insurance Standards Act would require all private employers in the Nation to provide basic health insurance coverage for virtually all their employees and their employees' immediate families. Precedents for this requirement are the minimum wage law, workmen's compensation, cash sickness and occupational health and safety legislation.

The bill would require a minimum standard of health insurance benefits covering the highest priority medical needs. Coverage would be required for inpatient hospital care, surgical and medical care, inpatient and outpatient physicians' services, laboratory, x-ray and other ancillary medical services, maternity care, well-child care, and vision care for children. Initially coverage of prescription drugs, outpatient psychiatric care and dental care for children would not be required. However, in later years when the priority benefits are in place and as resources become available, we would hope to be able to add to the list of minimum benefits.

The benefits under this act would be financed through premium payments jointly made by employers and employees. For the first two and one-half years after enactment the maximum employee contribution would be 35 percent of the total premium paid; thereafter, the employee contribution would be limited to 25 percent. Employees would have the option to select only the mandated basic benefits in preference to more comprehensive benefit programs offered by the employer. Covered employees (those with 13 or more weeks of employment) would remain entitled to coverage and employer contributions for 90 days following termination of employment. This feature will temporarily protect the transitionally unemployed and the families whose breadwinners die by giving them time to apply for any public programs they may be entitled to, or for conversion coverage or pool coverage.

To achieve cost consciousness and reduce the tendency toward unnecessary utilization of health care services, a maximum hospital room and board deductible of two days per person, no greater than a $100 deductible for all other services, and coinsurance up to 25 percent of expenditures are included in the plan. However, when an individual's medical bills for basic services reached $5,000, there could be no further deductibles or coinsurance for that year and for the next 2 years. Catastrophic protection for at least $50,000 per person would be required, with automatic restoration of at least $2,000 in benefits each year.

The bill would require that employees be given the option to participate in a Health Maintenance Organization, if available, along with the more traditional health plans. We believe this is a highly important feature of the bill. As I have noted earlier, experience under the Federal Employee Program and other experience with prepaid capitation plans indicate that they result in more efficient use of scarce medical resources, which may in turn lead to lower consumer costs.

2. Family Health Insurance Plan

The second part of the administration's health financing proposal is the Family Health Insurance Plan. This plan would replace Medicaid for poor families with children and would remove the major inequities in the current program.

The committee is well aware of the inequities and work disincentives in the Medicaid program. The Family Health Insurance Plan and the National Health Insurance Standards program would, together, reduce these problems. The Family Health Insurance Plan would remove the current inequities in Medicaid with respect to families headed by men, and with respect to the working poor. It would eliminate the patch work of different income eligibility criteria and

benefits among the States. And most important, combined with the National Health Insurance Standards program, it would prevent a sudden loss of all health financing benefits when earnings rise, a problem which now occurs under Medicaid.

Under the Family Health Insurance Plan, basic health insurance protection will be provided for low income families with children not covered by an employer plan. Income eligibility would be uniform nationally, and cut-off levels would range from a maximum of $2,500 for a one-person family to $7,000 for families with seven or more. For a family of four, maximum income for eligibility would be $5,000. We estimate that more than three million families, or almost 15 million people, would be covered by the program.

Benefits would also be uniform nationally, and would include 30 days of inpatient care or an equivalent amount in extended care or home health care; inpatient and outpatient services of physicians; maternity care and family planning; well-child care; vision care for children; laboratory and x-ray services; and emergency services. Here, too, we would hope to be able to expand the scope of benefits in the future in tandem with expansions in the employer-employee plan when the priority benefits are in place and as resources permit. Under the bill, should the States desire to provide supplemental coverage, the Federal Government would provide 100 percent financing of the administration of the additional benefits.

The Family Health Insurance Plan will be financed with Federal general revenues and with family contributions, in the form of premiums, deductibles, and coinsurance, which would increase as income rises.

The poorest families would not be required to make any contribution: a family of four would not be required to share the cost if its income were $3,000 or less. Deductibles and coinsurance would not, in any event, apply to well-child care, maternity care, or family planning services. As in the employer-employee plan, families would have the option of enrolling in a health maintenance organization.

Although the family health insurance plan would replace medicaid for poor families with children, under title III of our bill, the current medicaid program for the aged, blind, disabled, and children in foster care would be retained.

The proposals I have outlined, combined with medicare and other Federal programs, provide a minimum standard of protection for almost all families with children and for most individuals in the Nation, without destroying existing private programs and collective bargaining arrangements.

COST CONTROL STRATEGY

The administration's cost control strategy employs a variety of techniques. We seek both an immediate and a long-run reduction in the rate at which health care costs have been rising. First, we consider our Health Maintenance Organization proposal as part of our cost control strategy because the evidence indicates such groups are more efficient and may be less costly. The cost-effectiveness provisions we proposed and your committee incorporated in H.R. 1, which would also become a part of the National Health Insurance Partnership Act,

are another element of our strategy. These provisions include: authority to deny Federal reimbursement for interest and depreciation on major capital expenditures which are inconsistent with plans of official State and local planning agencies; authority to limit reimbursements to less than full cost for those institutions whose aggregate costs are obviously out of line with those of comparable institutions; and authority to limit prevailing fee increases to an economic index. Similarly, the authority in H.R. 1 for experimentation with different reimbursement and peer review approaches is part of our cost-effectiveness policy. Further, the regulatory proposal I am about to describe would also emphasize cost-awareness among providers, the public, and carriers.

A key factor in our health care strategy is several entirely new proposals regarding cost and quality control which we will submit to this committee shortly.

(The information referred to follows:)

NEW PROPOSALS REGARDING COST AND QUALITY CONTROLS FOR THE HEALTH SECTOR

We are in the process of finalizing a set of amendments to the *National Health Insurance Partnership Act* which would strengthen the regulatory base for health insurance and improve consumer information concerning health care costs and delivery system alternatives. These will further improve the prospects for achieving effective cost and quality control in the health services sector. We will present these amendments during the Executive sessions.

These would regulate the health insurance industry and tighten controls on provider costs and inefficiencies.

REGULATION OF INSURERS AND PROVIDERS

HEALTH INSURANCE REGULATION

When the administration first proposed that all employers be required to purchase health insurance, a privately produced product, it recognized that it would be necessary to provide assurances that the product delivered to the consumer would be reasonably priced and backed by reputable, financially sound companies. Regulation is a necessary corollary to the mandating of private insurance. In developing our regulatory proposals, as in developing our financing proposals, we have sought to build on existing foundations, while at the same time improving and strengthening them. Effective insurance regulatory mechanisms are already in operation in many States; in other States additional authority will be necessary.

For example, in at least 21 States insurance companies are required to file health insurance rates, but in approximately half the States no such requirement is now imposed. All States require insurance companies to file annual financial statements, but in some States independent audits of insurance companies are required only once every 3 to 5 years. A recent study discovered that at least 28 insurance companies failed over a 16-month period, leaving their policyholders in severe jeopardy; one State, in which 10 of the 28 companies were domiciled, was moved by these events to enact an insolvency law protecting policyholders similar to statutes already in effect in a number of States.

Where State regulatory authority is lacking, we will seek through agreements with the States to insure that the needed authority is put in place. We believe those States will act promptly to adopt authority meeting Federal standards. Where this is not the case, the Federal Government will be forced to exercise standby authority. Under our amendments we intend to secure agreements with States under which States will:

1. Require annual independent audits of participating insurance companies.
2. Create State mechanisms to protect consumers against the insolvency of health insurance carriers. A Federal mechanism will also be established if a State does not pass the necessary legislation.
3. Provide "file and use" procedures for NHISA premium rates under NHISA insurance contracts, with authority for the States to disapprove extraordinary rates.
4. Require disclosure by insurers of their administrative expenses as a percentage of premiums. Standard accounting procedures necessary to make this possible will be proposed by the industry and the States for approval by the Secretary of Health, Education, and Welfare.
5. Create insurance pools in every State, open to small employers, the self-employed, and those who are not employed but are ineligible for federally financed health programs.
6. Finally, require health insurance companies to inform prospective policyholders as to benefits, exclusions, premium costs and delivery system choices.

We believe that the amendments I have described and which we will submit to the Congress will protect the consumers of mandated employer-employee health insurance.

HEALTH PROVIDER REGULATION

In order to help the consumer become a prudent buyer in the medical care market and to protect the consumer against unnecessary increases in health care costs, we shall take the following measures and seek additional authority for them where needed:

1. Providers will be required by the States to inform the public as to charges for standard items and other patient access matters.
2. We will request authority to preclude reimbursement under FHIP/NHISA for interest, depreciation and services with regard to construction of new hospitals and the purchase of special equipment that has not been approved affirmatively by the appropriate State health planning agency. As noted above, H.R. 1 would grant this authority only when State agencies have disapproved such expenditures.
3. We will establish on an experimental basis local quality review organizations composed of outside medical experts, including nonproviders in some instances, as provided for in H.R. 1.
4. We also propose to require NHISA carriers to apply control measures and statistical reporting measures in accordance with Federal guidelines, such as strict review of utilization of health care services. Specific plans for implementation with regard to wages and prices will be developed in conjunction with the Committee on the Health In-

dustry established by the President under Phase II of his New Economic Policy.

5. State planning agencies will be required in cooperation with areawide planning agencies and as a condition of Federal grant support and approval to identify geographic areas of physician and facility oversupply and undersupply. States are to develop and apply detailed criteria based on Federal guidelines, and publish this information.

Let us now look briefly at the impact the administration's proposals would have on the health care problems I discussed earlier.

Impact of the Administration's Proposals on Health Care Problems

SUPPLY AND DISTRIBUTION OF SERVICES

While financing programs cannot alone improve the supply and distribution of health care services, the form which financing takes can have some impact. For example, the National Health Insurance Partnership Act specifically provides that services of pediatric nurse practitioners and nurse midwives working under the supervision of physicians must be covered. This provision complements efforts in our health manpower proposal to increase the supply of paramedical personnel in order to release physicians for more complex tasks.

ORGANIZATION AND DELIVERY OF SERVICES

With regard to the organization and delivery of services, the benefits required by the NHIPA are designed to correct the failures of existing private health insurance, by changing the emphasis from hospital and surgical care to preventive services, health maintenance, and outpatient care. This structure of benefits would begin to move the Nation away from the present overuse of high-cost inpatient services. Furthermore, the HMO option would remove an impediment, which is built into most private health insurance today, to the free choice of care and would provide an incentive for wider development of this organizational form. This provision would complement our HMO assistance proposal. Further, title IV of NHIPA would eliminate existing State barriers to HMO's operating under this bill.

FINANCIAL ACCESS

With respect to the problem of financial access, the National Health Insurance Partnership Act, combined with existing programs would provide financial protection against illness for almost everyone in the Nation. Under the National Health Insurance Standards Act, all private workers including the working poor, will have access to broad coverage with low premium sharing. Other poor families with children would receive basic health insurance protection under the family health insurance plan. All working families would have protection against catastrophic illness under the National Health Insurance Standards.

COST AND QUALITY

We have also sought to cope with the problems of cost and quality in the National Health Insurance Partnership Act and the new regulatory proposals, I have described. We believe that, taken together, these proposals will effectively protect the consumer against unwarranted cost inflation and insure maintenance of quality in both health insurance and health care services.

Having described the administration's proposals, I should now like to turn to several of the other competing proposals also before this committee.

Comparisons With Other Proposals

In developing our positions, we analyzed various other proposals introduced in the 91st and 92d Congresses. Comparisons of these proposals and their costs are set forth in your committee print, "Analysis of Health Insurance Proposals Introduced in the 92d Congress."

Most of the proposals attempt to cope with the same problems. All presume that some people lack the ability to buy adequate health care, and that services are not available and accessible to all. Most of the proposals recognize that resources must be developed to anticipate the demand that is likely to be created by additional financing. There is also little dispute among them that the design of financing programs will affect the organization, delivery, cost and quality of services.

There is much, however, to debate in the alternative proposals. Some deal merely with financing of a specific type of benefits for a specific group; some provide only a financing plan for the whole population; and some propose comprehensive programs that pertain to manpower, planning and the organization of services, as well as to financing of health care. They range from proposals that assume the health industry is virtually beyond repair to proposals that assume there are few, if any, deficiencies in the health care industry.

These proposals fall into three large categories: those which would fully federalize health financing; those which would rely on tax incentive and tax credit provisions; and those which would focus on coverage of catastrophic illness costs.

Fully Federalized Programs

The typical fully federalized program, as represented by H.R. 22, the Health Security Act, introduced by Representatives Griffiths, Corman, and others, proposes to provide all citizens with virtually all personal health care services financed entirely by Federal funds. It proposes to do this by eliminating patient charges by providers for the services covered by health security and at the same time by limiting total Federal health financing expenditures to twice the amount of revenue raised by additional payroll taxes.

In addition to paying for services out of the total revenues, the Health Security Act would set aside an amount—eventually an annual percentage—to develop health resources.

Annual Federal budgets for health care would be determined from statistics on per capita outlays for each type and form of service cov-

ered. Within this budgetary process, decisions on disbursements would flow from the central Federal agency to regional Federal agencies and, in turn, to area Federal agencies. All providers would negotiate for the reimbursement they feel they need, using prescribed cost accounting systems and whatever justifications they are able to marshal. For other providers, such as physicians, the Federal program would also establish fee-for-service budgets and capitation amounts.

MANPOWER AND RESOURCE DISTRIBUTION

Health security would establish a health resources development fund to provide funds for manpower training and comprehensive health service systems. Health security also promises to reallocate our Nation's health resources by intentionally adjusting budget allocation to each region in order to equalize differences in per capita outlays experienced in prior periods. Presumably, "equal" access to care, both quantitatively and qualitatively, would result from budgetary decisions of Federal agencies.

Proponents of a fully federalized program assume that Federal know-how and financial pressure are all that are needed to correct the maldistribution of manpower and other resources throughout the Nation—an assumption which I believe is grossly inaccurate and unrealistic, if not utopian. The proponents of H.R. 22 presume that the Federal Government could by fiat shift hospitals and other medical resources from State to State.

ORGANIZATION AND DELIVERY

The proponents of health security would also attack the problems of organization and delivery through the resource development budget and the budgetary process used to reimburse services. Supporters suggest that HMO's and physicians working on a salary or capitation arrangement would be first in line for payments from the budget while physicians practicing on a fee-for-service basis would be last in line.

We have stated that too often the incentives of our present health complex are misdirected, and that HMO's show promise of redressing these incentive problems. But the health security approach is wholly unrealistic in this respect as well. For example, if virtually all patient payments for health service were eliminated, it is very likely that the existing resources would be inundated. A fixed total budget would undoubtedly leave many patients unserved and providers unpaid.

Dissatisfied consumers would, if able to, undoubtedly purchase services outside the Federal system, raising total health care expenditures, as has occurred in England.

The proponents of such a system seem to assume that radical intervention by the Federal Government in health care, in an inflexible, predetermined, and monolithic manner, is the only way to solve health organization and delivery problems. I suggest that we are more likely to attain our common health objectives by stimulating competition and by promoting consumer education and freedom of individual choice, rather than by resorting to fiscal coercion and unrealistically global schemes.

FINANCIAL ACCESS

With regard to access, Health Security promises every citizen—rich, middle class, or poor—equal access to all covered services. We support this as a goal, but we challenge the wisdom of raising expectations beyond all hope of fulfillment in the near future. The resources are simply not in place to provide instant equal access, and it is likely that the coerciveness of this program would drive an intolerable number of our scarce professionals completely out of the delivery system. Enactment of this scheme would only create a new "credibility gap," of which this Nation has had a surfeit in the past.

COST

Of all the pending proposals, the fully federalized measures are the most costly: They would cost the federal taxpayer nearly $60 billion in new taxes. They would also cause an eight to 10 percent upsurge in health care spending in one year. While these are reason enough for concern, they are not the only costs. Even if our evaluations were incorrect, and somehow the effective, responsible operation of such a scheme could be accomplished, the real cost, or I should say, the most serious cost of all would be in the diversion of funds from other federal goals.

If this much of the federal budget were directed solely to health financing, what progress could be made, what initiatives launched, in welfare, education, ecology, nutrition, safety, civil rights and drug abuse control? What is the true cost of replacing the private health insurance industry, with its hundreds of thousands of employees, its billions in reserves and assets, it years of technical experience and, indeed, building and training a vast new federal bureaucracy?

To sum up our concerns about the full-federalized proposals, one of the most distressing aspects is the failure of the proponents to justify their case. They have not shown that it is necessary to establish a universal federalized program in order to assure that all Americans have adequate health insurance and adequate access to services. Nor have they shown that the means they have selected can effectively translate planning decisions into practice. Were this approach adopted, we would lose significant economic advantages which now exist in the pluralistic, competitive system for managing and financing health care. Over time, under a single federal system the inherent tendency of federal bureaucracies to resist change would adversely affect innovations in medical care. We can only conclude, without reservation, that the full-federalized proposal is simply infeasible.

CREDIT AND OTHER TAX INCENTIVE PROPOSALS

H.R. 4349, the National Health Care Act of 1971, developed by the Health Insurance Association of America and introduced by Congressman Burleson, H.R. 4960, the Health Care Insurance Act of 1971, developed by the American Medical Association and introduced by Congressmen Fulton and Broyhill, and other similar bills, would utilize amendments to the Internal Revenue Code to improve health care financing.

The plan proposed by the Health Insurance Association of America, H.R. 4349, and H.R. 4960, commonly known as Medicredit, would define minimum benefit programs. Employers who provided less than the minimum would be penalized by reduction in their business expense tax deductions for employer contributions to their employee health plans. Additional financing would be subsidized by increasing personal income tax deductions (as in the Burleson bill) or by creating an optional personal income tax credit (as in Medicredit). The latter would also provide those who have no taxable income with a credit voucher with which to purchase a qualified private health insurance policy.

H.R. 4349 would expand the minimum benefits over a six-year period, replace Medicaid, and offer specific proposals to improve health resource planning, manpower, facilities, and cost controls. The Medicredit bill addresses only financing problems, has one set of "approved" benefits for everyone, and would offer income tax credits to eveyone who itemized health care expenditures on his income tax return.

Manpower and Resource Distribution

The HIAA proposal would support manpower increases through student grants and loans. I am now looking at each of these under the same four problem-related headings under which we discussed our own proposals. Also the HIAA proposal would assure that health professionals, if they agreed to serve for 2 years in manpower-short areas, would receive an income equal to the national average for their specialty or a percentage above former earnings, whichever is greater. However, there is little evidence to suggest that sufficient providers will move to these areas on the strength of this assurance alone. Instead, the American Medical Association would rely on other legislative authorities to support manpower development and resource distribution.

Organization and Delivery of Services

While Medicredit proposes no changes in the organization and delivery of health services, the Burleson bill does attempt to do so. It would, for example, provide Federal support for comprehensive ambulatory centers. While this is consistent with one of the goals of the administration's HMO legislation—a shift to ambulatory rather than institutional care, this approach is too narrowly confined to physical structures. Our HMO approach would seek to bring about the shift by reorganizing existing resources, ambulatory as well as institutional, in a new organization form, combined with prepaid financing directed toward health maintenance and illness prevention.

Financial Access

With respect to financial access, the major shortcoming in both the tax credit and penalty approaches is the great unlikelihood of achieving universality in protection. No one, save the cash-assistance population under the insurance industry's plan, is obliged to offer or to take

coverage. Both proposals promote conformity with the recommended benefit structure by penalizing employers who offer something less than their standards would provide. This type of prod is no prod for the thousands of employers who do not now make such contributions. Millions of workers who are now enrolled in group health insurance plans must pay 100 percent of the premium for covering themselves and their dependents, and many others do not insure their dependents because they must assume the full cost of doing so. Under the tax credit or incentive approach, there would be many instances in which employees or their dependents would not accept offered plans because the programs would not require offering such coverage to all employees or require employer participation in the premium costs. It should also be recognized that, in the absence of an employer mandate, some plans which now exist will be dropped to avoid the penalty.

The tax credit approach has other defects beyond its failure to address the supply, organization, and delivery issues in meaningful ways. Credit vouchers may not be adaptable to group insurance operations. This could lead to a proliferation of individual policies, which are the most costly to administer and to sell. The insurance industry's proposal would also stimulate individual policy-holding although, perhaps, not as drastically as would the tax credit approach. The higher costs of health insurance might lead many people to forego the subsidy and health insurance altogether.

COST

These proposals, while more costly to the economy and the Federal taxpayer than the administration's proposals, are less costly than the fully federalized approaches. The tax credit proposals would allow provider charges to become the sole basis for determining the amounts of reimbursements and, therefore, they are not likely to have any cost-control effect.

The insurance industry's proposal would require all States to establish agencies to regulate institutional charges, based upon uniform cost-accounting systems and negotiated budgets. While this approach, which relies on the States, is more realistic administratively than the fully federalized approach, it still suffers from the difficulty of establishing budgets for thousands of individual hospitals, nursing homes, and home health agencies.

We believe that our approach of regulating insurers, which neither of the proposals would do, regulating providers and vigorously using constraint authorities under Medicare and H.R. 1, will produce more tangible and equitable results.

Catastrophic Illness Only

I should like to turn now to those proposals that pertain to catastrophic illness only. These are best exemplified by Senator Long's bill, S. 1376, Representative Hogan's bill, H.R. 817, and Representative Hall's bill, H.R. 177. Senator Long's proposal would be financed by new payroll taxes. The Hogan proposal would establish State-regulated insurance pools for private catastrophic policies and would authorize Federal subsidization of premiums for the poor. The Hall

bill, on the other hand, would replace Medicaid with a basic insurance program for the poor and would also require the States to provide catastrophic health coverage of the poor for all care beyond the limits of the basic insurance program. For the nonpoor the Hall bill would provide catastrophic health insurance financed by Federal payroll taxes. Both Senator Long and Representatives Hall would adopt the standards for providers and the methods of reimbursement used by Medicare.

MANPOWER AND RESOURCE DISTRIBUTION

Turning again to the same three problem areas with respect to manpower and resource distribution, these bills did not address these problems. However, by focusing upon only the most expensive kinds of illnesses and care and ignoring basic services, they are likely to lead to an even greater proliferation of costly facilities and specialties at the expense of more basic needs. We should not permit even further distortion in this direction to occur.

ORGANIZATION AND DELIVERY

Although these proposals do not purport to address the organization and delivery of health services, they would in fact have a serious impact upon them. Senator Long's proposal would provide some relief to insurance organizations, including HMO's by providing a Federal umbrella against very expensive illnesses, but this would provide only token stimulus to the development of HMO's. The Hall and Hogan approaches are entirely silent on this range of problems.

FINANCIAL ACCESS

With respect to financial access, Senator Long's plan would be extremely inequitable to those who have little or no basic health insurance, primarily the poor. The imposition of a 60-day deductible on institutional costs and a $2,000-per-family deductible on physicians' expenses is of little use to the uninsured, especially when such deductibles have to be met each year.

COSTS

The catastrophic proposals would result in extra costs to the Federal taxpayer, ranging from $3.1 to $3.3 billion. At the same time, the catastrophic plans would benefit very few people. They would do far less than what this Nation must do if it is to act with a full sense of its responsibility.

In summary, Mr. Chairman and members of the committee, I am convinced that the administration's proposals offer the best means of reaching the goals of universal financial access to quality health care—

By increasing and improving the supply and distribution of resources to meet the demand for care;

By improving the organization and delivery of services;

By insuring that no one is denied care for lack of financial ability, and by removing the fear of catastrophic costs; and, finally,

By constraining the rise in costs by sound methods of reimbursing and regulating insurers and providers.

The administration's proposals avoid the dangers of two extremes: one which would displace a flexible, pluralistic, and competitive system; the other which would do little or nothing to reform that system. We have preserved a share of responsibility for both the private and public sectors in achieving these goals. We would strengthen both sectors rather than strengthening one at the expense of the other. Our proposals on health care have been made within the context of many important and pervasive social needs, not health alone. We have taken into account the crucial questions of how to begin and with what timing, in order to avoid promising more than can be delivered.

The National Health Insurance Partnership Act will match increases in demand for health care with the development and improved distribution of health resources.

And last, we have retained freedom of choice, while advocating reforms which will make that freedom meaningful.

We look forward to working with your committee, Mr. Chairman, in providing any additional information the committee may need in its important consideration of health needs of the 1970's and beyond.

This concludes my prepared statement, Mr. Chairman. I would be glad to respond to the committee's questions.

The CHAIRMAN. Mr. Secretary, I think it would be helpful if the record contains the so-called White Paper: "Toward a Comprehensive Health Policy for the 1970's," dated May 1971. If you agree with me and there is no objection, the committee will include it at this point in the record.

Secretary RICHARDSON. We would be very glad to have it included, Mr. Chairman. We appreciate the suggestion.

(The information referred to follows:)

TOWARDS A COMPREHENSIVE HEALTH POLICY FOR THE 1970's

A WHITE PAPER

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

May 1971

FOREWORD

This White Paper lays before the American public the thoughts and processes that eventuated in the Administration's comprehensive health strategy. The White Paper is "political" in only one respect: given the choice between extending the activities of the Federal Government, and using the forces of the private sector to achieve an objective, the latter was preferred. Although "political," the choice can hardly be viewed as "partisan." Preference for action in the private sector is based on the fundamentals of our political economy—capitalistic, pluralistic, and competitive—as well as upon the desire to strengthen the capability of our private institutions in their efforts to provide health services, to finance such services, and to produce the resources that will be needed in the years ahead.

For the better part of a year, the Administration sought ideas and advice from every conceivable source—from within the Government as well as from individuals and organizations outside of the Government. No constraints were imposed upon these sources; the Administration sought the broadest range of alternatives for every identifiable problem, no matter how small or large. As a result, the Administration believes that no reasonable idea was denied a hearing.

In the winnowing process through which some options were discarded and others were retained, it became necessary to impose constraints. The President does not enjoy the luxury of considering any subject, no matter how important, in isolation. The problems of health care have to be dealt with, but so do the problems of welfare, public safety, environmental protection, national defense, and a host of others. There are no easy choices among these competing claims, no choices between "good" and "bad," but only between one good and another. Quite often, advocates of any particular public good tend to ignore the others, and thereby ignore the discipline of choosing. Yet choosing is the essence of governing.

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At some point in this process, therefore, choice was inescapable—not only among the competing claims but within a context that took into account other factors as well. These other factors included projections of the Gross National Product and Federal revenues; plans to combat a sluggish economy, unemployment, and inflation; and proposals that would bring the concepts of New Federalism to life—revenue sharing, welfare reform, manpower training reform, and reorganization of the Federal Government and its intergovernmental relations.

The comprehensive health strategy, accordingly, fits within a broader strategy. The books are not irrevocably closed on alternatives: If other reasonable choices present themselves—to obtain a better distribution of health manpower, for example—they will be welcomed.

One further note. Those who have grown used to viewing health care needs within the narrow focus of specific categorical problems—problems caused by a certain disease or problems afflicting certain population groups—are likely to be disappointed by the Administration's health strategy. For, with few exceptions, the strategy seeks to modify the entire system of health care. It became abundantly clear, in the process of defining precisely the nature of the "health care crisis," that the most basic and widespread problems were in fact systemic, and that further categorical and piecemeal efforts would very likely exacerbate rather than ameliorate the problems.

In publishing this White Paper, the Administration has two main objectives in mind. The first is to contribute to the public's understanding of the issues and of the reasons that led to the Administration's choices. The second is to help to elevate the debate on a matter of crucial importance to the Nation from the domain of rhetoric and opinion to the level of thoughtful consideration and demonstrable reasoning.

Elliot L. Richardson, Secretary

I

DEFINING THE PROBLEMS

Before the Administration would consider any specific solution to the "health care crisis," it required first a clear and precise statement of the problems—what was and what was not contributing to the crisis. The task at the outset, then, was to examine the health status of the Nation, the trends in the development of health care resources, the financing of care, and the Federal actions in each of these areas.

1. Health Status

The indices with which we measure health, it was quickly found, leave much to be desired, especially in terms of the definition of "health" the World Health Organization uses: a positive sense of physical and mental well-being. Our indices are of illness rather than of health, and statistics of death are statistics on existence, not only of health. Moreover, we lack indices of consumer satisfaction with health services received, and our measures of quality are also essentially negative and anecdotal—such as excessive surgery or over-reliance upon drugs.

With all of their inadequacies, the gross measures of health status indicate a long-term trend of improvement. A child born today, for example, can expect to live 30 percent longer on the average than a child born in 1920. Nonwhite children, while lagging behind white children in total life expectancy, have made the greatest gains—a third more life for non-white men, and more than a 50 percent increase in life span for non-white women. Although, for inexplicable reasons, the life expectancy of non-white males declined between 1967 and 1968, non-white women now have a longer life expectancy than white men.

Infant and neonatal deaths have been on the decline for sometime, and maternal death rates dropped by 66 percent between 1950 and 1967.

Days of disability have also declined in the past decade. Days lost from school or from work, as well as days of restricted activity in general, per person per year have shown a favorable trend. Bed-disability days, which had declined between 1960 and 1967, took a slight upturn in 1968.

There appear to be a number of factors contributing to these trends. Rising levels of income, which have brought with them better nutrition, housing, and clothing, higher levels of educational attainment, and general improvements in sanitation have all played a significant role. So too has

medical science in bringing a number of infectious diseases under control, in making successful inroads on some chronic illnesses, and in bringing about widespread improvements in diagnosis, treatment, and rehabilitation. There is no smallpox in the United States today, and cases of diphtheira, typhoid fever, and whooping cough are rare. The incidence of poliomyelitis, which killed or paralyzed thousands as recently as the 1950's, has been drastically reduced, and measles and rubella are being brought under control with newly developed vaccines. Among the chronic diseases, the discovery and use of drugs have dramatically changed the treatment of the mentally ill; and new methods of diagnosis and treatment have been highly successful against certain forms of cancer, rheumatic heart disease, and hypertensive heart disease.

In sum, the gross measures of health status indicated that health has been improving, not worsening, and the cause of the crisis in health care is not to be found in the general status of health.

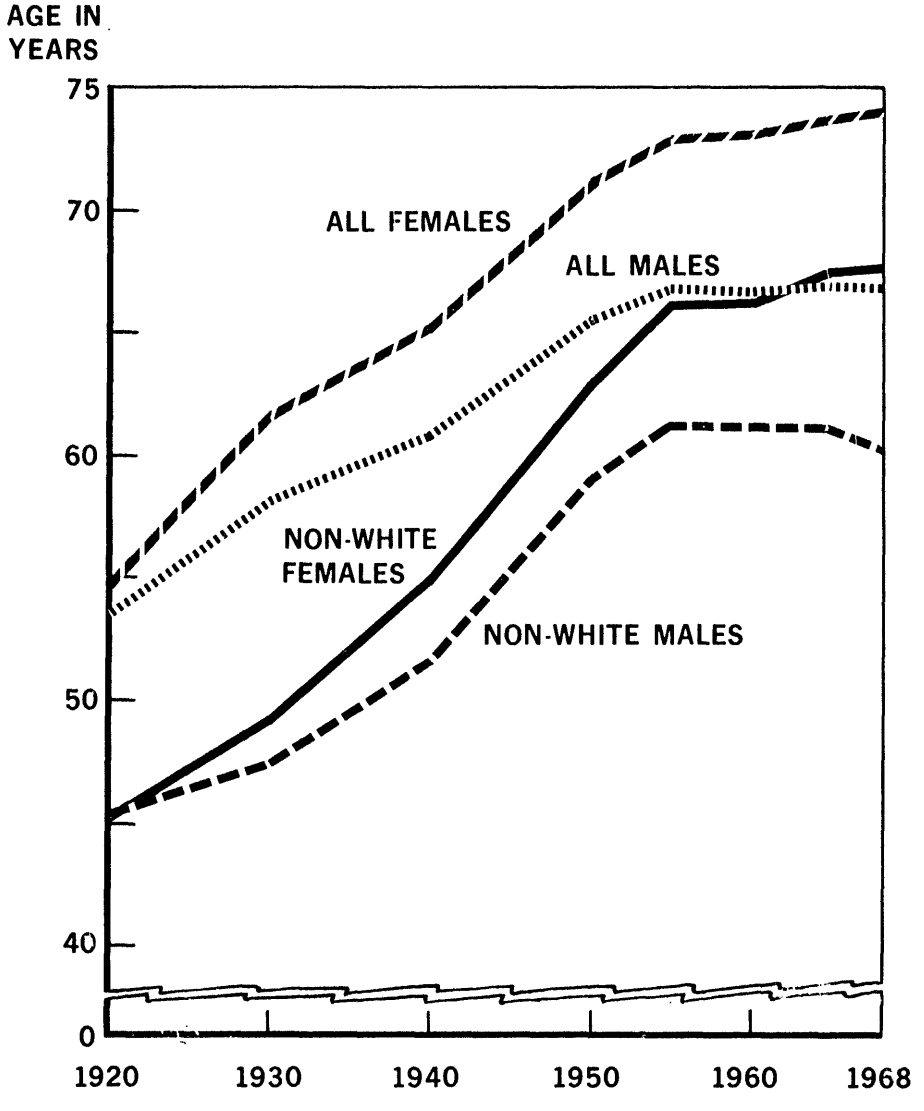
These gross measures, however, mask very large disparities in health status among sub-populations in the Nation. On nearly every index that we have, the poor and the racial minorities fare worse than their opposites. Their lives are shorter; they have more chronic and debilitating illnesses; their infant and maternal death rates are higher; their protection, through immunization, against infectious diseases, is far lower. They also have far less access to health services—and this is particularly true of poor and non-white children, millions of whom receive little or no dental or pediatric care.

Part of the health care crisis, then, is our awareness of these differences among our people—the denial to some of a life span as long and as relatively free of disabilities and illnesses as that which others enjoy—accompanied by a sense of injustice that denial entails, and by expectations that denial and its effects can and should be obviated.

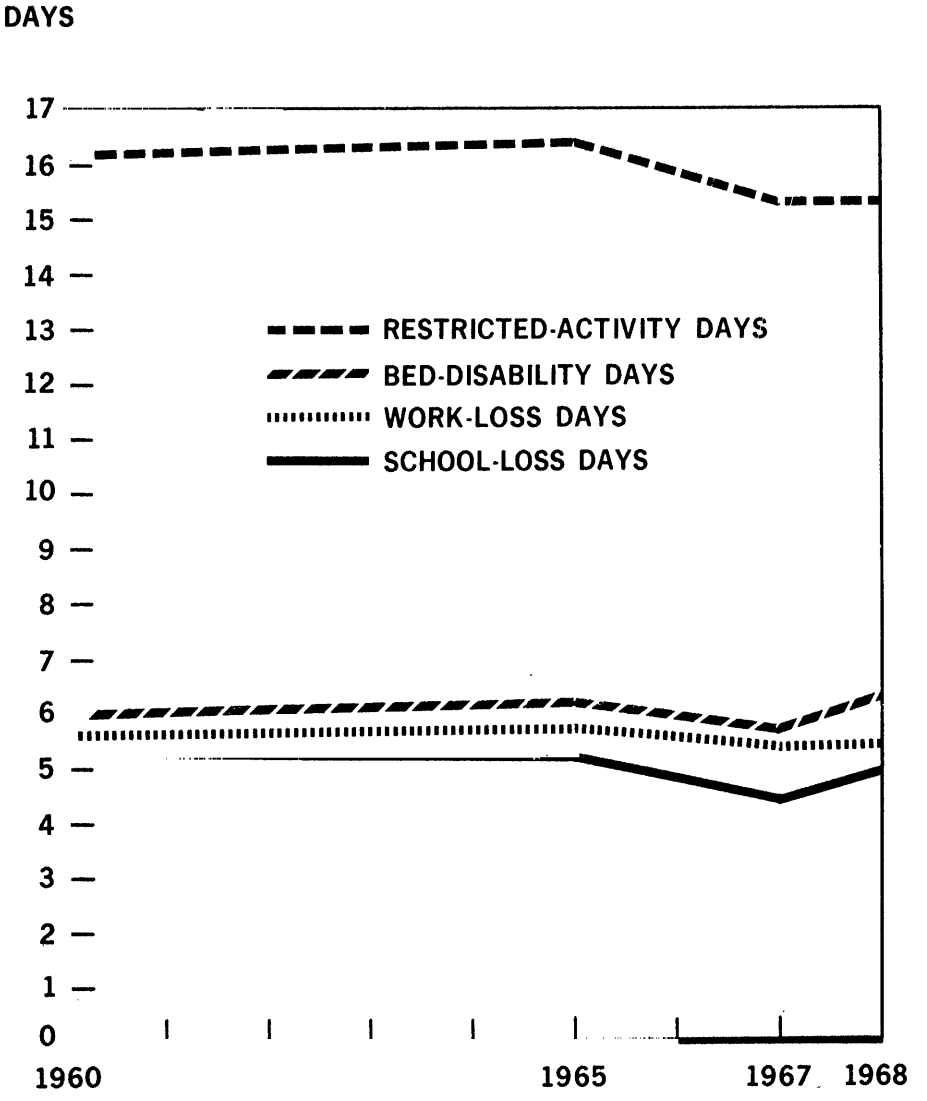
If this is an adequate description of part of the health care problem, in which race and income and related socio-economic variables are playing dominant roles, then we must begin to consider several alternatives to *medical* care to close the gap in *health* status. For at least some components of this problem, reforms in welfare, in education, and in civil liberties should pay dividends in health status.

Another type of disparity which contributes to the concern over health is the difference between the United States and other nations on several of the indices by which the national health status is measured. Once again, the comparisons are not statistically neat (definitions of "live births," for example, have varied among nations), but as gross measures they indicate that the United States is not performing as well as other advanced nations.

Expectation of life at birth, 1920 – 1968



Annual days of disability per person, 1960 – 1968



Our ranking as 13th in infant mortality rates is the key indicator of relatively poor performance. Even if all the statistical variations were straightened out, so that the rank of the United States rose to 11th or 10th, there would be little rejoicing. For the belief is that the United States, with its great abundance, should have the lowest infant death rate, and the expectations are that it can achieve that rank.

2. Health Care Resources

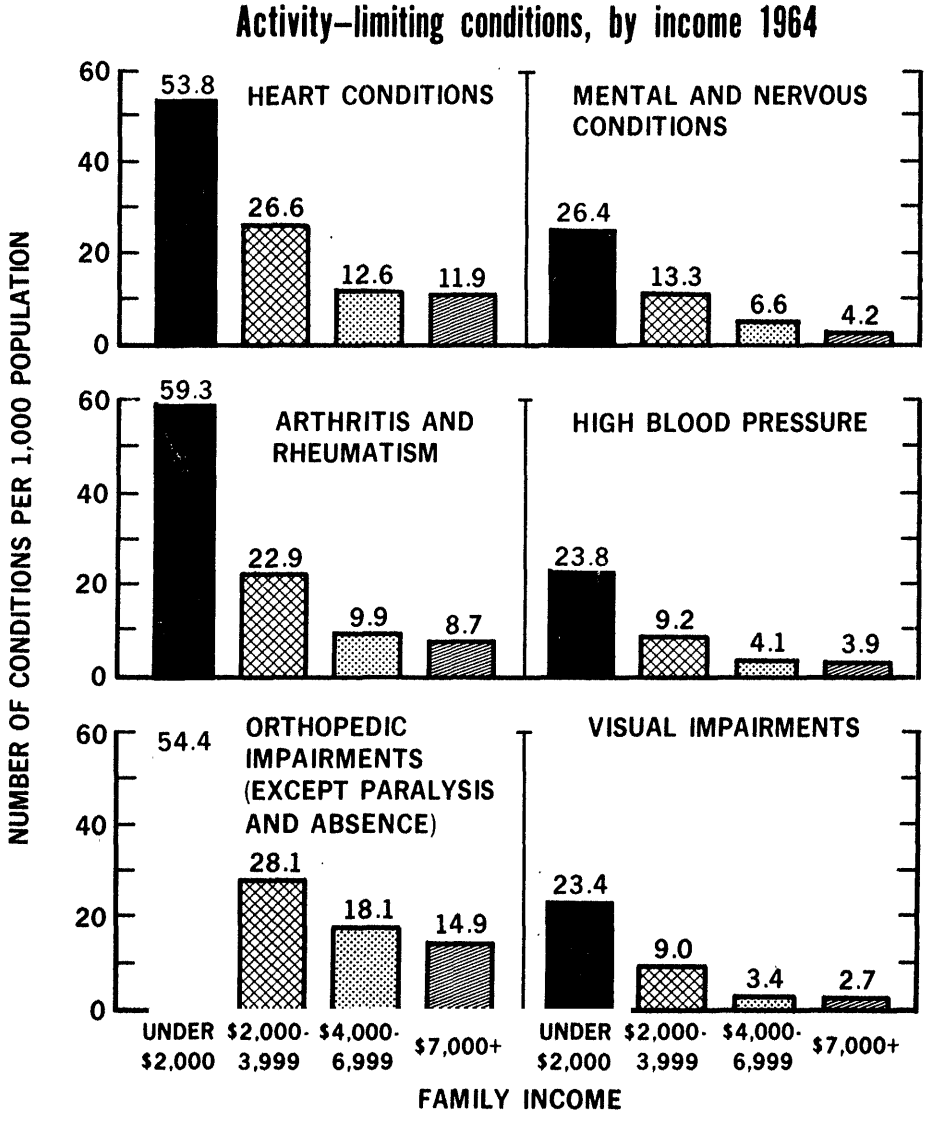
Health manpower and hospital facilities—the major health care resources—have been growing faster than population, especially in recent years. Excluding the military, the number of hospital beds per 1,000 people increased from 12.4 in 1963 to 13.5 in 1968. Between 1950 and 1966, while the population of the United States increased by 29 percent, the number of people in health occupations increased by more than 90 percent. In 1960, 2.9 percent of the civilian work force were in health occupations; by 1966, there were 3.7 percent.

The supply of physicians has also been increasing faster than the growth in population. Between 1950 and 1966, the supply of physicians increased by 34 percent (against 29 percent growth in population), and, between 1966 and 1970, the supply of active physicians grew at twice the population rate, yielding a change in ratios of physicians to population from 141 per 100,000 in 1967 to 155 per 100,000 last year.

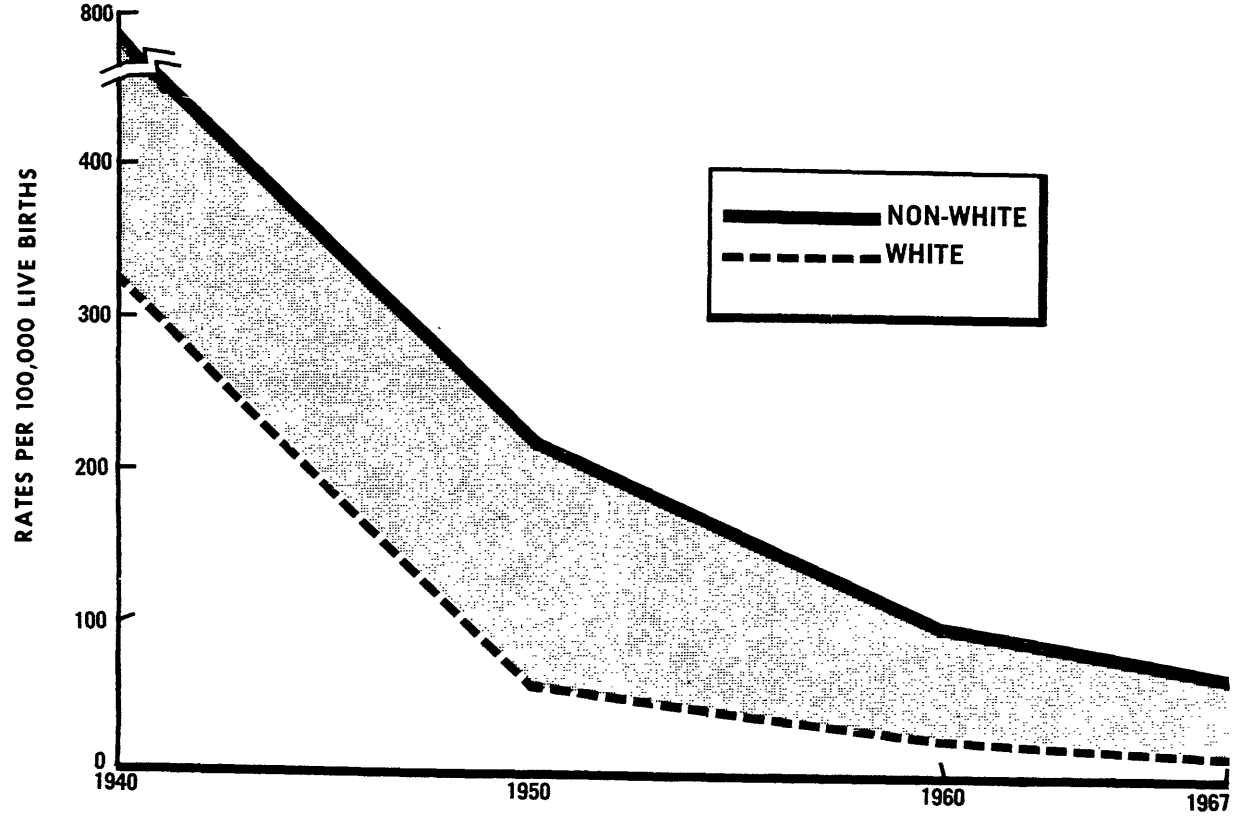
Both the growth in supply relative to population, and the fact that nearly every country outranking the United States on infant mortality rates has a smaller ratio of physicians and hospital beds to population, indicate that inadequate quantities of health care resources *in general* are not contributing to the health care crisis.

As in the measures of health status, the aggregate measures of health care resources hide more than they reveal.

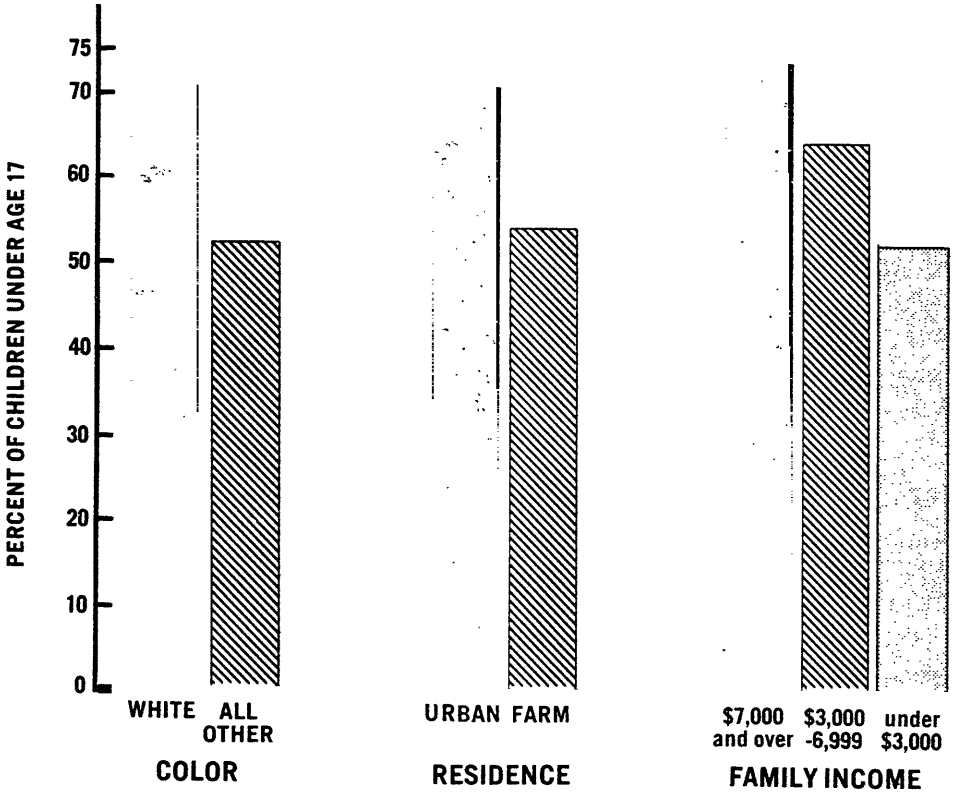
There are, for example, large geographic variations in the ratio of physicians to population. There are 82 active physicians per 100,000 people in Mississippi, but 228 in New York. A study of 1,500 cities and towns in the upper midwest in 1965 found 1,000 without any physician, and 200 others had only one. Large metropolitan areas average 185 physicians per 100,000 people, while the average is only 76 in non-metropolitan areas. Cities, particularly the ghettos, fare far worse than the suburbs in the ratio of physicians to population. In nine out of ten Appalachian States, there are substantially fewer physicians in relation to population in the less wealthy (and generally rural) counties than there are in the wealthier counties. And


Activity–limiting conditions, by income 1964
NUMBER OF CONDITIONS PER 1,000 POPULATION
60
40
20
0
53.8
HEART CONDITIONS
26.6
12.6
11.9
MENTAL AND NERVOUS CONDITIONS
26.4
13.3
6.6
4.2
59.3
ARTHRITIS AND RHEUMATISM
22.9
9.9
8.7
HIGH BLOOD PRESSURE
23.8
9.2
4.1
3.9
54.4
ORTHOPEDIC IMPAIRMENTS (EXCEPT PARALYSIS AND ABSENCE)
28.1
18.1
14.9
VISUAL IMPAIRMENTS
23.4
9.0
3.4
2.7
UNDER $2,000
$2,000-3,999
$4,000-6,999
$7,000+
FAMILY INCOME

Comparison of white and non–white maternal death rates



Percentage of children seeing physicians by race, location, and income



the same disparity between wealthy and poor counties, urban and rural, occurs elsewhere in the Nation.

Another part of the health care crisis, then, results from the large disparities in the geographic location of resources. Too many people simply lack convenient access to the services of physicians; too many communities are unable to attract physicians to practice there. Without physicians, or with relatively few physicians, hospital facitlities are unused or are under-used.

But geographic location is not the only factor that needs to be understood in examining our health care resources.

Primary care physicians—general practitioners, pediatricians, and internists—can handle most of the illnesses and other health care problems with which the population is afflicted. Their average fees are lower than specialists. They are generally more concerned about their patients as a whole and as members of a family than are specialists, and there is some evidence that patients who are cared for by primary care physicians tend to require less hospitalization than those who are treated by specialists. Moreover, judging from the experience of the American Medical Association's placement service in 1969, the demand is for primary care physicians. There were 2001 opportunities offered for primary care physicians, but only 864 seeking opportunities, leaving a deficit of 1,137. On the other hand, 170 opportunities were offered in surgery, but 448 seeking opportunities, leaving a surplus of 278. Pathology, obstetrics—gynecology, urology, radiology, and ophthalmology were also surplus categories.

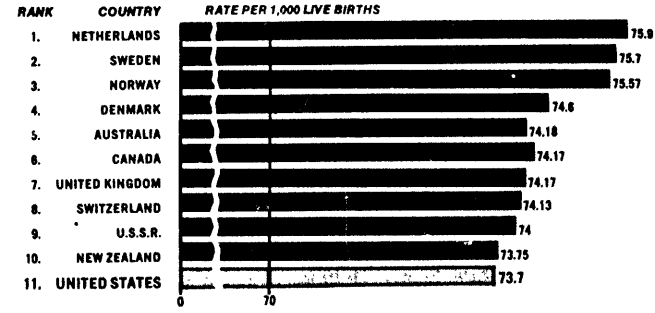
Yet the relative ratio of primary care physicians to population has been declining. In 1931, roughly 117,000 physicians out of 156,000 were primary care physicians, or 75 percent of the total. In 1967, there were roughly 115,000 primary care physicians out of 303,000 physicians, or 39 percent. From 94 primary care physicians per 100,000 people in 1931, the ratio had dropped to 73.

Two types of distributional problems, therefore, contribute to our health care problems. One is geographic, the other is type of medical practice.

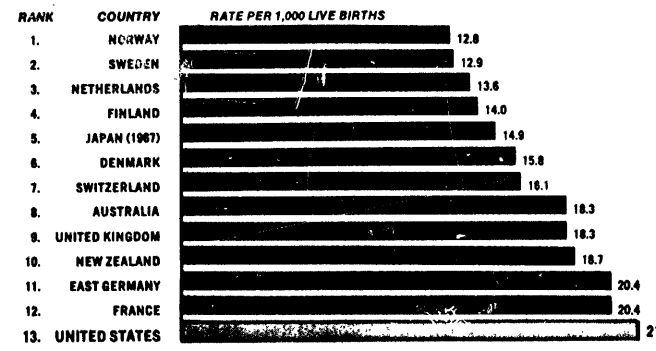
Improper management of our health care resources is another important contributor to the crisis in health care. Poor utilization of these resources restricts the quantity of services available, the geographic extent to which services might reach, and the ability to control costs.

The United States ranks...18th in the world in male life expectancy at birth

The United States ranks...11th in female life expectancy at birth



The United States ranks...13th in infant mortality



The evidence that we are making poor use of our health care resources has been accumulating for some time. The Joint Council of National Pediatric Societies, for example, has stated that 75 percent of the pediatric tasks performed by a physician could be done by a properly trained child health assistant. A significant proportion of the tasks performed by obstetricians, similarly, can be performed by nurse-midwives without any loss in the quality of care. And experience with several physicians assistants programs has demonstrated that ex-medical corpsmen, or comparably trained individuals, with some additional training can assume a large number of tasks performed now by general practitioners.

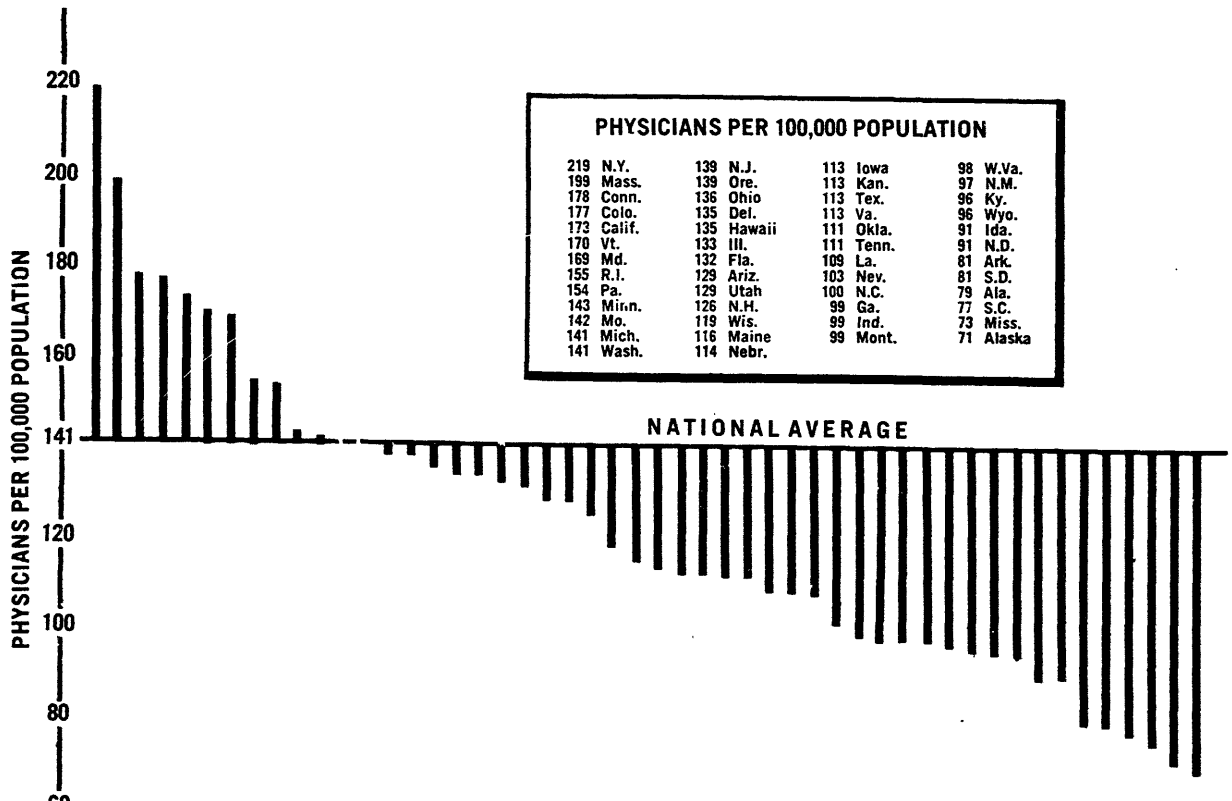
With regard to dental services, it has been amply demonstrated that one chairside assistant, efficiently used, increases a dentist's productivity by 50 percent; a second assistant adds another 25 percent; and by properly utilizing all the skills of the dental team, a dentist can more than double his productivity.

In a study of nurse manpower in 1963, it was found that the satisfaction of patients was highest when nurses devoted at least 50 percent of their time to patient care, but only 35 percent of their time, on the average, was so spent. Nurses in hospitals are still spending only 35 percent of their time in caring for patients; the remainder being utilized for administrative tasks. Nurses in physicians' offices spend even less time on the care of patients.

In every study of facilities, one finds varying percentages of patients who should be using more appropriate facilities. Patients who could be treated in the offices of physicians or could receive x-rays and other laboratory services from ambulatory care facilities are found, instead, occupying hospital beds. Other patients in hospital beds could be equally well cared for in extended care facilities or nursing homes. And there are patients in nursing homes who should be in residential facilities or boarding homes, or who would benefit from services delivered to them in their homes. Moreover, there are patients in hospitals and other facilities who stay longer than they need to for proper care. Finally, too many hospitals maintain expensive facilities that are rarely used. In 1967, 31 percent of the hospitals that had open-heart surgery facilities had not used them for a year. In addition to the cost of maintaining such facilities, they also pose a risk to the patient—the capability, when used, is likely to have deteriorated in quality.

The extent to which health care resources are poorly utilized throughout the Nation has not been measured, nor have the costs of mismanagement been calculated. Just a 10 percent improvement in efficiency would yield a saving of more than $5 billion.

Ratio of physicians to population, interstate comparisons



PHYSICIANS PER 100,000 POPULATION

219	N.Y.	139	N.J.	113	Iowa	98	W.Va.
199	Mass.	139	Ore.	113	Kan.	97	N.M.
178	Conn.	136	Ohio	113	Tex.	96	Ky.
177	Colo.	135	Del.	113	Va.	96	Wyo.
173	Calif.	135	Hawaii	111	Okla.	91	Ida.
170	Vt.	133	Ill.	111	Tenn.	91	N.D.
169	Md.	132	Fla.	109	La.	81	Ark.
155	R.I.	129	Ariz.	103	Nev.	81	S.D.
154	Pa.	129	Utah	100	N.C.	79	Ala.
143	Minn.	126	N.H.	99	Ga.	77	S.C.
142	Mo.	119	Wis.	99	Ind.	73	Miss.
141	Mich.	116	Maine	99	Mont.	71	Alaska
141	Wash.	114	Nebr.				

3. Organization of Services

In part, the mismanagement of resources is a function of the manner in which the resources are organized for the delivery of services, and therefore, the organization of services can be pinpointed as a causal factor in the health care crisis.

The system by which services are provided in this country has been described pejoratively as a "non-system" as a "cottage industry of small entrepreneurs (physicians)," and as "push-cart vending in the age of supermarkets." While increasing the size of units in the industry is not the solution to all of its problems, we must look at the scale and interrelationships among the components. Until a certain scale is reached, it is difficult if not impossible to use scarce skills on tasks for which they are best suited, or to make trade-offs between, say, hospital and home health services.

Organization of services is so intimately tied to the financing of services that further discussion of this point will be interwoven with the discussion of financing below.

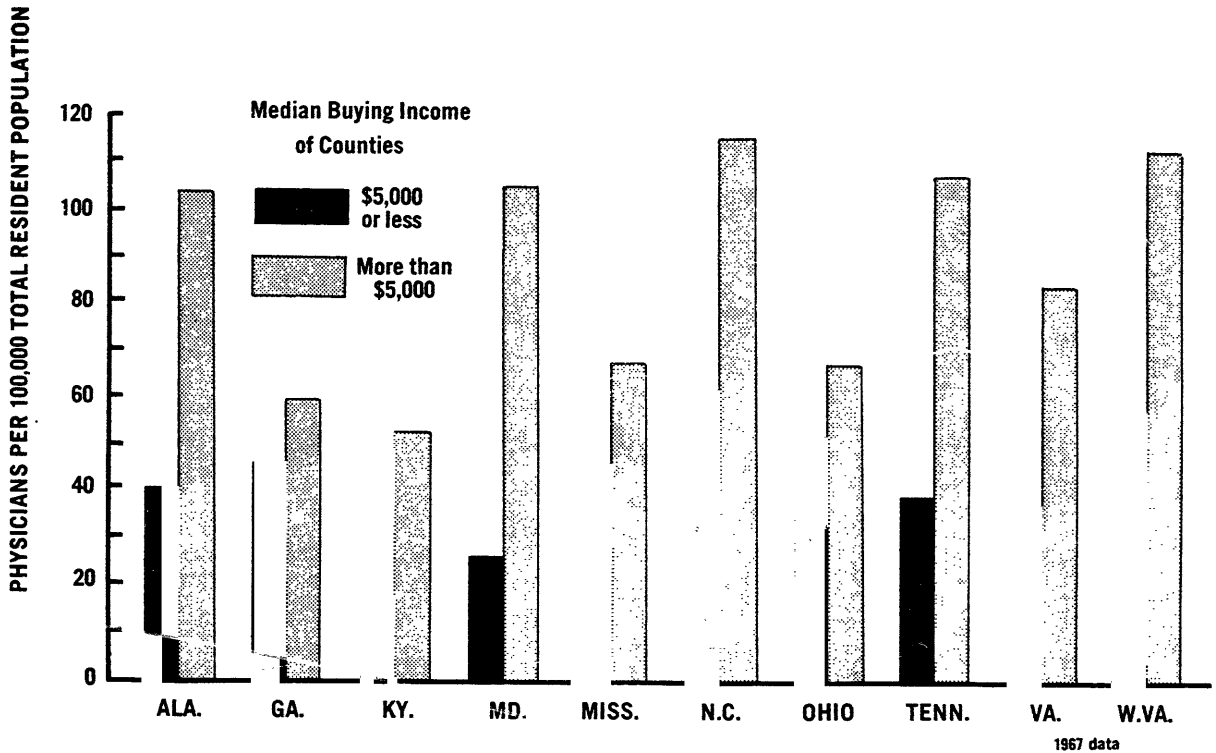
4. Financing Health Services

Expenditures on personal health care amounted to $58 billion in fiscal year 1969. The largest part—almost 63 percent—came from private sources, the remainder from public sources. About 80 percent of the population under 65 has some private health insurance, mainly for hospital and surgical coverage. About 75 percent of the working population is protected through employer-employee plans developed largely since World War II, through collective bargaining agreements. Although the workers' protection was initiated primarily to provide them with hospital and surgical coverage, protection for other types of care has been growing rapidly. Seventy percent of the population under 65 years of age is covered now for in-hospital medical visits, 65 percent for laboratory and x-ray studies, and 43 percent for visits of physicians in the patients' home or at the physicians' office.

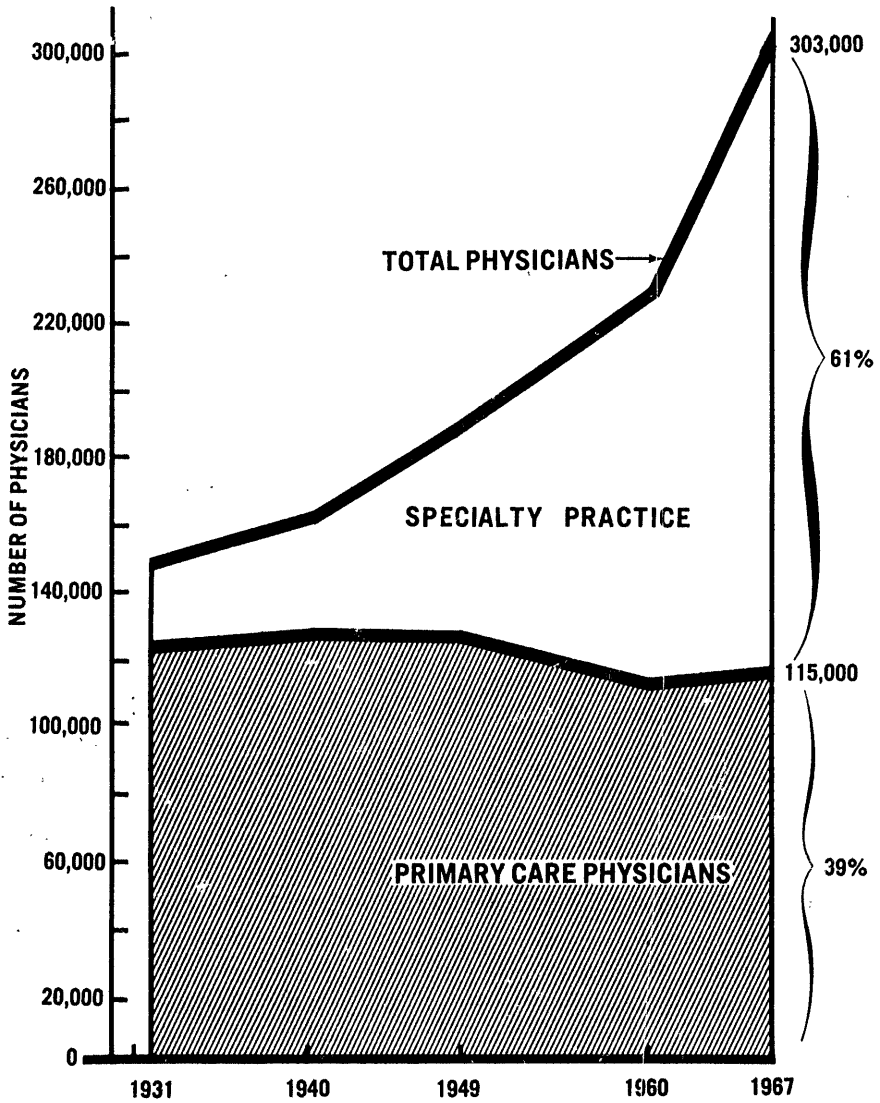
For those not covered by private insurance, Medicare and Medicaid were introduced to meet some of the needs. Medicare provides protection for more than 95 percent of the elderly, and Medicaid provides some protection for 15 million of the aged poor, the blind, the disabled, and families with children.

Over time, then, both the private and public sectors have responded to the need for protection against unplanned hospital and surgical expenses, and for other forms of care. But the growing amount and diversification of insurance coverage does not define a problem.

Ratio of physicians to population in Appalachian States, by wealth of county



Physicians in primary care and specialty practices, 1931 – 1967



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There appear to be two key problems, one relating to financial barriers to the access of care by specific population groups, and the other to inadequate protection.

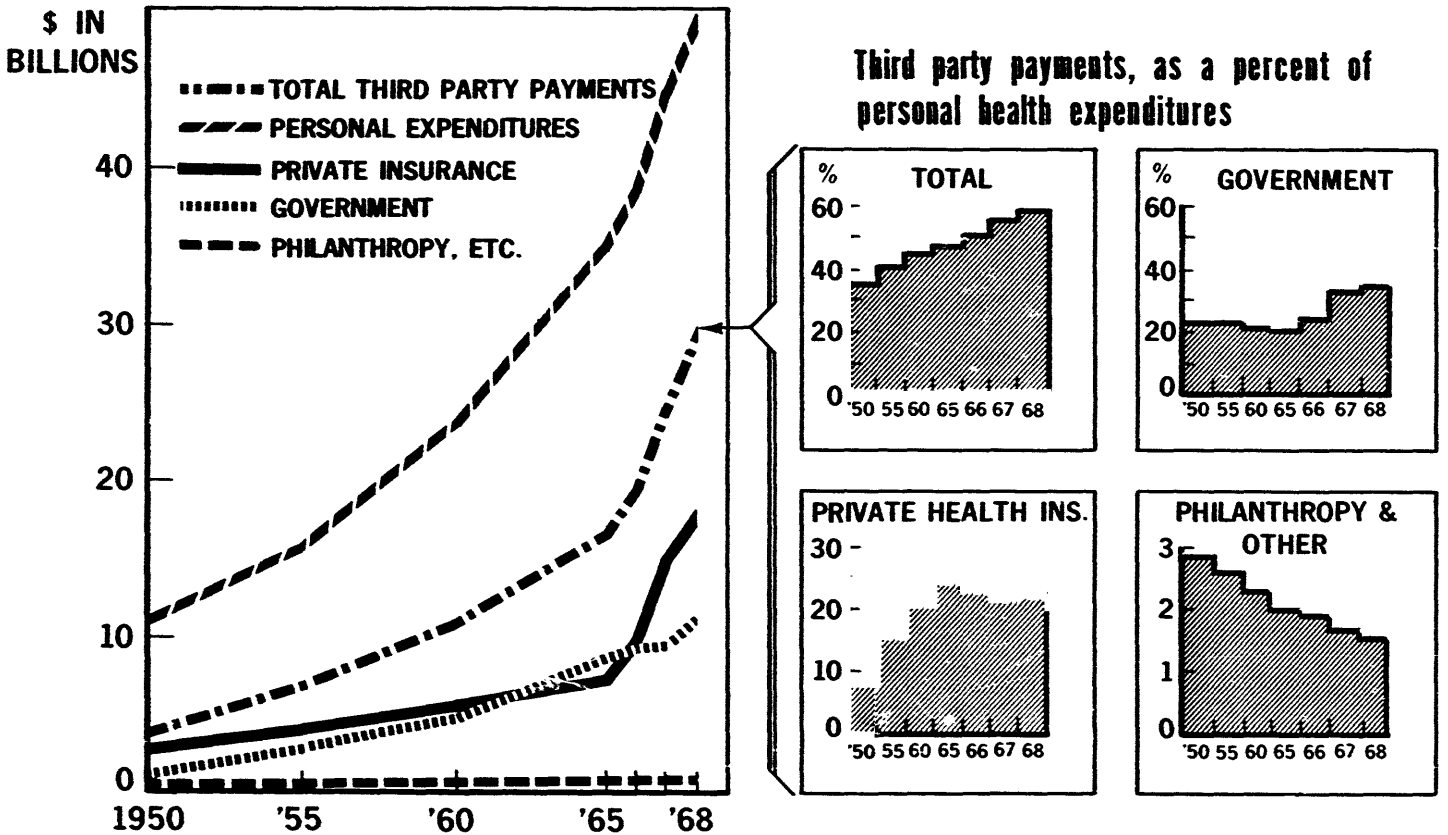
For example, while employer plans cover a majority of the population, they do not protect all of the working population, particularly the working poor. In addition, some of the plans cover the workers but not their dependents. Eligibility for Medicaid also poses financial barriers. Eligibility varies widely among the States, many of which exclude the working poor and adults in families headed by a male. Under these circumstances, half the families with incomes under $5,000 a year and two-thirds of the families with incomes under $3,000 have no insurance. Others excluded from protection are: children and mothers in low-and middle-income families; the unemployed and their dependents; lower income self-employed people; employed people (mainly the working poor) whose employers offer no health plans; and migrant and seasonal workers.

The inadequacy of benefits is the second key problem. While more private health insurance provides good protection against the costs of inpatient hospital care and surgery, outpatient care and preventive services are often excluded. It also excludes or limits preventive services and maternity care, and most families are inadequately protected against catastrophic incidents.

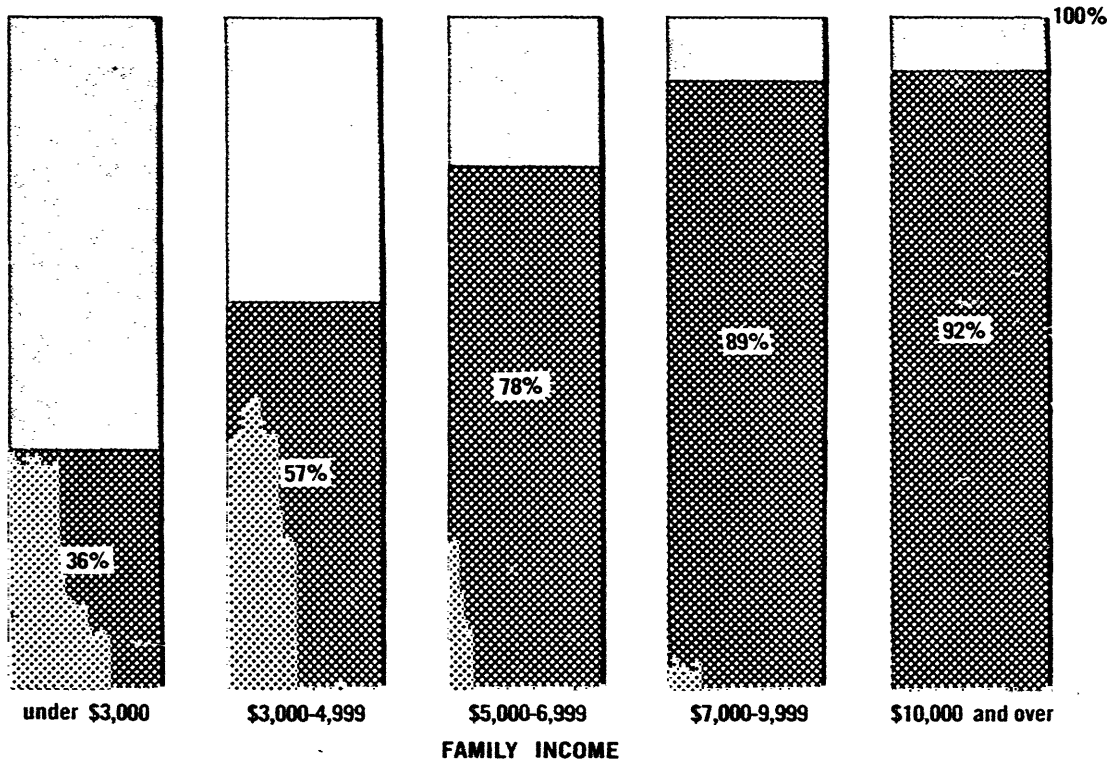
For the most part, private and public financing of health care has reinforced the existing system of delivering care, including the defects in the system. For Medicare and Medicaid to be passed by the Congress, for example, it had to fit into the existing means of delivering care. Apart from the organizations that have provided care on a prepaid basis (which will be discussed under "health maintenance organizations"), the usual mode of delivery has helped produce a financing response that has lacked cost control measures or restrained the use of high cost facilities and procedures. Indeed, it has encouraged the inappropriate use of high cost facilities and services when other less expensive alternatives were available. And finally, both the manner of organizing services and their financing have favored care and rehabilitation over prevention.

Another part of the health care crisis, in sum, stems from intolerable exclusions of large numbers in the population from financial access to care, inadequate benefits, and unnecessarily high costs resulting from a mutually reinforcing financing and delivery system.

Health care expenditures: Third party payments, 1950 – 1968



Proportion of persons under age 65 with hospital insurance in relation to family income



5. Medical Costs

Medical costs have been alluded to in several of the preceding sections, but since the inflation in medical costs is undeniably one of the aspects of the medical care crisis, the subject deserves special attention.

In fiscal year 1970, the Nation spent $67 billion on health, nearly three-fifths again as much as had been spent only four years earlier. While undoubtedly there were improvements in the quality of care for at least some of the population, more than 75 percent of the increase in expenditures for hospital care and nearly 70 percent of the increase for physician services, were the consequences of inflation.

In the decade of the 1960's, medical care prices rose far more rapidly than prices in general. Hospital charges rose four times as fast as other items in the Consumer Price Index, and physicians' fees at twice the rate. These two items—hospital care and physicians' services—are the major contributors to the inflation of medical costs.

Some of the causes for inflation in medical costs have already been mentioned: poor utilization of scarce resources, incentives for the use of the highest cost facilities, and lack of cost control measures. But there are other causes, some of which are exceedingly complex and are not fully understood. There are, for example, legal barriers in some States to the formation of group practices, and other legal barriers prohibiting physicians and dentists from delegating responsibilities of certain kinds or to certain numbers of assistants. The "market" for care is one in which a great deal of information is veiled from the consumer—i.e., the consumer is unable to pass judgment on the quality of services received, and he is frequently in circumstances (acutely ill) where he cannot bargain over the services. It is a "market" furthermore, where increasingly one party sets prices for services, a second receives them, and a third pays for them, so that no one is concerned about rising costs. The health industry has consistently underpaid its employees (excepting physicians) who, in effect, subsidized a portion of the patients' care. And, finally, productivity in this industry lags behind the productivity of the goods-producing sector, thereby creating an inflationary gap. Insofar as physicians' fees alone are considered, the physicians' demand for income has probably risen faster than any other occupation's demand. A recent study found that, on the average, a physician's rate of return on his educational investment (which includes both his outlays on education and the income he has foregone as a student) is currently about 24 percent. In other words, in four years, his income will match all of his educational costs.

6. Medical and Dental Education

Still another aspect of the health care crisis has been the financial crisis of a large number of the Nation's medical and dental schools. Many schools have been dipping into their endowment funds; others have been limping along, on the verge of bankruptcy year after year. At the same time, they have been urged to expand their enrollments and to take on new roles in the training of manpower and in providing community services.

The components of medical education—research, services, and teaching—are so interwoven that it has been virtually impossible to determine the causes of the financial difficulties. Several studies are currently in progress to sort out this problem. It appears that at least part of the explanation will be found among the following reasons.

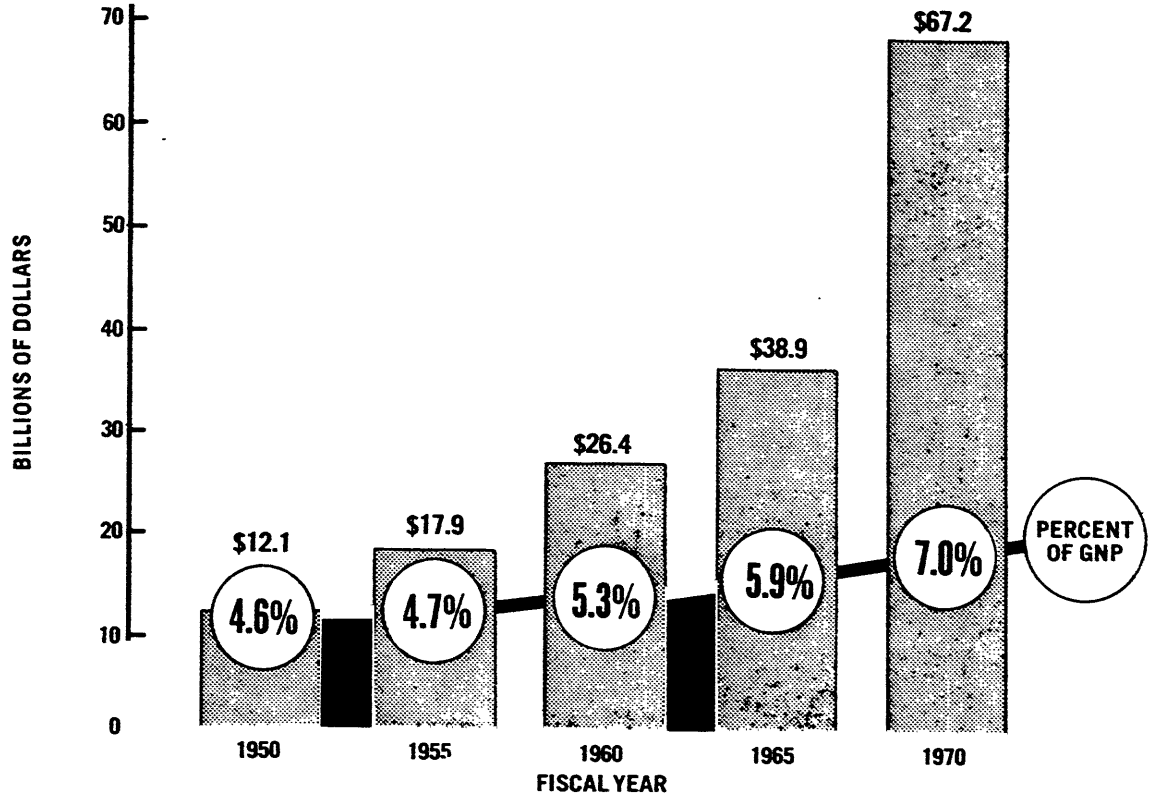
Services offered in teaching hospitals differ markedly from those in community hospitals. They are more "labor-intensive;" they have more and better laboratory backup capabilities; and they provide care for the most difficult medical cases. Accordingly, costs are higher than in community hospitals, and reimbursements do not compensate fully for the additional costs.

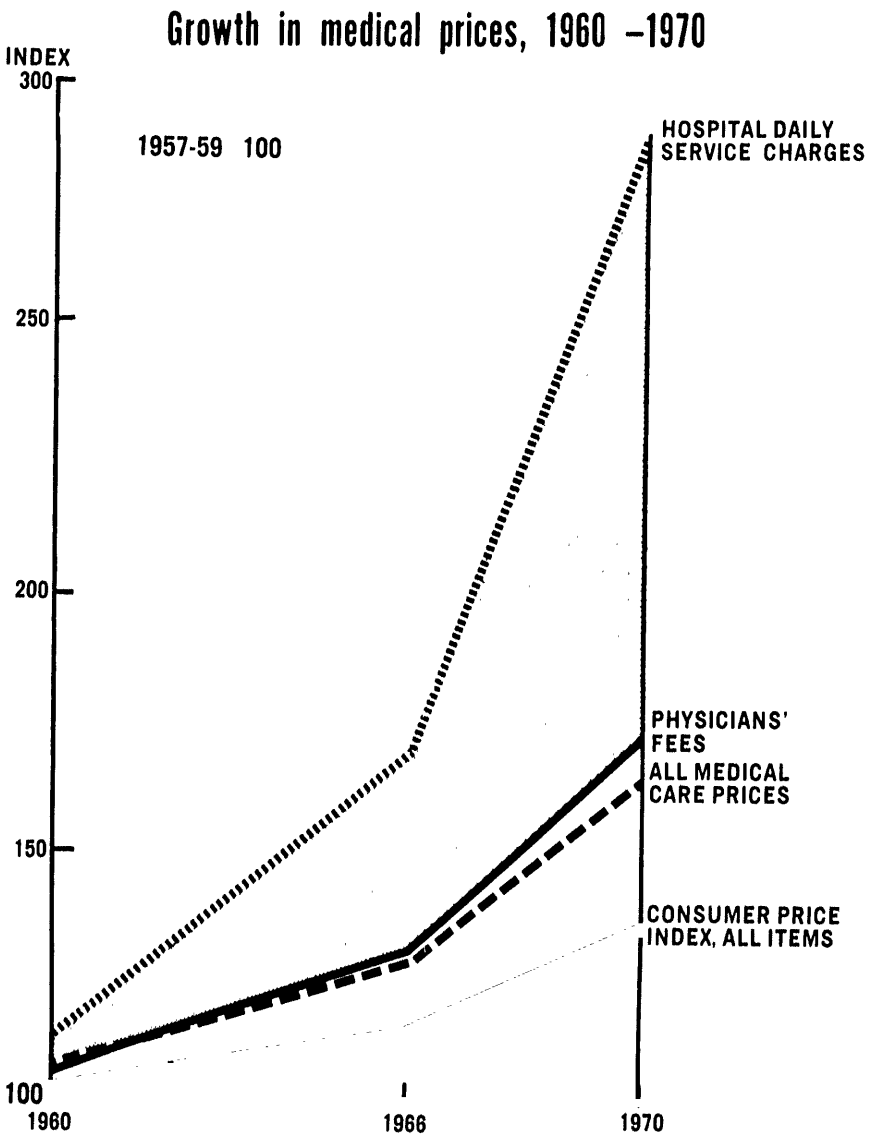
There has been little incentive for efficiency in the educational process. Most medical schools have their own basic science departments—for the pre-clinical years of training—duplicating in large measure the basic science departments of universities. While there have been efforts in recent years to prune and reform curriculums, reducing the length of a medical education in the process, far more needs to be done in this respect.

Medical schools have sought their own teaching hospitals, even though there may have been a surplus of hospital beds in the area, and when they could have converted a community hospital into a teaching hospital, thereby upgrading its quality of care.

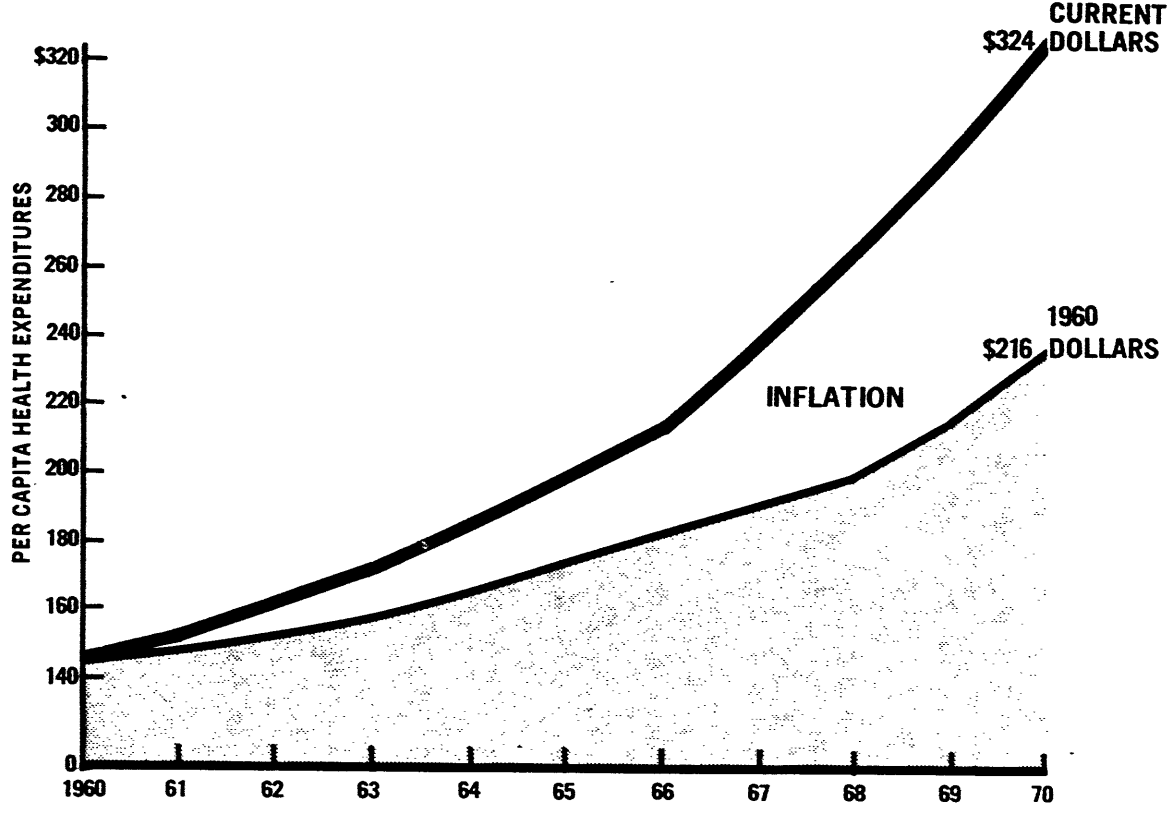
There are undoubtedly many other reasons, including inadequate tuition charges, the decline in voluntary donations, and the lack of productivity increases commensurate with those in the goods industry. The inescapable fact, in any case, is that the professional schools are in trouble.

Growth in health expenditures, 1950 –1970




Growth in medical prices, 1960 –1970
INDEX
300
250
200
150
100
1957-59 100
HOSPITAL DAILY SERVICE CHARGES
PHYSICIANS' FEES
ALL MEDICAL CARE PRICES
CONSUMER PRICE INDEX, ALL ITEMS
1960
1966
1970

Inflation's share of health expenditures in the 1960's



II

SOLUTIONS TO THE PROBLEMS

The solutions proposed by the Administration form an interlocking strategy. The entire "health care crisis" is addressed, from prevention of illness and injury to the financing of health services, from incentives to encourage a better distribution of health services to assistance and incentives for our professional schools.

Since the President's health message was delivered on February 18, and the Secretary of the Department of Health, Education, and Welfare testified on February 22 before the Senate Health Subcommittee on the Health Care Crisis in America, two key criticisms of the Administration's strategy have emerged. The first raises the question of "generosity"—has the Administration offered sufficient support? The second asks whether private health insurance should not be replaced with public insurance?

These are difficult issues. The extent to which anyone or any institution is generous depends upon the other things it wants to do or has to do. As pointed out in the Foreword, the claims for medical care cannot be treated in isolation; there are other, equally important claims, some of which will have a major, indirect impact on health. It is easy to say, "I would do more than you for so-and-so," if one does not have to add, "And to do more, I'll take from there." To do more in medical care is to do less either in other public sector programs or in the private sector (i.e., raise taxes). The central issue, therefore, is really whether, given all the other competing claims, the Administration's strategy is reasonable at this time. In future years, other claims may not be as urgent, and resources may thus be freed for additional health efforts.

The second issue—reliance upon the private insurance industry—in part poses the dilemma of the half-filled bottle. Some will look at it and say it is half-empty, rather than half-filled. The Administration looks at the accomplishments of the health insurance industry in the absence of guidance or regulation over the past two or three decades—its increasing coverage and diversification of benefits—and concludes that, on balance, the bottle is half-filled. It believes that no insurmountable problems have arisen, and that, with reforms, the bottle can be filled.

It is not an issue, to continue the metaphor, of "new wine in old bottles." That, too, is an easy assertion. Rather, it is a matter of preserving and strengthening institutions in the private sector, in the interest of maintaining pluralistic sources of ideas and power. For in doing so, the

Nation maintains the checks and balances that have been the strength of its political economy. To abolish the health insurance industry, and to replace it with a single Governmental system, is to set in motion a series of events with a predictable outcome. At some point, and the point is not far off, the economies of scale are transformed into diseconomies. The single, enormous organization begins to break down under the weight of administrative complexities—coordination among the parts becomes inordinately difficult, layers of bureaucratic hierarchies frustrate communications, and attention to quality becomes distracted. These are common and universal experiences with large organizations. There is no point in comparing, as has been done, a single governmental insurance system with the present Social Security Administration because the SSA collects and dispenses money on a formula basis in the absence of any discretionary freedom. But a single governmental system would be involved in a vast number of judgmental issues affecting all parts of the Nation. Moreover, a monolithic governmental system would (in the extant proposal for such a system) force economization through the imposition of a budget ceiling—only so much, and not any more, for the system as a whole. This assumes, however, a planning and budgeting capability that, in reality, would take years to muster. It would also, obviously, invest enormous responsibility in the central system. Furthermore, one should not assume that costs can be transferred from the heterogenous system we have to a single payroll system without some slippage. The experience of the United Kingdom indicates a marked amount of slippage—people buy services outside of the system, so that the true costs are equal to the system expenditures plus outside purchases.

Finally, the Administration has seen no evidence that justifies the conclusion that the private health insurance industry has been so derelict in performance, and so unresponsive to private needs, that the only solution is to abolish the industry. Instruments of reform, rather than those of warfare, appear to be more appropriate to the occasion.

And now we turn to the Administration's proposals for a comprehensive health strategy.

1. Prevention

Preventing premature deaths, illness, and injury is a major part of the Administration's strategy. Not only does prevention alleviate human suffering, and perhaps contribute to "a positive sense of physical and mental well-being," but expenditures on prevention can be traded off economically with expenditures on treatment and rehabilitation. A major proportion of the prevention proposals strikes at the inequities experienced by the poor. Other proposals are targeted upon major problems afflicting large numbers in our population, irrespective of income. Four criteria guided selection from

among all the alternatives. First, the problem was important and widespread. Second, effective means for dealing with the problem were available. Third, new opportunities had emerged (as in cancer research) which would be well worth exploiting. And fourth, the likely benefits justified the expected costs.

Welfare Reforms. The President's proposed welfare reforms, while serving other purposes as well, are an essential element in the health strategy. Firmly established relationships between income and health status point to an elevation in health status through income maintenance. In addition, the negative aspects of the current welfare programs, which encourage the breakup of families and the rearing of children in the absence of their fathers, are undoubtedly contributing to poor mental health; their elimination should therefore contribute to improvements in mental as well as physical health.

Nutrition. Inadequate nutrition has been linked with a number of physical and mental health problems, from iron deficiency anemia to diminution of intellectual performance. In the past 2 years, the Administration has increased the allotment of food stamps, and has decreased their price. Nearly all of the 3,000 counties in the Nation now have a food stamp or commodity distribution program; they serve more than 12 million people. Federal expenditures on food stamps nearly tripled between fiscal years 1970 and 1971—from $577 million to $1.7 billion. The President has requested $1.9 billion in his FY '72 budget. Nutrition programs for children, including the school lunch program, nearly doubled between fiscal years 1970 and 1971, reaching $951 million in FY 1971, and an additional $40 million has been requested for FY '72. The Administration has also liberalized the regulations of the school lunch program to reach more of the needy children.

In order to enable people to make their own decisions, the Administration seeks to substitute income for services wherever feasible. Accordingly, the Administration is considering at this time substituting additional income for food stamps in its welfare reform proposals.

Poor nutrition is not a problem solely of the disadvantaged. The affluent frequently consume more calories than they can reasonably expend in work or play; they are consuming more low-nutrition snack food than ever before as well as a number of foods with "empty calories." One indicator of the deterioration in the American diet is the 65 percent increase in the consumption of sweets between 1958 and 1968. The Administration proposes bringing together the forces of the Food and Drug Administration, the Federal Trade Commission, the National Academy of Sciences—National Research Council, the Advertising Council of America, and the food industry to develop nutritional guidelines, nutritional labeling, and information for

consumers on proper eating, as well as enforcing regulations to ensure that the nutritional value of food products is not misleadingly stated in advertising.

Family Planning. As a health measure, family planning not only allows women to avoid the birth of unwanted children (a mental health factor, among other things), but can also prevent illness and death of mothers and children through the proper spacing of births or the avoidance of births under high risk circumstances. In 1963-65, the infant death rate of the fifth child born to non-white women under the age of 20 was 127.6 per 1,000 births, in contrast with the average infant death rate for non-white women under the age of 19 of 49.5 per 1,000 live births. For fiscal year 1972, the Administration has requested $173 million for services and research on population and family planning—an increase of $64 million over the preceding year. With the family planning funds, services will be provided for half the women who want but cannot afford them. This will constitute substantial progress toward the President's goal set in July 1969—a five-year target date for universal access to family planning services.

Occupational Health and Safety. On-the-job accidents resulted in 14,500 deaths and more than 2,000,000 disabling injuries last year. The Administration's new Occupational Health and Safety Act (1970) enables the Secretary of Labor to implement existing safety standards and to establish other Federal standards within the next 2 years to promote occupational health and safety. The law also authorizes emergency temporary standards in the event of grave dangers from toxic agents or new hazards, and establishes strict enforcement and inspection measures. The Department of Health, Education, and Welfare is creating a new National Institute for Occupational Health and Safety to conduct research and experiments that will lead to improved and new standards.

Automobile Accidents and Alcoholism. In 1969, 56,000 people were killed and 4,700,000 were injured in motor vehicle accidents. Half of the deaths involved drivers or pedestrians under the influence of alcohol. Drinking drivers and pedestrians were involved in at least 800,000 automobile accidents. The Administration has initiated a comprehensive program to reduce alcohol-related deaths and injuries on our highways. The program constitutes an integrated package of counter-measures designed to identify, control, and provide surveillance of the drunk driver. Its activities will impinge on law enforcement, traffic courts, special counseling and assistance for drivers, and public education. The Administration has requested more than a fourfold increase in the appropriation for this program—from its fiscal 1971 level of $8 million to $35 million in fiscal 1972.

Pollution Control. There is increasing evidence that persistently high levels of air pollution increase the incidence of respiratory diseases, some skin conditions, and some of the chronic diseases. Steps that are now being taken to reduce the pollution from automobiles drastically below current levels by 1976, to develop alternatives to the internal combustion engine, to reduce sulfur oxides emissions from fossil fuels, and to find new alternatives to fossil fuels will have long-term payoffs in prevention. Strong standards are placing the cost of pollution control on the industries that produce the pollution, and on the consumer of their products, rather than, as now, on society as a whole. Last year, public utilities and other industries spent nearly $500 million to control sulfur oxides emissions.

Health Research. The Administration's FY '72 budget has requested $1.8 billion for health research, somewhat more than $100 million for the preceding year, and $266 million above FY 1970. These funds, for the most part, will continue research on the prevention and control of the major diseases and impairments that afflict our citizens. In addition, the Administration has proposed to launch a major program to conquer cancer, based on enthusiastic reports from the scientific community that an impressive range of opportunities has opened up in fields such as genetics, molecular biology, virology, and cell physiology which show exceptional promise of fulfilling the objective. $100 million additional has been requested for this purpose, bringing the budget to more than $330 million for cancer research.

The Administration has also requested a sixfold increase in the budget for an intensified program of basic and clinical research on sickle-cell anemia. This disease, which takes its name from the shape of cells found in persons with the disease, results in general lassitude and periods of crisis (attacks) characterized by severe bone pain and organ dysfunction. It increases the susceptibility of a person to infectious diseases. Children with sickle-cell anemia tend to do poorly in school, and adults have major employment difficulties resulting from fatigue and absences. The disease is hereditary and is found almost exclusively in persons of African descent. It is estimated that about 10 percent of the black population in America carry the sickle-cell genetic trait, and about one in 500 black Americans actually has the disease.

Prevention of Communicable Diseases. Among the venereal diseases, gonorrhea has been increasing at the rate of 10 to 15 percent a year over the past 4 years, and cases of syphilis also are on the upswing. It is estimated that there were 2.5 million cases of gonorrhea and 100,000 cases of syphilis last year.

There has also been a decline in immunizations against certain communicable diseases. The major problems are in urban poverty areas, where the proportion of children between the ages of 1 and 4 who have received measles vaccinations declined from 46 percent in 1969 to 41

percent in 1970. Vaccinations against diphtheria, pertussis, and tetanus declined in the same period from 27 percent to 23 percent, and polio vaccinations have dropped from 55 percent to 50 percent. Overall, 10 to 15 percent fewer of the young population in urban poverty areas received vaccinations against these diseases in 1970 than in 1969. The proportion of the population now immunized is so low that new outbreaks of measles, diphtheria, and polio could occur. The Administration intends to take corrective action. Because of the 50 percent drop in the price of rubella vaccine, and slippages in the purchase of this vaccine by State Departments of Health, $6 million can be re-allocated for vaccinations against the communicable diseases enumerated above.

Furthermore, the Administration plans to step up efforts considerably to enable communities to regain control over communicable diseases. An additional $10 million would be allocated for these purposes through the Partnership for Health program.

Lead Paint Poisoning. Paint with lead in it poisons about 400,000 children (predominantly poor) annually. It is estimated that 16,000 of these children require treatment, 3,200 incur moderate to severe brain damage, and 800 are so severely brain damaged that they require care for the rest of their lives. The Administration plans to make a significant start on programs to overcome this problem. The FY 1972 budget will allocate $2 million for this objective.

Product Safety. The Administration will expand its efforts to protect consumers against hazardous foods, drugs, and other products potentially dangerous to health. Inspection of domestic and imported foodstuffs, along with research on foods containing mycotoxins (fungal or bacterial poisons) and poisonous metals, will be stepped up. A program to review chemicals in foods will be established, and a cooperative program with industry will be initiated to assure the quality of foods. Efforts to improve the safety and efficacy of drugs will also be increased. For these and related purposes, $9.5 million has been incorporated in the FY 1972 budget, an increase of 11.5 percent over the preceding year.

Indian Health. Preventive health programs are the major thrust of the direct Federal responsibility for Indian health. As the result of previous efforts, infant death rates have dropped more than half in the last 15 years, and tuberculosis deaths have declined more than threefold. Current emphases are on sanitary conditions, physical rehabilitation, improved nutrition, and lowering rates of alcoholism and suicide. The Administration has proposed increasing the funding of Indian health programs by $18 million, rising from $141 million in FY 1971 to $159 million in FY 72, with a special emphasis on building sanitary facilities in homes without them.

Personal Responsibility for Health. Impressive gains in the prevention of illness and death could be made if our citizens were better informed about the actions they might take—and were encouraged to take—to improve their health. Over-indulgence in foods and alcoholic beverages, cigarette smoking, excessive use of drugs and nostrums, inadequate exercise, and insufficient attention to indicative physiological changes, all contribute to unnecessary and avoidable illnesses. The Administration has stimulated the formation of a National Health Education Foundation, a private, nonprofit organization that will receive no Federal funds. It will be sponsored by business, labor, the health professions, the insurance industry, and health and welfare organizations. The Foundation will undertake a comprehensive health education program to promote preventive actions that citizens can undertake on their own behalf.

Financial Incentives for Preventive Health Care. As part of its insurance proposals, which are discussed later, the Administration has recommended benefit packages that include incentives for preventive health services, ranging from immunizations to screening examinations.

These, then, constitute the alternatives the Administration has selected to prevent illnesses and injuries. It has rejected a number of alternatives on the basis of the criteria mentioned at the outset of this section. As time and circumstances change, and as we increase our knowledge about how to undertake other cost-effective preventive measures, the list will undoubtedly be lengthened.

2. Innovation and Reform in Health Care: Health Maintenance Organizations

Another key part of the Administration's health strategy is the Health Maintenance Organization (HMOs). HMOs simultaneously attack many of the problems comprising the health care crisis. They emphasize prevention and early care; they provide incentives for holding down costs and for increasing the productivity of resources; they offer opportunities for improving the quality of care; they provide a means for improving the geographic distribution of care; and, by mobilizing private capital and managerial talent, they reduce the need for Federal funds and direct controls. They also contain shortcomings, which will be described later on, that must be guarded against.

HMOs are organized *systems* of health care, providing comprehensive services for enrolled members, for a fixed, prepaid annual fee. No matter how each HMO may choose to organize itself (and there are various models), from the consumer's viewpoint they all provide a mix of outpatient and hospital services through a single organization and a single payment mechanism.*

*The Kaiser Permanente health care organization is an example of an HMO.

Because HMO revenues are fixed, their incentives are to keep patients well, for they benefit from patient well-days, not sickness. Their entire cost structure is geared to preventing illness and, failing that, to promoting prompt recovery through the least costly services consistent with maintaining quality. In contrast with prevailing cost-plus insurance plans, the HMO's financial incentives encourage the least utilization of high cost forms of care, and also tend to limit unnecessary procedures.

HMOs provide settings for innovative teaching programs (using the entire team of health professionals and supporting personnel), as well as for continuing education programs for practitioners. They also provide a setting in which new technologies and management tools can be most effectively employed, in which the delegation of tasks from physicians to supporting personnel is encouraged, and in which close and constant professional review of performance will provide quality controls among colleagues.

HMOs are not wholly new, and more than 7 million Americans now receive comprehensive health care from HMO-type organizations, and about 20 percent of the population lives within their service areas. The evidence that has been derived from the existing organizations provided the basis for the Administration's decision to encourage their rapid and widespread development.

In contrast with more traditional and alternative modes of care, HMOs show lower utilization rates for the most expensive types of care (measured by hospital days in particular); they tend to reduce the consumer's total health-care outlay; and—the ultimate test—they appear to deliver services of high quality. Available research studies show that HMO members are more likely than other population groups to receive such preventive measures as general checkups and prenatal care, and to seek care within one day of the onset of symptoms of illness or injuries.

These studies show that hospitalization is significantly reduced in HMOs, and that this reduction is accomplished by prevention, by performing more procedures in the doctor's office (minor surgery, for example), and by reducing unnecessary procedures. They show that alternative modes of service overhospitalize for common respiratory conditions and for such minor surgical conditions as benign neoplasms, tonsillectomies, and accidental injuries. Reduced utilization within the HMO framework is selective—it reflects rigorous professional controls and is not sought as an end in itself. Typical findings are shown in the accompanying table.

COMPARATIVE PERFORMANCE OF HMOs ON HOSPITAL USE

	HMO	*Other*
Number of hospital days per 1,000 persons per year	744	955
Number of hospital admissions per 1,000 persons per year	70	88
Hospitalized surgical cases per 1,000 persons per year	49	69
Tonsillectomies per 1,000 persons per year	47	94

(Data standardized for age, sex, income, residence, and, excepting tonsillectomy rates, for out-of-plan services.)

SOURCES: Denson et al., *American Journal of Public Health* 50 (November 1960). Denson et al., *Hospital Monograph Series* 3 (American Hospital Association, 1958).

A variety of research studies and investigations have contrasted the cost of health care under HMOs with that of traditional practice. They all tend to the same conclusion: that HMOs lower the total health-care costs of families and individuals, and that their premiums cover a greater percentage of total costs.

This conclusion is supported by data from the Social Security Administration on Medicare experience: they show that some HMOs are saving as much as 15 percent on their elderly enrollees, in comparison with costs under traditional modes of practice. Another significant measure of at least potential cost-savings within the HMO framework is that of reduced hospital utilization rates. Based on 1968 figures, if the hospital stays of all Medicare beneficiaries who were admitted to the hospital could have been reduced by just one day on the average, the costs would have been reduced by $314.6 million. And the number of hospital beds required would have been reduced by 15,000 for the year. At an annual operating expense of $25,000, the savings in one year on the beds would have been $375 million. Current Medicare data as well as the results of one particularly careful study of family health care expenses are shown on the next table.

COMPARATIVE PERFORMANCE OF HMOs ON COST

Annual Health Costs per Family

	HMO	*Insurance Plan One*	*Insurance Plan Two*
Premium costs	$122	$115	$110
Out-of-pocket costs	102	137	149
Total costs	224	252	259

(Data standardized for age, sex, location, family size, and occupational class.)

SOURCE: "Family Medical Care under Three Types of Health Insurance," Columbia University School of Public Health, 1962.

Average Medicare Benefit Payments per Person for HMO and non-HMO Beneficiaries in Two Regions, 1968

	Medicare Payments
Region One	
non-HMO persons	$388
HMO persons	330
HMO as a percent of non-HMO	85% (15% savings)
Region Two	
non-HMO persons	$399
HMO persons	379
HMO as a percent of non-HMO	93% (7% savings)

(Data standardized by age and residence.)

SOURCE: Social Security Administration, Office of Research and Statistics.

The best, and perhaps the only test of any health care system is the health of its patients. Less hospitalization, less surgery, and lower costs do not in themselves equal desirable care. Costs and services can be low for undesirable reasons.

Results for three indicators—premature birth rates, infant mortality, and elderly mortality—suggest that HMOs can improve chances for life itself. Such results, shown below, confirm the 1967 findings of the National Advisory Commission on Health Manpower that HMOs deliver high quality care:

COMPARATIVE PERFORMANCE OF HMOs ON HEALTH

Prematurity and Mortality

	HMO	*Traditional Mode*
Premature births per 100 live births		
white	5.5	6.0
non-white	8.8	10.8
Infant mortality per 1,000 births		
white	22.7	27.3
non-white	33.7	43.8
Annual mortality of elderly population (18 months or more after plan membership)	7.8%	8.8%

(Data standardized for age, sex, income, residence, and, where appropriate, age of mother.)

SOURCES: Shapiro et al., *American Journal of Public Health* 50 (September 1960) *and* 57 (May 1967).

The shortcomings of HMOs, mentioned earlier, appear to be these: One careful study found that knowledge about HMOs and the predisposition to choose them over alternative systems are greater among older persons who are heads of large families in the mid-range of income groups. In other words, they are people whom one would expect to make the most sophisticated choices. This suggests that effective means of informing consumers should precede the expansion of HMOs among all population groups.

More significantly, other studies have found that some individuals perceive HMOs as impersonal, inconvenient, and require long waiting to get services. They also feel that there is a "clinical" or even a "charity" atmosphere in the health care facilities. Most of these perceptions apply to

alternative forms of care as well—but not all of them, and not so intensely. In short, there may be attitudinal barriers to the rapid expansion of HMOs, which will require a conscious effort to reduce or eliminate.

The Administration's Proposals. During FY 1972, the Administration will use various existing authorities to stimulate the development of HMOs. The authorities include: Partnership for Health, Regional Medical Programs, Health Services Research and Development, Hill-Burton, and possibly others. But new legislative and administrative initiatives will be needed to build up HMO capabilities across the Nation for the general population, and, more importantly, in areas where health care resources are scarce.

The Administration seeks authorities, therefore, to improve the distribution of health care resources by providing operating grants for HMOs in medically underserved areas, to cover some portion of initial operating deficits, and to provide direct loans to public institutions for initial operating deficits. A sum of $22 million has been requested for both purposes. In scarcity areas now served by Neighborhood Health Centers, and similar models, the Administration would seek to have such facilities eventually become part of HMOs.

For grants and contracts with which to plan the development of new HMOs for the general population, the Administration is proposing an obligation of $23 million.

Authority for guaranteeing loans sufficient to generate $300 million in ambulatory facilities, and for operating deficits of private sponsors, has also been requested. In recognition of the higher costs that would be sustained by medical schools in operating HMOs, the Administration seeks $4 million in grants and contracts for this purpose.

The Administration has also requested $15 million in grants to assist the development of new Family Health Centers in scarcity areas, with the view toward converting them into HMOs or HMO-affiliates.

The Administration's plan would also provide for prepayment to public and private HMOs for the care of Indians, as well as for manpower training in HMO settings. Moreover, while experience over the years indicates that HMOs provide high quality of care, the Administration would provide additional checks, as part of a general plan to review for quality of care and for the utilization of resources in all its new proposals. Accordingly, the Administration proposes establishing Professional Standards Review Organizations (PSROs) within the States to determine whether the quality of care meets professional standards, and whether resources are being used efficiently and effectively. They will review both health insurance and HMO

contracts. They will be under the direction of the Secretary of Health, Education, and Welfare, who will also be assisted by a National Professional Review Council in contracting with PSROs. This Council will review the activities of the local PSROs, and publish information on comparative performance. Furthermore, to provide another checkpoint, and in line with the Administration's efforts to improve the planning capability of State and local governments, State and local planning agencies will review and comment on HMO proposals.

With regard to planning, the Administration is examining the interrelationships among State and areawide planning, Regional Medical Programs, health maintenance organizations, and Area Health Education Centers (discussed below) to develop a more rational structure than exists today for the achievement of their overlapping objectives. The Administration is reviewing these alternatives with a view to their legislative base and the opportunities for consolidation.

Finally, the Administration would use the supremacy laws of the Constitution to pre-empt, in connection with Federal insurance programs, those legal barriers that limit the use of allied health personnel or the organizational form of HMOs.

The goals of the Administration are to develop 450 HMOs by the end of fiscal year 1973, 100 of which would serve areas with a scarcity of health care resources. By the end of fiscal year 1976, the plan calls for 1,700 HMOs with the potential of enrolling 40 million people, 10 million of whom would be in families with incomes under $8,000 a year. By the end of the decade, the goal will be to have a sufficient number of HMOs to enroll 90 percent of the population, if they desired to enroll. Most importantly, the choice of traditional modes of care would remain.

In the development of HMOs, as well as in the development of other community services that depend in part upon Federal resources, the Administration is committed to putting together "packages" of resources that are now to be found only in categorical, earmarked pigeonholes. That is, as an action complementing the proposed consolidation of grants, the Administration proposes to enable those seeking to achieve national purposes, but are now impeded and frustrated by the compartmentalization of Federal funding, to negotiate at a single point of access in the Government and with a single instrument for the combination of resources needed to achieve the purposes. The Administration recognizes that while specific problems have their advocates, at the community level the problems are interrelated. The resources that have been available for the specific problems must be reassembled for a realistic and holistic community program.

3. Health Manpower

In the statement of the causes of the "health care crisis," the main problems were identified as: poor distribution of physicians, both in geographic location and in type of practice, poor utilization of our manpower resources, and financial difficulties of our professional schools. Although not contributing to the crisis, there are other problems that a comprehensive manpower strategy should cope with. One is that between now and the end of the decade, the population is likely to increase by 22-27 million people, with a marked increase in the elderly—about 4 million more people over the age of 65 than today. While the number of children under 19 years of age will probably decline by approximately 2 million, thereby freeing some health resources, the increase in the elderly—the group that consumes the largest amount of health services in proportion to their numbers—will more than take up whatever slack is created.

As a consequence of expanded insurance coverage, effective demand for health services is likely to increase. Moreover, both personal income and educational attainment will increase in the decade ahead, and because income and education correlate with demand for health services, we can expect additional demands from this cause.

Finally, in reviewing the enrollments in professional schools by race and sex, the Administration has found that women and members of racial minorities are vastly under-represented in relation to their numbers in the population. In 1969, fewer than 3 percent of all candidates for medical degrees were black, and only 8 percent of all medical students were women. In dental practice at the present time, the figures are only 2 percent in each case. Medical and dental schools are trying to turn this situation around, as evidenced by the composition of their entering classes last year—more than 6 percent black and 11 percent women. But, clearly, more needs to be done.

Using a broader measure—family income—one finds similar results. In recent years, fewer than 10 percent of medical students were from families with $5,000 annual income or less, although such families constitute 25 percent of all families in the Nation.

Thus, providing opportunities for members of racial minorities, women, and students from low-income circumstances to attend professional schools must, in the name of fairness and justice, be included in a manpower strategy.

The Administration's proposals in their entirety come to grips with all of these problems. Indeed, for example, it is firmly convinced that no

reasonable means of improving the distribution of health manpower—the most severe problem—has been rejected.

Improving the Distribution of Manpower Resources. In addition to the improvement in distribution that is anticipated through the development of HMOs in scarcity areas (see preceding section), the Administration proposes a wholly innovative $45 million fund—Health Manpower Educational Initiative Awards—about $40 million of which will be used to create Area Health Education Centers (AHECs) in underserved parts of the country, both urban and rural. These centers will be affiliated with medical schools or university health science centers and will perform the dual function of education in the health disciplines and direct service to the surrounding community.

While a long-range strategy based on HMOs and AHECs is being implemented, the Administration will take immediate steps to supply health manpower in areas of critical shortage. The Emergency Health Personnel Act of 1970 authorizes the Secretary of Health, Education, and Welfare to send doctors, dentists, nurses, and other health workers into scarcity areas, at the request of public or non-profit health agencies and with the approval of State and local governments and district medical societies. A $10 million appropriation for fiscal 1972 will support an initial 600 to 1,000 health personnel in pilot projects.

The Emergency Health Personnel Act is not a permanent solution to the problems of manpower maldistribution—but it represents a useful transition device until the overall Administration strategy takes hold.

To encourage primary care physicians, dentists, and nurses to practice in medically underserved areas, the Administration proposes to forgive $5,000 in loans, plus interest, that physicians and dentists borrow as students, or 25 percent of nurses' loans, for each year served in such areas.

The Administration would offer two other types of incentives to shift the distribution of medical students more towards primary care. At the undergraduate level, preceptorships or clerkships would be established whereby medical students could gain firsthand experience in the practice of primary care medicine. At the graduate level, assistance would be provided for setting up primary care residency programs in the Area Health Education Centers.

In sum, to improve the distribution of health services, the Administration is supporting the formation of HMOs and Area Health Education Centers in scarcity areas, the training of physicians assistants, such as MEDEX, forgiveness of loans for the education of health personnel

according to the type of practice and the location of that practice, special projects for the training of primary physicians and their aides, assistance for technical development and its use (such as closed-circuit TV), and the initiation of an emergency health service corps. While the Administration cannot guarantee any specific degree of success for these measures, it believes that all reasonable measures have been included, and it will continue to search for new ones.

Improving the Utilization of Health Manpower. As health maintenance organizations develop and spread, the utilization of health manpower will be improved. The ratio of physicians to population in HMO-type organizations today, for example, is approximately 1 to 1,000, in contrast with the average ratio throughout the Nation of 1 to 590, indicating that HMOs use physician services more efficiently.

Beyond the expected accomplishments of HMOs, the Administration would also undertake several other major efforts to improve the utilization of health manpower. These include using present capacity to its utmost and expanding capacity to train physicians assistants, especially those who could be delegated a significant percentage of the tasks of general practitioners, obstetricians, and pediatricians. Programs such as MEDEX, which draw upon the trained cadre of ex-military corpsmen, in conjunction with MEDIHC—an information program used to acquaint military corpsmen of opportunities for civilian health careers—will also be expanded. Opportunities would also be expanded for nurses to become pediatric nurse practitioners, nurse midwives, and public health nurses. Further development of programs to train dentists to use one or more chairside assistants effectively is also envisioned. Somewhat in excess of $26 million would be allocated for these purposes in Fiscal Year 1972.

Another major effort would be to train physicians and dentists, while still in professional school, to work with all the members of their teams and to learn how to use their subordinates efficiently and effectively, thus conserving their own time and skills for the care they can uniquely give. Project grants would be awarded for this purpose.

Special efforts would also be made to bring inactive nurses back into the labor force. There are nearly as many inactive as active nurses, and experiences under several auspices have indicated that some nurses can be persuaded to undertake short retraining courses and then resume their nursing careers.

Technological development also offers opportunities for improving the utilization of scarce manpower skills, while also serving other purposes such as improving the quality of care and the distribution of services. To

illustrate: In Salem, Missouri, under the auspices of a Regional Medical Program grant, a general practitioner's office is linked by computer to a university. Patients who come in for a physical participate in feeding information into the computer, through a process similar to self-instruction teaching machines, and nurses add information from tests they perform. A great deal of information is available to the physician by the time he sees the patient, and his own judgmental decisions are entered into the patient's computer-recorded file. Technology, the use of the patient as a participant in the process, and the use of nurses substituting for tasks previously performed by the physician each can contribute to improving utilization. The Administration will continue to support efforts of this nature.

Student Assistance. One objective of the Administration, as noted earlier, is to enlarge the opportunities of the disadvantaged to enter professional careers. Accordingly, under the Administration's plans, scholarship support would increase from $15 million currently to $29 million. The average amount of scholarship assistance for medical, dental, and osteopathic students would triple—going from $1,000 to $3,000. These scholarships would be awarded for the first two years of study, the years in which greatest attrition normally occurs. Students from disadvantaged backgrounds would be expected to borrow, on guaranteed loans, to complete their education, but a special provision in the Administration's plan would permit these students to forego payment on their loans should they be unable to complete their education. Because studies have found that the *thought* of indebtedness deters disadvantaged students from seeking higher education, the Administration proposes to remove this barrier.

For all other students of medicine, osteopathy, and dentistry, guaranteed loans up to $5,000 a year would be available. No student, henceforth, will have to forego a professional education because he is unable to gain access to adequate financing. While the loan indebtedness of the students may appear to be large, several points are to be noted in this regard. First, if the professional schools reduce the length of the curriculum from 4 to 3 years, the student's maximum loan indebtedness would drop from $20,000 to $15,000 for his profession education. Second, the income expectation of physicians is quite large, and repayment should be relatively easy. Third, the risk for students is quite low—the chances of graduating for an entering student is about 92 percent today, and the percentage climbs after each succeeding year. Finally, a student who anticipates the maximum indebtedness of $20,000 could cancel his indentedness by entering a primary care field and by practicing in a scarcity area for 4 years.

The Administration has also proposed extending scholarship support for nursing students, whether they study in baccalaureate institutions, junior

colleges, or in hospital diploma schools, and increasing the maximum loan guarantee from $1,500 today to $2,500 a year.

Improving the Financial Stability of Health Professional Schools. The Administration proposes a nearly threefold increase in Federal support for basic medical, dental, and osteopathic education. The funds would be provided for students graduated, rather than for students enrolled, and the schools would receive $6,000 for each student graduated (a "capitation" grant). These funds, plus the funds for the special projects mentioned earlier, and Federal funds for other purposes (participation in HMOs, in Regional Medical Programs, and so forth), should relieve most and possibly all of the schools' present financial distress. For a few schools, "emergency" grants may still have to be provided, but the goal is to eliminate "crisis" financing in the near future.

It should be noted that if the health professional schools continue to train students in 4 years, they will receive $1,500 per student each year, but if they shift to a 3 year curriculum, they will receive $2,000 per student. The report of the Carnegie Commission on Higher Education and the Nation's Health (October 1970) estimated that a shift to 3 years would produce potentially a saving of more than a third of the total cost of training physicians and dentists. That would depend, however, on how the schools go about collapsing the curriculum. For the student, the shift would mean a saving of one year's expenditures on his education (again, depending on how the curriculum is shortened), plus the earnings now foregone during the fourth year of training. For the manpower supply, it will mean a one-time bonus of an extra graduating class.

By rewarding the schools for their output—their graduates—the Administration's proposals should also provide incentives for increasing the efficiency of the educational process. It offers an incentive to the schools to fill places vacated by "drop-outs" and to integrate the basic science curriculum of the professional schools with the basic science departments in nearby or parent universities. Attrition is now running about 8 percent of enrollment, or between 800 and 900 medical students. About 250 of these places will be filled by, for example, American students who are studying in foreign medical schools. But the unfilled places—550 to 650—represent the output of five to seven medical schools, which is a costly loss to society.

Increasing the Supply of Health Manpower. While poor distribution and utilization are at the root of our health manpower problems, the Administration's strategy proceeds from the assumption that these problems, for the most part, must be addressed at the margin—in terms of each new increment in manpower—where prospects for success are greatest. Physicians and dentists with established and successful practices in affluent suburbs are

not likely to move to scarcity areas, and they cannot be ordered to move into urban ghettoes or into isolated urual areas. It is also wholly unrealistic to expect an experienced radiologist or pathologist suddenly to switch to primary care. Moreover, although older physicians can and do employ assistants of one kind or another, most of them lack either the inclination or the knowledge to make the fullest possible use of assistants. In each of these instances, it makes far more sense to look to the new professional as the agent for change. Finally, we must plan ahead for changes in population and in the effective demand for services, mentioned earlier, and increase the supply accordingly. The penalty for *not* acting to increase the supply of health manpower could be very high. Therefore, the Administration proposes to use special project grants and construction awards (both grants and guaranteed loans) to increase the supply of health manpower.

Less crucial, but not unimportant in the resolution of the health manpower problems of the Nation, is the assistance the Federal Government can offer to such other health professionals as veterinarians, podiatrists, pharmacists, and optometrists. The Administration has requested new authority to expand educational opportunities in these fields for disadvantaged students, to train new types of health service personnel, to promote preventive medicine, to include them in the team approach to delivering health services, and to improve the distribution of trained personnel in these professions.

Finally, the Administration's manpower strategy calls for a number of related and interlocking actions to improve the use of our manpower resources. The first is an intensive examination and resolution of the problems associated with medical malpractice. The second is to improve the opportunities for upward mobility among individuals in allied health and nursing professions; this will be accomplished by assisting in the development of equivalency examinations to enable these individuals to substitute experience for education. The third is to develop model laws and other procedures by which legal barriers to career development and the efficient use of manpower can be lowered or eliminated.

The Administration has proposed a comprehensive manpower strategy designed to overcome the crucial problems of today, and to prepare for the likely eventualities of the future. The Administration's FY 1972 budget calls for a total of more than $1.1 billion for education and training of health manpower; more than half of this total would be administered by the Department of Health, Education, and Welfare.

4. Improving the Financing of Health Services

The key problems that were identified in relation to the financing of services were: inadequate access to care because of financial barriers,

inadequate benefits for many people who have insurance coverage, and unnecessarily high costs resulting from a mutually reinforcing financing and delivery system. The Administration's objectives, therefore, are to reverse these circumstances—i.e., to increase access to care by lowering financial barriers, to see that insurance coverage provides adequate benefits, and to provide a link between the financing and delivery system so that unnecessarily high costs may be avoided.

The Administration proposes a *national* health insurance program, providing some financial protection for everyone. It is not a *nationalized* health insurance program, for it does not require the Federal Government to assume the entire national health care bill. It is a partnership between the public and private sectors, designed to build upon the durable parts of the existing base of private and public health insurance, and extend coverage to all families with children.

National Health Insurance Partnership Act (NHIP). A substantial majority of American families have some form of health insurance, primarily through employer-employee plans. To extend this coverage to all employed individuals and families that include employed persons, and to ensure that the benefits are adequate, the Administration proposes the National Health Insurance Partnership Act. This Act would require employers to provide basic health insurance benefits for their employees and their families, and to share the costs with them.

Because the employer-employee plan would not meet the needs of families headed by an adult who is not usually employed, and thus ensure adequate protection for "poor" and "working poor" families, the Administration proposes, as a complement to this Act, a Federally-assisted Family Health Insurance Plan (FHIP). FHIP would replace the current Medicaid program for low-income families with children, but Medicaid will continue to provide benefits for the poor who are blind, disabled, and aged.

Medicare will continue to provide protection for the elderly, but the burden of the monthly premiums will be removed through absorption into employee-employer contributions to Social Security.

Under NHIP, every employer subject to the Act will be required to provide approved health insurance coverage for all employees who work more than 25 hours a week, and employees will be able to bring suit in Federal courts to compel compliance with the Act.

To qualify for approval under the Act, employers must offer insurance plans, with the following benefits, to every employee and each member of his family:

—inpatient hospital care;

—physician's visits at home, hospital, office or clinic, including well-child care;

—routine eye examinations for children under the age of twelve;

—maternity care, prenatal and postnatal physician's services, and family planning services;

—emergency ambulatory care, including dental services, for accidental and other injuries; and

—X-ray and laboratory services.

Providers of services under these insurance plans will be required to satisfy the conditions of quality control, claims review, and utilization review now required by Medicare. (See also the comments on Professional Standards Review Organizations at the end of the section on health maintenance organizations.)

Every plan must also allow the employee the option of enrolling in a prepaid health maintenance organization—a requirement that forges a link between the financing and delivery systems.

Every employee may be expected to assume a limited share of the financial costs for the medical services used by his family. This share ("deductibles") may not be in excess of the reasonable cost of two days' hospital room and board for hospital inpatient services, plus 25 percent of the remaining cost of such services ("coinsurance"). There would also be a deductible of $100 for each family member, up to three members, for covered medical and other health services, plus 25 percent coinsurance of the remaining cost of such services. When total expenses of an individual reach $5,000, the employee pays no further deductibles or coinsurance, meaning his maximum is about $1,500.

Approved plans must also provide maximum benefits of at least $50,000 per family member over the life of the contract, with $2,000 of the exhausted benefits restored each year. For pre-existing conditions, benefits may not be denied for more than 6 months from the date of the initial coverage, and the plan may contain no such exclusion for maternity care. Coverage must be extended, if the employee so desires, for at least 90 days after his employment has been terminated.

The cost of coverage under the Act would be borne jointly by employers and employees. During a transition period of two and one-half

years, the employer would be required to contribute at least 65 percent of the plan. Thereafter, the minimum employer contribution would be 75 percent. The lower contribution rate in the initial period is intended to ease the burden of adjustment to the new system.

The Administration's proposal would become effective on July 1, 1973.

The Family Health Insurance Plan (FHIP). Poor and near-poor families will be provided with health insurance protection through the proposed Federal Family Health Insurance Plan, FHIP is designed to replace Title XIX of the Social Security Act—popularly known as Medicaid—for low-income families with children. The shortcomings of Medicaid are so great, it has become essential to replace it. These shortcomings include striking variations in the value of benefits to families in similar circumstances residing in different States, and wide variations in benefits, eligibility, and population coverage. Thus, Federal dollars are being distributed very unevenly and inequitably among the low-income population in the program.

Moreover, exclusion of the "working poor" increases the inequities of the existing welfare system, so that half of the ten million poor children in the Nation receive no publicly assisted health services. This discrimination creates two potentially serious side-effects for the family. First, it encourages marital breakup, since female-headed families can qualify for benefits, while male-headed families, in most cases, cannot. Second, it discourages the male head of a family from working by making full benefits available to families headed by unemployed males, while denying similar benefits to those headed by employed males.

A further inequity is that public assistance recipients receive full benefits, at no cost, up to the income at which they leave the welfare rolls. At that point, they lose all benefits. Families whose earnings take them just above the cutoff may therefore be worse off than if they were still on welfare. This abrupt termination of benefits can be a serious barrier to self-sufficiency. Those who are familiar with the Administration's welfare reform proposals will note that the proposed health insurance reforms are meshed with welfare reforms. Moreover, while families would make increasing payments for insurance, their income would be rising under welfare reforms.

The shortcomings of Medicaid suggest that an equitable program of medical assistance for low-income families must meet additional criteria for there to be a fully effective program. It must eliminate geographical inequities, categorical inequities, work disincentives, and ensure adequate protection. It should also promote the development of health maintenance organizations, and foster efficiency in the health sector.

In the Administration's proposal, eligibility for FHIP would be based upon family income, adjusted for family size. Families with incomes up to $5,000 for a family of four (the median size of FHIP families), who do not have health insurance protection through a required employer-employee plan, would be eligible for FHIP. About 5.4 million families with children fall below these income limits, and about 3 million of these would be eligible for FHIP benefits, including mirgrants, domestics, and other part-time workers as well as non-workers. The income limits for family sizes up to seven are shown below.

Family Size	*Income Limit for FHIP Eligibility*
2	$3,400
3	4,200
4	5,000
5	5,800
6	6,400
7	7,000

These income limits were chosen because they include the population with the least adequate private health insurance coverage, and for whom private coverage is unlikely to provide the required protection. While 85 percent of families with incomes above $5,000 have some private health insurance, only 45 percent of those below $5,000 have private coverage. Even in the income range from $5,000 to $7,000, almost 80 percent of all families have some private insurance. The most substantial gap in private coverage exists for families below the $5,000 income level. FHIP is designed to fill that gap for those who do not qualify for mandatory employer-employee insurance under the NHIP Act.

A small fraction of the families above the FHIP eligibility cutoff does not now have private coverage, and an additional number have inadequate health insurance protection. The NHIP Act will provide coverage for most of these families. Employer-employee health insurance will close the gap without displacing the private coverage now enjoyed by the vast majority of families in these higher income brackets, and without imposing a huge expense on the general taxpayer.

Families enrolled in FHIP will be eligible for assistance in meeting expenses for:

—Physicians' visits at home, office or clinic, up to a maximum of eight visits per person per year; this maximum will not apply, however, to visits for prenatal, postnatal, or well-child care, or family planning;

—Maternity care, prenatal and postnatal physicians' services, well-child visits for children below the age of 5 years, and family planning services;

—Out-of-hospital laboratory, x-ray and surgery;

—Emergency ambulatory care within 24 hours of accidental injury; and

—Hospital care and related physicians' services, up to 30 days per person per year; or the cost-equivalent of hospital care for skilled nursing home services or approved home health services.

All providers of covered services will be subject to the conditions of quality control, claims review, and utilization review required by Medicare. Families enrolled in FHIP may elect to receive services either from individual providers or from a health maintenance organization. In the latter case, FHIP will make a direct payment to the HMO, on a capitation basis, equal to average FHIP reimbursements to covered families in the area.

The specific package of covered services includes the essential medical services required for adequate family health care. Outpatient care is covered in order to encourage the use of preventive and health maintenance services that reduce the probability of serious illness and the necessity of prolonged hospital stays. In addition, the inclusion of outpatient services will discourage the use of costly inpatient procedures when less expensive outpatient treatment may be substituted.

As explained earlier, the value of benefits under a medical assistance program should decline smoothly as income rises to the eligibility cutoff level, in order to avoid the disincentive effect of an abrupt termination of benefits at that point.

There are two principal ways in which the value of coverage can be reduced as income rises. First, the family may be required to pay income-related premiums in order to qualify for coverage. Second, coverage under the program may require covered families to make deductible and coinsurance payments, with the size of these payments scaled to family income. FHIP includes both forms of family contributions. Since these features are central to the design of FHIP, it is important that they be clearly understood.

The FHIP premium is a periodic payment based solely on family income, regardless of the family's use of medical care. It is directly analogous to premiums paid for private insurance, except that it is scaled to income. (Families covered by FHIP would have their premiums deducted from their assistance checks.) A family of four would pay the following annual FHIP premiums at the indicated income levels:

Family Income	*FHIP Premium*
$0-3,000	$0
3,500	25
4,000	50
4,500	75
5,000	100

In addition to the FHIP premium, the value of benefits would be reduced by income-related deductibles and coinsurance. The FHIP deductible is defined in terms of the number of days of hospital services for which the covered family is financially responsible; both the deductible and coinsurance vary with family income. The deductible and coinsurance provisions for a family of four are shown in the table below.

Family Income	*Hospital Deductible**	*Other Deductible*	*Outpatient Coinsurance***
$0 - 3,000	0	0	0%
3,000 - 3,500	1 day	0	0
3,500 - 4,000	1 day	$50/family	0
4,000 - 4,500	1 day	$50/family	10
4,500 - 5,000	2 days	$100/family	25

*Assessed at average per diem charges for room and board, not actual charges.

**Applied to all outpatient services except maternity and well-child care.

As the table indicates, a family of four with income below $3,000 would pay no deductible or coinsurance. At an income of $4,000, the family would pay for the first day of hospital care used by each family member, a $50 annual deductible and 10 percent of the cost of outpatient care, except for maternity and well-child care. The hospital deductible is assessed at the average daily cost of room and board (currently about $50), rather than actual expenses incurred. Any expenses in excess of the family's deductible and coinsurance liabilities would be reimbursed by FHIP.

Taken together, the FHIP provisions slowly increase the financial liability of a family at the income cutoff for FHIP eligibility to approximately the beginning level under the NHIP Act, so there will be no reduction in benefits, or increase in cost of coverage, as the family loses its FHIP eligibility. Thus, there will be no work disincentive associated with the program.

The cost-sharing charges in FHIP are carefully graduated with income to ensure that they do not present an insurmountable barrier to necessary care, while still being significant enough to discourage excessive utilization of health services. Moreover, the form of the cost-sharing provisions will provide positive incentives for efficient choices among the various types of care and providers. A one-day hospital deductible will discourage the use of high-cost inpatient facilities for procedures that can be performed as effectively on an outpatient basis. By eliminating the family portion of Medicaid, taxpayers will save $1.8 billion against the total Federal cost, resulting in a net additional Federal cost above Medicaid for FHIP of $1.2 billion.

The States, relieved of responsibility for their share of the family portion of Medicaid, may save as much as $1.8 billion. The States will be encouraged to use a part of this saving to supplement the basic Federal benefit package by providing services not covered by FHIP.

The effective date for the Family Health Insurance Program would be July 1, 1973.

Ensuring Access to Medical Care for Other Groups. Neither the National Health Insurance Partnership nor the Family Health Insurance Program will meet the medical care needs of the elderly, poor adults not living in families with children, and the self-employed. The Administration's health strategy also makes provision for these groups.

First, it proposes to eliminate the premium now charged aged beneficiaries for outpatient protection. This change will save elderly persons an estimated $1.4 billion a year in premium payments, offset in part (by $400 million) in additional cost-sharing. It will be financed by changing Social Security payroll deductions. Second, the Administration proposes that Medicare beneficiaries be enabled to use their coverage to enroll in a health maintenance organization.

FHIP will replace only the family portion of Medicaid. The Medicaid program for adult categories—providing medical assistance for the aged, the blind, and the disabled—will continue unchanged. The Department of Health, Education and Welfare is reviewing this program to see how it might be improved.

In order to ensure that health insurance is available to self-employed persons and unemployed single individuals or couples, the National Health Insurance Partnership Act will require those insurance companies offering employer-employee plans to participate in pools that will make group plans available to any individual or family not eligible for this coverage. Premiums for these group plans will be subject to approval by the Department of Health, Education and Welfare, and the plans will be required to provide the same minimum benefits as employer-employee plans. Although the plans will not be subsidized, individuals enrolled in them will be able to take advantage of savings possible through group coverage. The group plans will also ensure that no one is denied coverage because he is a "poor risk."

Regulation of the Health Insurance Industry. In the past, some insurance carriers have abused their trust by not conveying to the consumer with clarity the coverage and exclusions in his contract. Some have failed to perform claims and utilization reviews, or excluded high risk groups, or cancelled policies suddenly. The Administration proposes to regulate the insurance industry, which is essentially unregulated at this time. Not only will the abuses be prevented in the future, but citizens will have better and cheaper coverage through competition among carriers.

Additional Benefits in the Future. As the economy expands, and additional resources become available for health services, it should be feasible to add benefits to both parts of the National Health Insurance Partnership plan. Among the range of alternative benefits, the most desirable addition that can be foreseen at this time would be for outpatient psychiatric care, prescription drugs, and dental care for children. Besides additional resources for these purposes, we shall also need to develop techniques with which to review and evaluate the utilization of these services, to avoid either under- or over-utilization.

These, then, are the Administration's health insurance proposals. They are national in scope; they draw upon the strengths of both the private and public sectors; they offer the means for correcting past weaknesses. The Administration's plan lowers financial barriers to health care, enlarges the benefits, and affords a number of opportunities for bringing costs within a reasonable range.

Summary of Efforts to Control Medical Costs

The Administration's proposals contain an interrelated set of measures to reduce the inflation in medical costs. The objectives are twofold: to reduce the annual per capita expenditures on medical care, and to reduce the unit cost of providing care.

With respect to reducing the rate of increase in annual per capita expenditures, the relevant proposals of the Administration are those that: emphasize a broad and concerted preventive effort, including the actions that citizens may take on their own to reduce the need for care; the reduction in unnecessary utilization of services through scaled deductibles and coinsurance in the health insurance plans and through co-payments under Medicare; and the availability of low-cost group insurance rates for those people now covered by high-cost individual plans.

With respect to reducing the rate of increase in the unit cost of providing care, the relevant proposals of the Administration are those that: encourage the establishment of health maintenance organizations, with their own built-in incentives for efficiency; strengthen State and local planning capability to rationalize expenditures on capital facilities and other resources; promote the use of physicians assistants and other assistants of physicians and dentists, as well as capital equipment, to substitute less-expensive care without a loss in quality; prospective reimbursement experiments under Medicare; ceilings on physicians' fees; and review for quality and performance by Professional Standards Review Organizations—to reduce unnecessary surgery and the maintenance of under-utilized but expensive facilities (such as seldom-used open-heart surgery teams), as well as improper utilization of health care resources.

While it is impossible at this time to specify the degree to which these anti-inflationary measures will be successful, or their precise effects in reducing the rise in medical costs, they constitute a knitting together of an array of means with which to attack this problem. As other reasonable courses of action present themselves for controlling medical costs, they will be adopted.

The CHAIRMAN. Mr. Secretary, Senator Byrd of Virginia asked you last April 26 for 5-year cost estimates under your bill. These estimates were not available by May 27 when the hearing record was printed. Do you have those estimates of cost now?

Secretary RICHARDSON. Yes; we do, Mr. Chairman. I believe they are included in the material furnished to the committee.

The CHAIRMAN. Within the White Paper?

Secretary RICHARDSON. We have them. I have them here and can offer them for the record.

The CHAIRMAN. I wish you would, because I don't know just where they are included in the material you have before the committee.

Secretary RICHARDSON. I was in error, Mr. Chairman. You don't have them yet, but I can offer them for inclusion in the record at this point.

The CHAIRMAN. You don't have them available to recite right now for some reason, Mr. Secretary?

Secretary RICHARDSON. This book is so fat it will take a minute to find it, but we have it here.

(The information referred to follows:)

5-YEAR COST ESTIMATES

Attached are the fiscal 1974 estimates of the costs of S. 1623 and H.R. 7741, based upon the Department's study of all national health insurance proposals performed early this year.

Because of:

uncertainties as to the enactment date of H.R. 1;

the recent implementation of Phase II;

the desire at the time these bills were proposed to coincide the time of the implementation with that for Welfare Reform;

the availability of some later population data from the Census;

the availability of later cost and eligibility numbers from the States; and

we are preparing to submit later Administration cost estimates for FY 1974—78 for the Executive Sessions. These would include updating of the fiscal 1974 estimates and completion of the estimates for the following years.

NATIONAL HEALTH INSURANCE PARTNERSHIP ACT (S. 1623 AND H.R. 7741) 5-YEAR COST ESTIMATES

[In billions of dollars]

	Fiscal year—				
	1974	1975	1976	1977	1978
S. 1623	[1] 2.6	(1)	(1)	(1)	(1)
H.R. 7741	[1] 3.0	(1)	(1)	(1)	(1)

[1] Because of uncertainties as to the enactment date of H.R. 1, the recent implementation of phase II, the desire at the time these bills were proposed to coincide the time of the implementation with the welfare reform, the availability of some later population data from the census, and later cost and eligibility numbers from the States, we will be preparing later administration estimates including an update of fiscal 1974 and completion of estimates for the following years.

The CHAIRMAN. Mr. Secretary, as your predecessors would advise you, I am always interested in what something costs.

Secretary RICHARDSON. So are we, Mr. Chairman, and indeed some have accused us of being too cost conscious in the recommendations embodied in our bills.

Mr. Chairman, it might save time if we have it understood that we will furnish this at this point, or come back to it in the discussion as soon as we can find it.

The CHAIRMAN. All right, sir. While you are looking for that then, I, too, want some additional information that Senator Long asked for on April 26. As I recall from the hearing record, he wanted a State-by-State analysis of which States would have medicaid benefits not covered by your bill, and what the fiscal relief for each State would be under your bill.

I have used a figure of about $1.8 billion in total. I think that came from your Department actually, but I have not seen a State-by-State analysis of the distribution of those savings. They were not submitted at the hearing before the Finance Committee record closed on May 27 last.

Secretary RICHARDSON. We have done a great deal of work on this since then, Mr. Chairman, and we have a breakdown that could be inserted at this point. The $1.8 billion figure you used is approximately correct, although we anticipate that there might continue to be some continuing supplementation by the States of the basic benefits provided for in the family health insurance plan.

So, we are currently using as the total savings to the States a figure of $1.1 billion, assuming moderate supplementation might lower this to about $0.5 billion.

(The information referred to follows:)

IMPACT OF FHIP ON STATE MEDICAID BUDGETS

The attached data prepared by the Medical Services Administration shows the potential range in impact upon States ARDC-Related Mediccaid expenditures if FHIP is enacted.

This range is from $1.9 billion if no State supplements coverage, to $0.5 billion if all States fully supplement up to present Medicaid benefit levels all who would have been Medicaid beneficiaries.

The official Department estimate of FHIP's impact, issued on the 1st of August, was based on moderate State supplementation. Prediction of State behavior is difficult, although it is believed that if FHIP is enacted State savings under FHIP will be used to maintain current levels of care for at least those now covered by Medicaid. Thirty-four States and jurisdictions would spend $525 million less than their current AFDC-Medicaid expenditures in F.Y. 1974 even if they supplemented to maintain current levels.

IMPACT OF FHIP ON THE STATE MEDICAID BUDGETS

As background information for the Secretary's testimony before the Ways and Means Committee, MSA has prepared estimates of the probable impact that implementation of FHIP would have on the budgets of the States with Medicaid programs.

Two sets of estimates were prepared: the maximum which the States would save, assuming that with the implementation of FHIP, States would eliminate their Medicaid program for AFDC persons; and the more likely assumption that States would supplement FHIP at least for those currently receiving Medicaid benefits to assure that their health benefits were maintained at the current

level (i.e. States which currently provided services not in FHIP, such as dental care, would continue to do so, presumably with some of the funds saved on the services provided by FHIP).

We used two methods to prepare each estimate. The results, in general, were remarkably similar. The first was based on the States estimates of their total expenditures and their expenditures for items probably not included in FHIP. The second was based on estimates by the National Center for Social Statistics of the numbers of families probably eligible for Medicaid and estimates, by MSA, of the discrepancies between the average value of the FHIP package and the average value of the Medicaid package in that State to an AFDC cash assistance recipient. A detailed description of the methodologies and their limitations was forwarded in September; additional copies are available from MSA/OPPE.

Maximum savings to the States

The maximum savings to the States with the enactment of FHIP, would occur if States could simply withdraw from their AFDC Medicaid program leaving FHIP and counties, local agencies and charities to cover the costs of providing health services for the poor. It is estimated that if current law were extended, total Medicaid expenditures in this category would be $4.2 billion, of which $2.3 billion would be Federal and $1.9 billion would be State. If the States cancel AFDC-Medicaid, then they would save their full budget for that activity, or $1.9 billion. The largest savings would occur in the States with the largest Medicaid programs—New York, California, Pennsylvania, Illinois, Michigan, Massachusetts.

Probable savings if supplementation

On the other hand, the states which have been providing the major Medicaid benefits are the least likely to eliminate their programs. Their health insurance coverage for the poor contains many benefits not available through FHIP—e.g. prescribed drugs, dental care, unlimited hospital and physician services. Unlike the FHIP package, 32 states provide dental care, 33 states provide eyeglasses, hearing aids and other prosthetic devices, 46 states provide prescription drugs. Furthermore, many of the states are likely to absorb at least some of the cost of the FHIP premiums, deductibles and copayments.

If the states continue to cover, for their current recipients, those services not provided in FHIP, then the states would have to supplement the FHIP program with expenditures (not Federally matched) of almost $1.4 billion. Even with supplementation, most of the states would spend less on the medical care for their AFDC population than they currently expect to spend under Medicaid. In fact, 34 states and jurisdictions would spend $525 million less than their current AFDC-Medicaid budgets. The cost of state supplementation would exceed by $50 million the AFDC-Medicaid budgets of some 18 states. Generally, these 18 states are those with extremely favorable Federal Medicaid matching—e.g. Alabama, Georgia, Kentucky, Mississippi, North Carolina and South Carolina, who would obviously suffer most by lack of Federal matching of their supplementation. It is, not very likely that they would fully supplement the Medicaid package, and therefore, probable state savings under FHIP would be close to $500 million.

Thus with state supplementation of FHIP, the probable expenditure for medical assistance to families would total $4.9 billion and be distributed roughly as $3.2 billion Federal, $1.4 billion state and .3 billion, recipients in the form of premiums, deductibles and copayments not covered by state supplements. This compares to the anticipated expenditures for AFDC-Medicaid under current law of $4.2 billion of which $2.3 would be Federal and $1.9 would be state expenditures.

ESTIMATED MEDICAID EXPENDITURES FOR AFDC, 1974, CURRENT LAW

[Amounts in thousands]

	Total	Federal	State and local	Cost of State supplementation to provide present benefits, not in FHIP to current eligibles	If FHIP and State supplementation	
					States costs beyond State anticipated medicaid budget	State savings from State anticipated medicaid budget
Alabama	$62,025	$48,646	$13,379	$19,042	$5,663	
Alaska						
Arizona						
Arkansas	4,633	3,680	953	950		$3
California	834,316	417,157	417,157	311,200		105,957
Colorado	17,043	9,819	7,225	5,709		1,516
Connecticut	67,346	33,674	33,674	26,938		6,736
Delaware	8,695	4,348	4,348	2,513		1,835
District of Columbia	50,320	25,161	25,161	12,177		12,984
Florida	50,460	30,614	19,846	15,491		4,355
Georgia	67,484	47,016	20,468	20,716	250	
Guam	186	94	94	36		58
Hawaii	14,359	7,300	7,060	5,356		1,704
Idaho	6,525	4,669	1,856	1,618		238
Illinois	216,383	108,192	108,192	83,740		24,452
Indiana	50,039	27,546	22,492	19,565		2,927
Iowa	26,299	15,272	11,027	12,676	1,649	
Kansas	31,506	18,608	12,898	14,241	1,343	
Kentucky	45,946	33,766	12,180	16,035	3,855	
Louisiana	30,358	22,311	8,048	4,979		3,069
Maine	24,844	17,248	7,594	5,838		1,756
Maryland	56,026	28,013	28,013	12,550		15,463
Massachusetts	144,552	72,276	72,276	40,908		31,368
Michigan	183,761	91,881	91,881	56,047		35,834
Minnesota	26,319	14,995	11,364	11,186		178
Mississippi	20,000	16,600	3,400	6,140	2,740	
Missouri	22,066	13,135	8,929	7,966		963
Montana	5,196	3,491	1,705	2,312	607	
Nebraska	13,918	8,140	5,779	6,290	511	
Nevada	5,545	2,773	2,773	2,118		655
New Hampshire	7,984	4,740	3,244	3,505	261	
New Jersey	137,798	68,898	68,899	38,997		29,902
New Mexico	15,515	11,268	4,246	7,105	2,859	
New York	889,105	444,552	444,552	337,860		106,692
North Carolina	48,440	35,284	13,157	17,487	4,330	
North Dakota	3,876	2,762	1,113	1,694	581	
Ohio	97,469	52,292	45,177	38,110		7,067
Oklahoma	83,722	57,785	25,937	17,163		8,774
Oregon	18,477	10,603	7,874	6,651		1,223
Pennsylvania	262,000	145,279	116,722	74,146		42,576
Puerto Rico	80,978	20,863	60,115	6,559		53,556
Rhode Island	17,066	8,577	8,488	6,297		2,191
South Carolina	28,285	22,064	6,223	10,211	3,988	
South Dakota	3,345	2,332	1,014	1,030	16	
Tennessee	16,757	12,458	4,302	4,507	205	
Texas	124,863	81,386	43,477	38,333		5,144
Utah	12,613	8,812	3,799	5,070	1,271	
Vermont	12,458	8,061	4,397	4,036		361
Virgin Islands	1,269	534	736	147		589
Virginia	89,303	57,180	32,122	27,416		4,706
Washington	59,051	29,525	29,525	19,192		10,333
West Virginia	29,059	22,367	6,692	11,594	4,902	
Wisconsin	79,186	44,565	34,620	48,066	13,446	
Wyoming	910	571	339	216		123
Total	4,205,679	2,279,143	1,926,542	1,449,729	48,477	525,288

The CHAIRMAN. You will recall that in H.R. 1 in the medicaid portion of the bill, we did relieve the States of the necessity of enlarging their medicaid expenditures as a result of our perhaps broader definitions or eligibility for cash payments under the welfare programs.

Secretary RICHARDSON. Yes.

The CHAIRMAN. You will recall that. Do we assume that, or under this, would the States have to assume that under this bill?

Secretary RICHARDSON. No. We wouldn't affect this. We are proceeding on the basis that the family health insurance plan provides

adequate minimum benefits for all families. The problem arises only with respect to the adult categories which continue to be eligible under medicaid, and there to the extent that H.R. 1 would increase the number of eligibles.

We would not propose at this point to mandate the extension, although I think it is reasonable that the committee should consider this because when you had H.R. 1 before you, you did not have the prospective savings to the States that would result from the substitution of a new Federal program for medicaid.

So, the States could extend medicaid to these new eligibles, with some reduction of the $1.8 to $1.9 billion savings. We anticipated that they would be likely to do that even if not required, and that is why I said a moment ago that we are using the $1.1 billion as the fiscal relief to the States rather than the total, assuming that they did nothing to supplement FIP. This is about midway between the $1.9 maximum and the $0.5 minimum savings estimates.

The CHAIRMAN. Mr. Secretary, without objection, this information that I asked for earlier will be included in the record at the point where the request was made. Is there any objection? None is heard.

Mr. Secretary, you told the Finance Committee last spring that this bill would cost employers and their employees an additional $5 billion to $7 billion, I believe, above current premium payments, is that right?

Secretary RICHARDSON. Yes, sir. I think we have somewhat better figures now than we did then.

The CHAIRMAN. If you will let me have those better figures.

Secretary RICHARDSON. It is about $3.6 billion. The cost figures are set forth, which I am looking at now, on page 88 of the Ways and Means committee print entitled, "Analysis of Health Insurance Proposals" introduced in the 92d Congress."

The CHAIRMAN. Page what, now?

Secretary RICHARDSON. Page 88.

The CHAIRMAN. These are our own estimates or are these departmental estimates?

Secretary RICHARDSON. They were furnished to the committee by the Department. It shows as the health insurance total cost in the private sector in the absence of this new legislation a total of $26.4 billion with transferred costs of $3.3 billion and induced costs of $1.2 billion which raises the total private health insurance bill to $30 billion which is the $3.6 billion over the present forecast cost.

The CHAIRMAN. What part of that increased cost will be borne by the employer and what part by the employee under your bill?

Secretary RICHARDSON. In the first two and a half years, 65 percent of the premium would be paid by the employer and 35 percent by the employee. After that two and a half year period the ratio would become 75–25.

The CHAIRMAN. Mr. Secretary, you propose to eliminate that part of medicaid which covers most welfare families, do you?

Secretary RICHARDSON. Yes.

The CHAIRMAN. Do you agree or not that the major cost of the medicaid program would remain since FHIP would select out what may be considered the best risks, the younger poor families, and leave the aged and disabled and the blind. Is there anything to that point?

Secretary RICHARDSON. I think it is true, Mr. Chairman, that the costs associated with the health care of the aged, disabled, and blind are higher than they would be in the families which are covered under this program, but, of course, the result remains nonetheless that this program would reduce, as you pointed out earlier, the States' share of medicaid expenditures by $1.8 to $1.9 billion if they do not supplement benefits to families and $1.1 billion if they do adopt moderate supplementation or to $0.5 billion if all States fully supplement by providing all present medicaid benefits.

The CHAIRMAN. All right. Now, if this approach is good for families, why isn't it also good for the blind and the disabled?

Secretary RICHARDSON. I think the only possible answer to that is that there would be significant increased costs in some States.

The CHAIRMAN. I know, but what concerns me is that it seems that we have one program now and as a result of this approach we split that up into two programs. Is it advisable for us to do that? Are we doing it just because of the additional cost or why?

Secretary RICHARDSON. The only important reason, Mr. Chairman, is additional cost.

The CHAIRMAN. All right.

Secretary RICHARDSON. There is the consideration further, which is also a cost consideration, but a slightly different one, that if we were to include particularly the aged, although the problem also exists to some extent with respect to the disabled, we would be faced with the question of how to finance the cost of long-term care. We are working very hard on this question, Mr. Chairman, recognizing that there are certain inherent difficulties with a system that involves medicare for hospitalization and extended health care of the aged, medicaid to pick up skilled nursing home care and longer term care, and with a different program for families. We see no way out at the moment of retaining medicaid at least for long-term care and so we concluded that it would be appropriate in conjunction with welfare reform to initiate a new fully federalized program of health insurance for families at this time, leaving further steps for the future.

The CHAIRMAN. Mr. Secretary, have you had any outside group such as the actuaries within the health insurance area evaluate the costs of your program to check their costs against your own estimates?

Secretary RICHARDSON. Yes, Mr. Chairman. The figures that we have furnished for the costs of this program and the other proposals pending before the committee which are included in the August committee print entitled, "Analysis of Health Insurance Proposals," were developed by the Office of the Actuary of the Social Security Administration.

The CHAIRMAN. In consultation with these other actuaries or not?

Secretary RICHARDSON. You mean outside the Department?

The CHAIRMAN. Yes.

Secretary RICHARDSON. We have reviewed them with actuaries representing the health insurance industry and with other actuaries in the Federal Government also, including the Commerce Department.

The CHAIRMAN. I know, but we had this same problem when we began medicare. Also to some extent, we looked at it in medicaid, not

enough perhaps, but we did look at it. Maybe the better word is to say we scanned medicaid.

At any rate, at the time we were discussing medicare initially the Department's estimate and the estimates given us by these outside actuaries in insurance and elsewhere were at great variance and we had some difficulty in arriving initially at any real accurate conclusion as to what that program would entail.

We were assured by those within the Department that their estimates were right. It turned out that they were not, that even the estimates by the actuaries within the insurance business were low compared to what we later experienced. That is why I am asking these questions. Do they agree with your estimates or do they have higher estimates of cost? We will find out from them later, but I just wanted to get the whole picture in the record at this point.

Secretary RICHARDSON. The committee print describes the methodology used. Mr. Chairman, and I think it is quite candid in pointing out the inherent difficulties in arriving at firm estimates, particularly of induced costs which are defined in the committee print as the costs that are brought about through the greater utilization which results from freer access to care.

But I understand that the outside actuaries have agreed with the methodology that was used in developing these estimates.

The CHAIRMAN. But on the basis of their use of the same methodology, how much variation is there between your people and their people as to the costs?

Secretary RICHARDSON. I would have to ask Mr. Trowbridge, the Chief Actuary.

Mr. BALL. They thought we might be a little high, Mr. Secretary, for the Administration plan.

Secretary RICHARDSON. Mr. Ball.

The CHAIRMAN. All right, Mr. Ball. You were at that table in 1965, when we tried to ascertain the costs of medicare.

Mr. BALL. Mr. Chairman, I was there when our actuaries were debating the private insurance actuaries and they were both wrong.

The CHAIRMAN. If you are going to speak to this subject, give us a better estimate than we had in 1965.

Mr. BALL. All I am doing, Mr. Chairman, is just being a relay from Mr. Trowbridge back here who said that our estimates for the Administration plan were first thought to be somewhat high by the private insurance actuaries on this point. If you want to go into that further, I suggest that he come up here himself.

The CHAIRMAN. I don't want to delay it. We will compare notes later, but at this point, you are above the insurance actuaries' estimates. That is most reassuring.

Now, Mr. Secretary, let me go to what I think are some strange anomolies within your bill. I am not taking issue. I am merely trying to learn and I shall through the course of the hearings, not only on your bill, but all of the other bills. I want to put the critical eye on this one right now since you are here.

You include among the benefits one routine eye examination a year for children under 12, do you?

Secretary RICHARDSON. Yes.

The CHAIRMAN. That is whether done by a physician or an optometrist?

Secretary RICHARDSON. Yes.

The CHAIRMAN. Yet the bill would also cover all eye examinations for all members of the family if the examination is done by a physician, but not by an optometrist; is that right?

Secretary RICHARDSON. I hadn't been aware of that, Mr. Chairman.

The CHAIRMAN. Maybe it is good that I am calling this to your attention.

Secretary RICHARDSON. We expect to profit greatly, Mr. Chairman, from this.

The CHAIRMAN. I was going to ask you your reasoning as to this anomoly, but if you will put that in the record maybe you want it changed in the bill.

(The information referred to follows:)

VISION CARE AND OPTOMETRY BENEFITS UNDER NHIPA

Vision care as a physician's service would be provided under H.R. 7741 or S. 1623 in the same manner as other physician services. Namely, without durational limit under NHISA and as part of the physician service coverage of up to 8 visits per eligible per year under FHIP. Medical necessity and peer review activities would apply.

It is also intended that children under the age of 12 be insured for one routine eye examination, even if by a licensed optometrist, in each calendar year. This would not count against the 8 visit general limit under FHIP. Such service as originally proposed would be subject to any applicable deductible or coinsurance, but as a form of well-child care, we would consider elimination of such cost-sharing on these services during Executive sessions.

The purpose of this additional benefit is to increase the financial availability, and encourage the beneficial results of diagnostic vision services for children. Other considerations, primarily cost and lack of broadly-based insurance experience, are reasons for not including a similar benefit for adults.

The CHAIRMAN. I am not being critical. I just want to know why.

Secretary RICHARDSON. I understand. There are going to be a number of changes we would want to make that have resulted, some of them already, by the review of the bill by various people, including the staff of this committee, but we felt that rather than try to do this in a piecemeal way we would defer this sort of technical amendment and improvement until the committee had had a full opportunity to consider it and until indeed the committee decided that it wished to move in the direction of the general strategy set forth in the legislation.

The CHAIRMAN. You suggest that we mark a ring around this part for further consideration and possible amendment.

Secretary RICHARDSON. Yes. There are quite a number of these things as you are aware.

The CHAIRMAN. In your benefit provision you require a deductible equal to the reasonable cost of the first 2 days of hospital care.

Secretary RICHARDSON. Yes.

The CHAIRMAN. How will anyone know at the time of hospitalization just what the reasonable cost will be for the first 2 days?

Secretary RICHARDSON. We propose, Mr. Chairman, to adopt the practice for this purpose that has been applied in determining the deductible for medicare which is to proclaim a uniform flat deductible.

The CHAIRMAN. You will have to change the bill in that respect.

Secretary RICHARDSON. It would have to be changed.

The CHAIRMAN. The reason I asked the question is that I was aware of the letter that came from your Department to the GAO in which it was said that we have delays of several years in determining reasonable cost of hospitalization under medicare. With respect to the deductible under medicare, is what I am talking about.

Secretary RICHARDSON. There is a different sort of lag here in the process of determining the payment.

The CHAIRMAN. I don't want to go into it and take lengthy time here, but there is another point we can circle.

Secretary RICHARDSON. Yes.

The CHAIRMAN. You would require that all the basic health policies in the entire Nation must reimburse physicians on the same basis is medicare; is that right?

Secretary RICHARDSON. Yes.

The CHAIRMAN. Now, even if this is good policy, and I wonder and I guess you think it is, how would the hundreds of health insurance carriers obtain access to all the physician charge profiles which medicare carriers maintain now and how would we know who should pay for the data?

Secretary RICHARDSON. We believe, Mr. Chairman, that for this reason and also in order to make patients aware of the physicians who have agreed to accept assignments at the published rates, that these should be published for the areas to which they apply.

The CHAIRMAN. You would get the form that way, itself.

Secretary RICHARDSON. Yes.

The CHAIRMAN. In the basic employer plan services are covered I believe under language that says "if needed," is that right? In the basic employer plan services are covered. Did I read the bill right?

Secretary RICHARDSON. Yes.

The CHAIRMAN. That phrase is not included in the bill with respect to the benefits under FHIP. Are poor families to get this care even if they don't need it?

Secretary RICHARDSON. No. I think we intend it in both cases.

The CHAIRMAN. That is another area we need to look to then for possible amendment.

Secretary RICHARDSON. Yes.

The CHAIRMAN. Your bill would require each health plan to arrange to avoid overlapping or duplicate coverage and I think that is highly desirable. How would you do this?

Secretary RICHARDSON. We are not satisfied, Mr. Chairman, that we can fully and adequately answer that question at this stage.

The CHAIRMAN. My point is that I doubt that it is done in the bill as it now stands.

Secretary RICHARDSON. No, I don't think it is clear enough in the bill. It needs to be made emphatically clear that the insurance carriers are required to institute measures to prevent such duplication.

The CHAIRMAN. All right. That either needs to be done within the bill or have you given authority through regulation to do that then?

Secretary RICHARDSON. Yes.

The CHAIRMAN. You include deductible and coinsurance provisions in your basic plan in part I suppose to introduce some controls on utilization of services.

Is that your reasoning or is it some other reasoning?

Secretary RICHARDSON. That is the primary reason, Mr. Chairman. The secondary reason is a matter of relative cost.

The CHAIRMAN. But you permit the basic plan to be supplemented with a plan which would cover all the deductibles in coinsurance. That involves cost.

To the extent that this happens you would lose all of the utilization control element, would you not?

Secretary RICHARDSON. Yes, Mr. Chairman, but I think there are two reasons why we did not feel that we could go so far as to try to prevent such supplementary coverage.

One is that this would represent a rather drastic interference in freedom of relation between employer and employees and choice with respect to prepayment plans and the second is that the same cost considerations don't apply.

In proposing to require all employers to make a basic insurance plan available to their employees we are in effect mandating an additional business expense to all these employers to the extent of 65 percent of the cost in the beginning and later 75 percent so that this is why we couldn't go further from the cost point of view.

But there is no reason why we should tell an empoyer and his employees that they shouldn't share a higher total premium if they chose to do so.

The CHAIRMAN. I am not arguing with you. I am just trying to get your thinking at this point. In the plan for low income families you provide most of the exclusions to coverage which also apply in the medicare program, do you not?

Secretary RICHARDSON. Yes.

The CHAIRMAN. But in the employer plan that would cover regularly employed workers and their families you do not have these exclusions, do you?

Secretary RICHARDSON. There is some variance and the problem here really is attributable partly to the higher utilization and incidence of illness as the actuary estimates it with respect to the family health insurance plan.

The CHAIRMAN. Let me ask you if you really intend this result and let me give you an example.

The basic employer plan would have to cover a physician who treats his own family and all of the services of a podiatrist including cutting corns, warts, callouses, and so forth. Do you intend this?

Secretary RICHARDSON. I think the short answer is yes.

The CHAIRMAN. You do. Your bill would not cover the services of a psychiatrist, yet would cover treatment of mental conditions by a physician who is not a psychiatrist.

Did you intend that? And why is it a good idea if you do?

Secretary RICHARDSON. The problem is the problem, Mr. Chairman, of coverage of psychiatric services generally. This is an area in which as you well know there has been relatively little experience on the part of insurance programs and it means therefore that firm estimates of utilization are very difficult to reach.

Of course there would be an additional element of cost. As I mentioned in my prepared statement we would hope to be able, at a sec-

ond stage, to expand coverage or rather to expand benefits to include psychiatric services but the exclusion of care specifically of a psychiatrist as distinguished from the mental health care of a physician is simply a function of the conclusion that we couldn't propose to cover psychiatric services generally.

The CHAIRMAN. Mr. Secretary, on the cost estimates again for your bill, have your actuaries taken into account that the basic health plan for employees would be required to cover the following items?

One, all of the services of podiatrists including routine foot care; two, services which are required because of an act of war; three, all routine physical checkups; eye examinations when performed by a physician; hearing examinations performed by a physician; and cosmetic surgery performed by a physician.

Secretary RICHARDSON. I can only assume that they have, Mr. Chairman, but I will make sure what the answer is and supply it for the record.

(Information referred to follows:)

ACTUARIAL ASSUMPTIONS REGARDING DEFINITIONS OF COVERED SERVICES

In estimating H.R. 7741 and S. 1623 costs, the Department's actuaries assumed that present Medicare definition of covered services would apply whenever appropriate, and that medical necessity provisions would be administered by the insurance carriers underwriting the risks.

Thus, for instance, purely routine physical exams, would not always be reimbursed where there is no diagnosis or injury, nor would eye examinations by physicians other than opthalmologists or otolaryngologists, podiatrists services not comparable to eligible physicians services or cosmetic surgery except as part of medically necessary improvements of vital functions, and so forth. Routine eye and hearing care by a physician would be covered under the program, if determined to be medically necessary by the carriers. Carrier determinations would be guided by peer review.

The CHAIRMAN. Now I have one that I think amused me more perhaps than any other and I wonder what is the reasoning back of it.

I wonder why you used the figure 350 hours as the point at which the employer has to give his employee coverage. If a man goes to work at a regular 8-hour, 5 days a week, 40-hour week job, the employer would have to offer the coverage at 3 p.m. on Thursday of the ninth week of employment.

I was wondering why 3 p.m. on Thursday?

Secretary RICHARDSON. Mr. Chairman.

The CHAIRMAN. I am not being facetious. There must be some reasoning. Do you want to avoid a Friday, the 13th. I wonder.

Secretary RICHARDSON. I don't think we were really that ingenious, Mr. Chairman. We are simply seeking to deal with the situation in which an employee might work somewhat irregularly and in order to determine when an employee could be considered in effect full-time so as to justify the requirement that the employer include him.

To refer only to the number of weeks within which he works or the number of days seemed inadequate to try to deal with that problem of irregularity.

The CHAIRMAN. Mr. Secretary, I am assuming now and you tell me if I am incorrect but I just assume that you prefer Senator Bennett's bill S. 1663 over Mr. Byrnes' bill H.R. 7741, do you not?

Secretary RICHARDSON. I don't think I can endorse the word assumption as applied to this, Mr. Chairman.

The CHAIRMAN. I just wondered where Senator Bennett's bill came from. He is a brilliant Senator. Maybe he developed it himself.

Secretary RICHARDSON. No; the history of the matter is very simple, Mr. Chairman.

The CHAIRMAN. I am not interested in going into that. I just want to know frankly what would be the cost of this provision that was written into Mr. Byrnes' bill I assume after it left the White House.

Secretary RICHARDSON. We estimated it at about $400 million, Mr. Chairman.

The CHAIRMAN. I know Mr. Byrnes, like I am, is interested in all possible savings. I am not surprised that he saw evidence here to justify it.

Secretary RICHARDSON. He was concerned, Mr. Chairman, with the situation of the small employer.

The CHAIRMAN. I am going to yield to him now. Don't you think it is better to let him speak to the point.

Secretary RICHARDSON. Yes; by all means.

Mr. BYRNES. Mr. Chairman, I would be glad to take the witness chair on this point.

The CHAIRMAN. Not the witness chair. I am just trying to give you a chance to respond.

Secretary RICHARDSON. I felt it only necessary, Mr. Chairman, to make clear that your initial assumption is not entirely founded.

The CHAIRMAN. That is all I wanted was that assurance from you that your prefer the Byrnes' bill to the bill introduced by Senator Bennett.

Mr. BYRNES. Mr. Chairman, I think it should be recognized that there is a difference of opinion between the Secretary and myself and it is my understanding that as far as the President is concerned, he is not taking sides on that particular issue.

If that is a fair presentation of the situation, Mr. Secretary, tell me.

Secretary RICHARDSON. He regards this as a matter for the wisdom and judgment of this committee.

The CHAIRMAN. I commend the President for not getting into a controversy between my two good friends, Senator Bennett and Mr. Byrnes. He is to be commended.

Mr. BYRNES. Mr. Chairman, I have no questions at this time but I do want to compliment the Secretary on his statement and also the basic material prepared by your staff for our use as we get into this most complex subject matter.

I think you have done a very fine job on the preliminary basic material that we need and I want to express my appreciation.

The CHAIRMAN. There is no question about that, Mr. Secretary, that you and your department as usual have been very helpful this morning.

We will expect you to be even more so when we get you in Executive Session.

Secretary RICHARDSON. We look forward to that, Mr. Chairman.

The CHAIRMAN. Mr. Betts?

Mr. BETTS. Mr. Secretary, I want to followthrough what the chairman and Mr. Byrnes have said. I think your presentation shows a lot of work and a lot of thought.

I certainly want to compliment you and the Department and the staff and everybody who had a part in it. I have no particular question but some observations. I think, when we get into the meat of it in the executive session.

I have also been concerned a little bit about the rationale of the 65 percent–35 percent differential between employer and employee and then in two and a half years becoming 75–25. Why isn't it 50–50 like the social security? There must be some reason.

It has always seemed to me that health was as important as security. Is that a compromise between the unemployment compensation tax in which the employer pays all and the social security which is half and half?

Secretary RICHARDSON. Well, I think one answer to this, Mr. Betts is that health insurance is in a sense a current fringe benefit. There is a range in participation by employer and employee under collective bargaining plans, but in some instances the employer covers the full cost.

So we really came down in effect about midway between the two extremes within the collective bargaining process.

The average as it turns out currently is about 70 percent under present employer-employee plans.

Mr. BETTS. In other words, the rationale is it is more or less of a compromise.

Secretary RICHARDSON. Yes, but a compromise which reflects the realities of the situation.

Mr. BETTS. I assume from some of your statements that the whole problem is bound up with some other legislation, is that correct?

In other words, you mentioned that the cost of services and the like, that problem will find some solution in phase II. Would you care to comment on that?

Secretary RICHARDSON. Yes. Well, phase II of course is a considerably more far reaching approach to the restraint of cost increases than we had proposed to have incorporated in permanent legislation.

Phase II will be the paramount reliance for containing cost increases so long as the authorities contemplated by that program are in effect.

But we also have developed legislation which we hope to submit to the Congress shortly that will reflect our approach to regulation as well as to the problem of cost controls to supplement the various provisions in H.R. 1 and in these bills now before you that are also addressed to this problem.

In other words, as I indicated in my testimony, the problem of cost restraints involves for example the utilization of health-maintenance organizations. It involves peer review, utilization review, the publication of the percentile of Federal participation in fee schedules.

I have, and I am looking for it at the moment, a list of all the elements of all our legislation that involves cost constraints of one form or another, Mr. Betts, and I would think it would be appropriate to have it inserted in the record at this point.

Mr. BETTS. I think it should be.

The CHAIRMAN. Without objection it will be included in the record at this point.

(Information referred to follows:)

LIST OF COST CONSTRAINTS

The attached illustrates the types of cost controls—in addition to the temporary Phase II Economic Controls—which would be in force under the National Health Insurance Partnership Act.

The additional legislative documents to secure authority for the activities not already part of DHEW operations will be submitted to the Committee shortly, in the form of amendments authorizing Health Insurance Carrier Regulation and additional provides cost and provides controls.

NHIPA COST-CONSTRAINTS

A. On hospital/ECF charges

1. Reasonable Cost Reimbursement
2. Experimental Target Reimbursement (H.R. 1)
3. Authority to Disallow Exceptionally high costs (H.R. 1)
4. Authority to Disallow Unwarranted Capital costs and services costs
5. Incentive Reimbursement
6. Current Economic Policy
7. Posting of prices and access information.

B. On physician fees

1. Reasonable Fees
2. Index-Based Adjustments in prevailing charges (H.R. 1)
3. Experimental Methods (H.R. 1)
4. Current Economic Policy
5. PSRO and other peer and quality review.

C. On delivery system

1. Maximum use of Health Maintenance Organization
2. Professional Service Review Organizations
3. Utilization Review
4. Restructuring of Benefits Toward Ambulatory Care
5. Identification of geographic areas with over-supply as a condition of grants to states.

D. On carriers

1. Maximum use of HMO's
2. Cost Reimbursement for Public Plans
3. Public Disclosure of Retentions
4. Public Accountability through annual independent audit
5. Competition
6. All states to have rate filing and use authority to deny extraordinary NHISA rates.

E. On patients

1. Increased Information on Provider Charges for Standard Items
2. Deductibles encouraged, especially for Institutional care, for all but poor
3. Co-insurance encouraged for all but poor.

Mr. BETTS. I was simply observing that this measure has linked with it a lot of other legislation such as legislation concerning preventive care and increase in medical personnel and that this is only one part of a vast program to solve the problems in our overall national health program, is that correct?

Secretary RICHARDSON. That is correct.

Mr. BETTS. The answer to this question is probably obvious but I was thinking of the small businessman in whom Mr. Byrnes was interested in his bill, an employer of say three.

How does he get his health insurance? This bill requires him to take care of his employees. He is not incorporated. How does he take care of his health insurance?

Secretary RICHARDSON. He could either purchase it directly from an insurance company or he could elect to participate in the pool for his area that is also contemplated by this legislation.

The pool would be designed to provide lower cost group coverage for small employers and for individuals than they could otherwise obtain.

Mr. BETTS. So that the farmer or the small businessman can participate in his own program, is that correct?

Secretary RICHARDSON. Yes.

Mr. BETTS. I think that is important because as Mr. Byrnes pointed out the small businessman is going to have quite a financial burden in any program.

I am just interested in seeing that he has all the consideration possible. That was one of the reasons I was interested frankly in the 50–50 percent distribution of cost rather than 65–35.

Secretary RICHARDSON. Of course it was the concern for the additional cost to some employers especially smaller employers that led us to propose the 65–35 split in the first 2½ years with the increase in the employer contribution to 75 percent later on.

Otherwise we would have proposed a 75–25 differential of cost in the beginning.

Mr. BETTS. We are beginning to get letters on the proposal now and one of the things that has been called to my attention is this. Does this bill include, within the term surgery, oral surgery?

Secretary RICHARDSON. Yes; it distinguishes in coverage between oral surgery on the one side and more routine dental procedures on the other. The former are covered. The latter are not.

Mr. BETTS. Again I want to compliment you, Mr. Secretary, and we will see you in executive session.

Secretary RICHARDSON. Thank you very much, Mr. Betts.

The CHAIRMAN. Mr. Ullman?

Mr. ULLMAN. Mr. Secretary, let me see if I understand your program. First, insofar as the aged are concerned, you do nothing here to change the basic social security system to cover the older citizens?

Secretary RICHARDSON. That is correct.

Mr. ULLMAN. Second, you have mandated insurance coverage for virtually all employees in the Nation, the premiums to be split between the employee and the employer first on a 65–35 basis and after 2 years a 75–25 basis, right?

Secretary RICHARDSON. Yes.

Mr. ULLMAN. Then, what is the third aspect of your program now?

Secretary RICHARDSON. I think in following out the outline you have just started I would identify as the third major element the coverage of poor families in which there is no employed member covered under an employer plan.

This would be done under the family health insurance plan as a substitute for medicaid.

Mr. ULLMAN. Would you call this the federalization of medicaid?

Secretary RICHARDSON. Yes.

Mr. ULLMAN. In other words, you are federalizing medicaid, you are mandating private insurance coverage on the part of employers and you are leaving the elderly under social security?

Firstly, then, does this indicate that, in your judgment, the social security system, medicare I would say, is a permanent part of your strategy? There are a lot of people who would like to incorporate medicare in a new, all-encompassing national health insurance plan. Your basic judgment is that, looking ahead 10 or 15 years, you would say that medicare should stay as a separate program basically along the lines we have established.

Secretary RICHARDSON. Yes; and for two basic reasons.

First of all, we think that the same reason that employers and employees contribute to retirement benefits of the employee when he is no longer a wage earner makes it also logical that they should contribute to the cost of every medical care in a period when those costs are expected to be substantially higher than they are in his earlier years.

The other basic reason is that while there never seemed a very real prospect that private insurance arrangements could adequately handle health care coverage in the post retirement years, we think that with the measures that we have proposed to overcome deficiencies in private health insurance that it can do so for the years in which the employee is actively at work.

Mr. ULLMAN. Mr. Secretary, going then just to the two elements in your bill, the mandatory insurance for employees and the federalization of medicaid, do you think this really qualifies as a national health insurance program?

Secretary RICHARDSON. Yes; it would cover some 68 million working people and their families under the mandated coverage of the National Health Insurance Standards Act and it would cover 14.7 million people under the Family Health Insurance plan.

Mr. ULLMAN. These are people not now covered?

Secretary RICHARDSON. They are not all now, no. Many people under the Health Insurance Standards Act are already covered under employer-employee group plans through collective bargaining arrangements and so on.

Nonetheless though looking at the total population the coverage would amount to close to approximately 70 million working people and their families.

Mr. ULLMAN. Mr. Secretary, private health insurance, I understand, now covers about one-quarter of all health care expenditures.

What will the proportion be in the event that your recommendations become law?

Secretary RICHARDSON. I am sorry.

Mr. ULLMAN. Today private health insurance covers about one-quarter of all health care expenditures.

How would that be increased under your recommendations?

Secretary RICHARDSON. I would have thought that was a low figure. We estimated the total coverage by insurance of all health care expenditures as just under 75 percent under this program.

That is all third party coverage, in other words, all but the personal share, direct out-of-pocket share of all health care costs.

Mr. ULLMAN. I think we have a basic disagreement on the facts with respect to health care expenditures. That can be cleared up later. About four out of five Americans under age 65 have private hospital insur-

ance. How many more Americans would get hospital insurance as a result of your requirement with respect to employers?

Secretary RICHARDSON. The increase in hospital insurance is comparatively small, about 5-percent more. The increase in coverage that is brought about by this proposal is much more significant with respect to ambulatory and out-patient coverage which of course is important we think to reduce pressure on hospital beds and also catastrophic coverage which is under this proposal up to $50,000 for each individual.

Mr. ULLMAN. Going then to the physician's home and office visit, about 43 percent of Americans under 65 have insurance against those costs now.

How many more would have this protection under the employer require health insurance in your bill?

Secretary RICHARDSON. It would increase it to about 95 percent.

Mr. ULLMAN. From 43 percent to 95 percent?

Secretary RICHARDSON. Yes, if Government employee plans follow our benefit format.

Mr. ULLMAN. Just under this employer-employee requirement?

Secretary RICHARDSON. That also includes the expansion of coverage brought about by the Family Health Insurance plan too.

Mr. ULLMAN. Let me finally look very quickly to the Family Health Insurance program. There is also a problem of a notch in payment. I understand you have four categories of salary, of earnings in your proposal that would mandate different types of payments. I have asked the staff to prepare a chart on this. I would like to have them very briefly show it to you and have you comment on it because I think we have a real notch problem.

Would you make it available down below in some way so that as many members as possible can see it.

(The chart referred to follows:)

NOTCHES* UNDER FAMILY HEALTH INSURANCE
FAMILY OF FOUR

INCOME CLASS CHANGES	INCOME CHANGES	A NOTCH AMOUNT	B NOTCH AMOUNT
1 – 2	$3000 + $1	$40	$50
2 – 3	$3500 + $1	$50	$50
3 – 4	$4000 + $1	$55	$120
4 – 5	$4500 + $1	$160	$267.50
5 – INELIGIBLE	$5000 + $1	$695	$1512.50

EXAMPLE A. $1000 MEDICAL COSTS (INCLUDING 10 DAYS OF HOSPITAL CARE AT $40 A DAY ROOM AND BOARD CHARGE, $600 TOTAL HOSPITAL BILL).

EXAMPLE B. $2000 MEDICAL COSTS (INCLUDING 15 DAYS OF HOSPITAL CARE AT $50 A DAY ROOM AND BOARD CHARGE, $1200 TOTAL HOSPITAL BILL).

*NOT INCLUDING PREMIUMS

I think it is very important because what we have to look at is a workable plan. Hold it higher so that the Secretary can see it. What it shows is that the first income class is under $3,000. Under $3,000 it is 100-percent coverage on the part of the program. He has free medical care.

But if he has $3,001 income then he will have to pay a day's hospital care amounting to about $40.

Then you have a second category breaking at $3,500 and there will be an additional $50 if he has $3,501 because of what is it, a co-pay feature.

Secretary RICHARDSON. Yes.

Mr. ULLMAN. Is that what it is?

Secretary RICHARDSON. Yes.

Mr. ULLMAN. Then you have a third category at $4,000 which breaks at $4,000 and if he makes $4,001 then he has to pay an additional $55. What is that for?

Secretary RICHARDSON. Well, the increased amount is a combination in effect of deductibles and premiums.

Mr. ULLMAN. These are not cumulative however. These are new cost factors with the addition of $1 of income. Then at $4,501 you have another $160 that would have to be paid by the recipient. These are assuming a care in the hospital amounting to probably 10 days, total bills medical and hospital of around $1,000. Then if you go to example B. To a $2,000 cost, these figures substantially increase.

Would you agree that there is a notch problem here?

Secretary RICHARDSON. Yes, but I think it should be pointed out, Mr. Ullman, that between the $3,000 level and the $5,000 level you could if you chose reduce this problem by increasing the intervals instead of dividing them into fives.

The most serious problem as indicated in that chart is the one from $5,000 to ineligibility, but I would point out that in that connection when you come to the level of income shown there, there is likely to be a point at which somebody is employed in the family and we have tried to relate the family's share of costs under the Family Health Insurance plan with the family's share of costs in the National Health Insurance Standards mandated coverage so as to minimize this.

We think that the relative rate of increase of the family's share of costs has been made about as consistent as possible between, one, the objective of administrability and, two, the objective of elimination of a notch.

Mr. ULLMAN. That is a very critical problem. You see in this $5,000 category that if he makes $5,000 he gets pretty good coverage. If he makes $5,001 it would cost him on a $2,000 hospital bill $1,512. That is a rather major notch, is it not?

Mr. VENEMAN. I think Mr. Ullman, you are losing sight of one point. That is that when that person's earnings reach that $5,000 level presumably that person would be in the employment market. He would be then covered under the employee-employer mandatory program. I think the other thing that perhaps you are losing sight of is what we have now. I think as the Secretary has indicated you can smooth the scale out by adding additional breaking points. You can smooth it out.

The notch of $50 is really rather insignificant when you consider the fact that under the present medicaid program when that person earns

$1 more than his public assistance allowance he often loses all his medical benefits.

What we were trying to do in H.R. 1 when we were before this committee and what we are trying to do now is smooth out this medicaid problem.

Mr. ULLMAN. It is my position that we had a smoother transition in H.R. 1 than you have here.

Mr. VENEMAN. We have a "spend-down" in that, Mr. Ullman.

Mr. ULLMAN. It was more equitable and avoided the notch better than this; wouldn't you agree?

Mr. VENEMAN. No; I don't think so because you are dealing with two different things there really. When dealing with H.R. 1 we are dealing with the existing State administered medicaid program. Here we are dealing with an insurance program which I think is significantly different.

Mr. ULLMAN. Well, Mr. Secretary, I am not going to go into it further but I think we need to look very carefully at this. I think the notch problem here is much more serious than you admit to.

Thank you.

Mr. VENEMAN. It reminds me of Senator Williams before the Senate Finance Committee, Mr. Ullman.

Secretary RICHARDSON. I would say, Mr. Ullman, that on this kind of thing you are dealing with real problems of reconciling administrability, and the elimination of the notch in the interdigitation of two programs. We are open to any constructive way of achieving a resolution of these problems.

What we have presented to you is the best we have been able to come up with to this point.

The CHAIRMAN. The Chair had intended at this point to adjourn and come back in the morning but Mr. Corman tells me that he will not be here tomorrow, or Thursday either, and has two questions he would like to ask.

I will recognize him out of order unless there is some objection to it.

Mr. Corman?

Mr. CORMAN. Thank you, Mr. Chairman.

I wanted to ask, Mr. Secretary, do you anticipate regulating the cost of insurance that is required to be purchased by the employer for his employees?

Secretary RICHARDSON. Yes, through the means rather briefly summarized in my testimony.

We have given very careful consideration to the question of whether to institute a complete new Federal structure for this purpose or to rely in the first instance on the existing State machinery supplemented by a requirement that the States that don't have any regulatory machinery in effect do so.

Mr. CORMAN. What I am talking about is whether or not you are going to tell those people how much they are going to charge per policy.

The CHAIRMAN. We are not hearing you, Mr. Corman. Do you have your machine on?

Mr. CORMAN. Yes, sir; you are not going to tell them how much they can charge, right?

Secretary RICHARDSON. We are not going to prescribe rates federally.

Mr. CORMAN. Are you going to require uniform rates or may the companies give different rates for different ages and people in different states of health?

Secretary RICHARDSON. They may introduce the variances in premiums that they think are justified by the experience of the employee group. In other words, they may rely on experience ratings.

Mr. CORMAN. We will have a lot of people who work for employers who employ just a very few people. Is the insurance company going to be able to charge a different rate for a person 21 years old than for a person 50 years old?

Secretary RICHARDSON. Not within the group of employees of which that 21-year-old is a member. There would be a rate ordinarily for individuals and the individual rate would be the same for all individuals in the group. There would be a family rate the same but the groups might vary depending on the overall composition of those groups.

Mr. CORMAN. If I were an employer hiring 10 people, would I not consider it advantageous to hit 10 young, healthy persons? That is what I am trying to get at.

Secretary RICHARDSON. Ordinarily, no, because in the case of such an employer he would be able to get a better rate by participation in the pool than he could with a group that small.

Mr. CORMAN. In the pool arrangement there can be no different rates because of age or because of physical condition?

Secretary RICHARDSON. That is right.

Mr. CORMAN. So if I have some chronic illness and I get myself employed my employer can take a policy under the pool rate and I will be covered; is that right?

Secretary RICHARDSON. Yes.

Mr. CORMAN. Are you going to regulate the rates that can be charged by the health delivery people—hospitals and doctors and so forth?

Secretary RICHARDSON. Not directly. Of course, phase 2 is a different situation entirely but, as far as permanent legislation is concerned, we do not consider it feasible to create a rate of setting mechanism to be administered by the Federal Government.

We would rely primarily on such devices as utilization review, peer review, emphasis on the preventive aspects of medical care that would be the concern of health maintenance organizations under a capitation arrangement and so on.

Mr. CORMAN. Mr. Secretary, I appreciate haing this 5 minutes out of order. I just have to tell you that there is one sentence on page 39 that I agree with completely: "They would do far less than what this Nation must do if it is to act with a full sense of its responsibility." I use it in a different context.

To me that describes the administration's proposal accurately, and as to the costs of H.R. 22, I want to make it clear that I for one do not think you ought to promise something for nothing. H.R. 22 anticipates a substantial increase in the taxes that people would have to pay in the country. But in exchange for that increase in taxes they would be getting rather substantial health care. Maybe we will have a chance to explore those more definitively in executive session.

Secretary RICHARDSON. I am sure we will, Mr. Corman. I stated our own views to the problems we see with regard to H.R. 22 in my statement.

The CHAIRMAN. Are there any other members of the committee who will not be present on tomorrow or Thursday morning who do have questions of the Secretary?

The Chair will recognize the member if there is such.

Without objection then, let's adjourn until 10 o'clock tomorrow morning.

You can be back, Mr. Secretary?

Secretary RICHARDSON. Yes.

(Whereupon, at 12:05 p.m. the committee was adjourned, to reconvene at 10 a.m., Wednesday, October 20, 1971.)

NATIONAL HEALTH INSURANCE PROPOSALS

WEDNESDAY, OCTOBER 20, 1971

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in the committee room, Longworth House Office Building, Hon. Al Ullman presiding.

Mr. ULLMAN. The committee will please be in order.

Mr. Secretary, we are glad to have you back today.

As I recall, when we concluded yesterday, Mr. Corman was querying you.

Mr. Schneebeli, do you have any questions?

Mr. SCHNEEBELI. Yes. Thank you, Mr. Chairman.

Mr. Secretary, I think Mr. Ullman yesterday established the fact that the medicare system as presently constituted would not be affected by the proposed legislation. Is this correct?

STATEMENT OF HON. ELLIOT L. RICHARDSON, SECRETARY OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY HON. JOHN G. VENEMAN, UNDER SECRETARY; HON. MERLIN K. DUVAL, JR., ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS; HON. STEPHEN KURZMAN, ASSISTANT SECRETARY FOR LEGISLATION; HON. LAURENCE E. LYNN, JR., ASSISTANT SECRETARY FOR PLANNING AND EVALUATION; HON. ROBERT M. BALL, COMMISSIONER, SOCIAL SECURITY ADMINISTRATION; AND HON. HOWARD N. NEWMAN, COMMISSIONER, MEDICAL SERVICES ADMINISTRATION, SOCIAL AND REHABILITATION SERVICES ADMINISTRATION—Resumed

Secretary RICHARDSON. Yes, that is correct.

Mr. SCHNEEBELI. When an employee reaches 65 and continues to work, is he still eligible for the proposal in your bill, does he come under medicare or does he have a choice?

Secretary RICHARDSON. He would come under medicare since he would have contributed of course during his previous work history to the entitlements to coverage under that program.

Mr. SCHNEEBELI. Medicare would be much cheaper to the employee for the same coverage, is that correct?

Secretary RICHARDSON. Yes. It would mean, of course, that the employer did not need to include him among employees for whom he was contributing to premium costs under the required program.

Mr. SCHNEEBELI. Although they still make deductions for social security for him when he is working over 65 up to 72, is this correct?

Secretary RICHARDSON. Yes.

Mr. SCHNEEBELI. So he is still contributing.

Secretary RICHARDSON. Well, that is true, but in any case he would be entitled, having reached the age of 65, to medicare benefits, and that being so, then there would be no point in either his or his employer's contributing to the cost of a group plan under the National Health Insurance Standards Act.

Mr. SCHNEEBELI. Under H.R. 1 as proposed, social security deductions will be quite great in the foreseeable future. I think as a matter of fact, when we get up to 7.4 percent on $10,200, it will be over $750 a year for the employee deductions.

How much more will this plan cost the individual employee in addition to the $750 deductions already scheduled? What will the individual costs be?

Secretary RICHARDSON. For a family, the cost to the employee would be about $190.

Mr. SCHNEEBELI. A $190 deduction?

Secretary RICHARDSON. Well, the total cost of the package in 1974 for the family is about $490, and the individual employee's cost is 35 percent of that at the outset and then later 25 percent of it.

Mr. SCHNEEBELI. That is pretty close to $190, isn't it?

Mr. VENEMAN. Mr. Chairman, I think it might be well to point out that that is the maximum. I think we should recognize that many of these employees are presently covered under some kind of health plan and for many there would be no additional cost.

Mr. SCHNEEBELI. Getting back to the health plans under which you say some of them are presently covered, isn't that almost 100 percent, presently, employer cost?

Mr. VENEMAN. No.

Mr. SCHNEEBELI. What is the average?

Secretary RICHARDSON. It is about 70 percent on the average.

Mr. SCHNEEBELI. That is the average present cost?

Secretary RICHARDSON. Yes.

Mr. SCHNEEBELI. Of employers?

Secretary RICHARDSON. Yes.

Mr. SCHNEEBELI. So that is why you got the 65 percent for the first 2½ years?

Secretary RICHARDSON. Yes.

Mr. SCHNEEBELI. If we were to add this $190 to the $750, we would be pretty close to a $1,000 deduction a year for a person who earns $10,000, wouldn't we?

Secretary RICHARDSON. Yes.

Mr. SCHNEEBELI. That is a pretty good-sized payroll deduction of about $80 a month.

Secretary RICHARDSON. Well, of course, you are referring to the ultimate——

Mr. SCHNEEBELI. The two together, yes.

Secretary RICHARDSON (continuing). The ultimate tax rate now in H.R. 1 which would go into effect about 1978, and in the meanwhile, as I am sure the committee is aware, the Advisory Council on Social

Security has submitted a recommendation that the funding of the system could now, in the light of its relative maturity, be handled on a current cost basis. We have this recommendation under consideration in the administration and plan to submit our conclusions with regard to it to the Senate Finance Committee in time for their executive consideration of H.R. 1.

If it were adopted, it would eliminate the necessity for the rate increases in 1975 and 1977 that are presently called for.

Mr. SCHNEEBELI. Translated into actual figures, instead of 7.4 percent, what would it be?

Secretary RICHARDSON. Mr. Ball.

Mr. SCHNEEBELI. On your recommendations.

Secretary RICHARDSON. For the continuation of the present levels that are scheduled in H.R. 1 to go into effect as of January 1, 1972, is that right?

Mr. BALL. Yes, Mr. Secretary. The main effect, Mr. Schneebeli, is in the cash benefit program where under the Council's recommendation you could have a level rate for about the next 40 years, whereas the hospital insurance rate would have to go up.

Mr. SCHNEEBELI. Your combined rate?

Mr. BALL. So if you took the combined rate by what they would be suggesting, it would be a 5.4 percent rate, which is the next year rate in H.R. 1, and then you could hold that for a very long time. The hospital insurance would make it rise slightly so that by 1977 it would probably be about 5½ percent.

Mr. SCHNEEBELI. Total combined?

Mr. BALL. Yes.

Mr. SCHNEEBELI. Instead of 7.4 percent?

Mr. BALL. Yes.

Mr. SCHNEEBELI. That is a major change, isn't it?

Mr. BALL. Yes, and as the Secretary was saying, we are not at this point prepared to make a recommendation to the committee on it, but we have it under active consideration.

Mr. SCHNEEBELI. Then what I interpret from what you are saying is that the new employee cost of insurance would not be any more than the bill that we passed at 7.4 percent. The hospitalization plus your changed attitude on social security would not be any greater than your 1978 deduction figure for the present H.R. 1 figure.

Mr. BALL. If the committee were to adopt the Advisory Council recommendation, that is correct, but I ought to emphasize, Mr. Schneebeli, that in the long run in the next century, beginning about the year 2010, a current cost approach requires a somewhat higher rate.

Mr. SCHNEEBELI. I don't know that we are too worried about that at the present time.

Mr. BALL. Well, it goes to the fundamentals of the system.

Mr. SCHNEEBELI. I realize that. Isn't your actuarial forecast now 75 years?

Mr. BALL. Yes.

Secretary RICHARDSON. Mr. Schneebeli, on the course of the premium costs under the National Health Insurance Standards Act I have a tabulation which it might be helpful to have inserted in the record at this point.

Mr. SCHNEEBELI. I would ask that permission.
Mr. ULLMAN. Yes.
(The tabulation to be supplied follows:)

COURSE OF NHISA PREMIUM COSTS

A. ASSUMING 6 PERCENT INCREASE IN MEDICAL COSTS (7½ PERCENT INCREASE IN PREMIUM COSTS)

	NHISA premium category		
	Adult	Family	Composite
National average cost, fiscal year—			
1974	$180	$490	$390
[illegible]	196	534	425
[illegible]	214	582	463
1977	233	634	505
1978	254	691	550
Employer contribution, average cents per hour equivalent, fiscal year—			
1974	6	15	12
1975	6	17	13
1976	7	18	15
1977	9	23	19
1978	9	25	20

B. ASSUMING TRENDS IN AVERAGE INCREASES (PROJECTED TO 1974–78)

	NHISA premium category		
	Adult	Family	Composite
National average cost, fiscal year—			
1974	$180	$490	$390
1975	202	549	437
1976	223	606	482
1977	245	667	530
1978	267	728	578
Employer contribution, average cents per hour equivalent, fiscal year—			
1974	6	15	12
1975	7	17	14
1976	8	20	16
1977	9	24	19
1978	10	26	21

Secretary RICHARDSON. The accurate figure is 35 percent of $490, or $171.50, for the average workingman's family. This is all set forth in this table.

Mr. SCHNEEBELI. Thank you. I feel a little better realizing that the 7.4 percent probably will not remain in H.R. 1 as the figure that will be in effect. Is this what you are saying?

Secretary RICHARDSON. Yes.

Mr. SCHNEEBELI. In all likelihood.

Secretary RICHARDSON. That is the recommendation of the Advisory Council. I think I could say at this point that I believe that there is a lot of merit in the recommendation.

Mr. BYRNES. Would you yield?

Mr. SCHNEEBELI. Go ahead.

Mr. BYRNES. I would like to get this thing cleared up, so that there is no misunderstanding. My understanding of what you said is that you are going to study the Advisory Council's recommendation, but I hope you are not going to take it as the word of Solomon.

Secretary RICHARDSON. No, not at all.

Mr. BYRNES. You are not going to ignore it?

Secretary RICHARDSON. The process we have followed has been to ask to have it carefully analyzed by the chief actuary of the Social Security Administration. This has been underway. The next step was a review of his analysis by the Commissioner of Social Security and his staff and myself. It is presently under consideration by the trustees of the system and we hope to have a conclusion in the matter in time for a definite recommendation to the Senate Finance Committee by the time it acts on H.R. 1.

Then of course that would come back to this committee in conference.

Mr. BYRNES. I hope all you are saying is that there is, in the works, a study of this problem.

Secretary RICHARDSON. Exactly.

Mr. BYRNES. And that a basis of the study is the recommendation of the Advisory Commission, but that doesn't necessarily mean that all wisdom resides in that Commission. Is that correct?

Secretary RICHARDSON. That is correct. I think that it is important to get that clear.

Mr. SCHNEEBELI. Then in all likelihood the advisory committee is not too far off, perhaps 2 or 3 percentage points of what you may come up with. Why is there such a great difference between the advice we got at the time of deliberation on H.R. 1 of a 7.4 percent necessity and this present 5.5 percent we are talking about? That is a big gap. Why that variation in such a short period of time in the estimate of cost?

Secretary RICHARDSON. It's a function of the approach taken to the financing of the system.

Mr. SCHNEEBELI. Right now we have about a 15 months', 13 to 15 months' surplus, don't we?

Mr. BALL. Mr. Schneebeli, it isn't, as the Secretary was saying, really a matter of a difference of an estimate. It is a difference in an approach to financing. That is, under H.R. 1 the committee followed what has become traditional in the last 15 or 20 years of putting in contribution rates in the near term, high rates in 1975 and 1977, which are sufficient to produce a very, very large trust fund, and then the interest on that very large trust fund in the next century is used to hold down the contribution rates that would have to be charged in the next century.

In actual practice over the years, what the Congress has done as it has approached those high rates is that, instead of allowing them to go into effect and build these huge funds, there has usually been a change in the law on the benefit side, and then a new schedule put in which in the early years is just sufficient to cover outgoing and then high rates are put in in the very near term, which theoretically, in your actuarial cost estimate show a huge buildup of trust funds.

Mr. SCHNEEBELI. But the trust funds surplus has been a rather constant 12 to 15 months of anticipated payments, hasn't it?

Mr. BALL. In actual practice the system has been approximately on a pay-as-you-go basis in practice for the last 15 to 20 years.

In other words, in the law we have put in rates just a few years off which, if allowed to go into effect, would build huge funds, nearly $300 billion, by the close of the century and then your estimates use the in-

terest on those high funds in the next century to keep down the contribution rates but they are not allowed to actually go into effect.

The Council said since in practice the funds have been really kept pretty much on a current pay basis, let's not actually put into the law even near-term high contribution rates. Let's, instead, frankly face the fact that the system is going on a current cost basis.

That is what we are evaluating.

Mr. SCHNEEBELI. I am sorry to have gotten into this digression on H.R. 1, but I was trying to figure out what this new proposal might cost in the light of what we approved there. The two combined seemed to me initially to be an abnormally high figure.

When you get up to $800 or $900 payroll deduction a year for these two costs, it seemed to me to be abnormally high. I am glad that we may get a remission of this social security deduction.

One other question. On page 8, Mr. Secretary, you say under the subject of supply and distribution, that it is your intention to increase the number of doctors and nurses in medically unserved rural and innercity areas. There is not too much of an explanation of how you propose to do this. Of course, we have recognized this big void and need for a long time and they have tried to improve the situation. What are your proposals to improve the situation?

Secretary RICHARDSON. There are a number of interrelated measures that have been included in our health manpower legislation and in our health maintenance organization legislation.

They range, for example, from the creation of area health education centers so-called that would serve as points for the training of residents and interns in the area in association with the hospital and centers also for continuing education and the updating of the skills of the medical practitioners in the area.

This was a recommendation originally of the Carnegie Commission on Higher Education, and it has in view the thought that it would be more attractive to doctors in areas too sparsely populated to support a medical school to practice in those areas if they did have this kind of a center.

Mr. SCHNEEBELI. Would that be a Government-subsidized center we are talking about?

Secretary RICHARDSON. Yes, it would be, particularly in the initial stages.

Mr. SCHNEEBELI. Subsidized as to facility as well as doctor income, because there is still going to be that disparity of income between urban and rural medical practice.

Secretary RICHARDSON. The facility and some of the elements of training provided at the facility.

Mr. SCHNEEBELI. How are you going to attract the doctor there if he is going to get twice the income at some other point?

Secretary RICHARDSON. The concept behind this particular proposal is that it would be more attractive to him to practice in that area if he had this kind of opportunity to maintain his skills and to practice them as part of a medical center which was in its own way as good as any medical center in a city or more densely populated place.

Mr. SCHNEEBELI. I appreciate the fact that you make the facility available, but if you don't make the patient demand available to the

same degree, his income is not going to be the same so that you still have the problem of attracting the doctor to an area where his income is going to be a lot less despite the establishment of the medical facility because the demand is not there. How do you make up the difference there?

Secretary RICHARDSON. There would be somewhat less income probably, but there are other kinds of offsetting satisfactions, to not having to fight traffic, and to being within reach of recreational activities of various kinds.

What I am really trying to say is that there are a whole series of interrelated provisions. We have incorporated into our legislation just about every sensible idea that has come our way to help to make practice in remote areas and in innercities more attractive to the doctor.

The area health education center is one. We have incorporated into the manpower legislation provision for loan forgiveness for doctors who engage in practice in such areas with special emphasis on primary care.

Mr. SCHNEEBELI. That is education loan forgiveness?

Secretary RICHARDSON. Yes. We have proposed also that there would be made available through federal assistance in the adaptation of technological innovations means of tying in the outlying areas served by a doctor in remote parts of the country, closed-circuit television, for example, telemetry for the purpose of monitoring life state and developing diagnoses, the use of paramedical personnel who would serve within a network tied into the area health education center for example, and then there is in addition the Emergency Health Personnel Act which went into law at the end of last year, which the President has asked funds for and which we will be putting into effect within another two or three months or by the end of this calendar year as one way of getting doctors to serve in these areas.

It is fair to say that we have no sure-fire solution to this problem. It is going to be one whose very solution will depend to a very large extent on the degree to which young doctors coming out of medical schools are motivated to want to serve in this kind of area.

There is evidence, I think, and Dr. DuVal might want to supplement this, in saying that increasing numbers of medical students are looking toward a career of service to communities as distinguished simply from making as much money as they can.

Mr. SCHNEEBELI. Thank you, Mr. Secretary. I don't want to monopolize your time when other members are waiting to ask you questions. We can get into it in more detail in executive session. Thank you very much.

Mr. ULLMAN. Mrs. Griffiths will inquire.

Mrs. GRIFFITHS. Thank you, Mr. Chairman.

Mr. Secretary, I would like to thank you for that long and kind remark you had on my bill. Some of the people up here felt that it was quite unkind, but I didn't. I thought however, you protested too much.

You know, and I know, that my bill is going to be the law. Whether it is this year or some future year, my bill or something very close to it is going to have to be the law.

Secretary RICHARDSON. I hope not.

Mrs. GRIFFITHS. I know. You have already had your say, but you know that your bill isn't going to succeed.

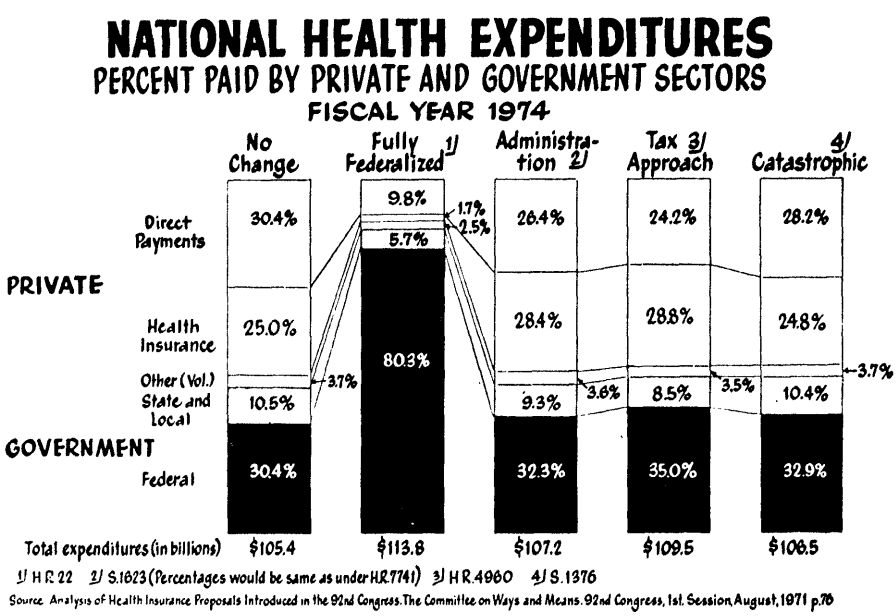
What I would really like to know is how come you know what my bill costs but not yours?

Secretary RICHARDSON. We have estimated the costs of all the legislation in the same essential way and all of these estimates are contained in the cost analyses furnished to the committee. I will be very glad, Mr. Chairman, at this point to present to the committee a chart we have had prepared which you have before you that indicates the costs and the methods of financing of each of the major bills before you, before the committee.

Mrs. GRIFFITHS. Good. Just set it up there because I have a few more questions I would like to ask.

Mr. ULLMAN. Without objection, it will be placed in the record just as their other chart at the appropriate place will be placed in the record. (May be found on p. 127.)

(The chart referred to by Mrs. Griffiths follows:)



Mrs. GRIFFITHS. You objected to my bill because it covered too many people and promised too much. Who does your bill leave out, Mr. Secretary?

Secretary RICHARDSON. Our bill leaves out the people who are now covered under Medicare. It leaves out the adult categories covered under Medicaid.

Mrs. GRIFFITHS. That would mean you will be leaving out ADC mothers, right?

Secretary RICHARDSON. No. The Family Health Insurance Plan, Title I of our bill, does cover poor families.

Mrs. GRIFFITHS. I see, but poor single people will be left out?

Secretary RICHARDSON. Poor single people and couples without children not eligible for medicaid or the proposed disabled worker beneficiary coverage in H.R. 1 are not covered.

Mrs. GRIFFITHS. They will be left out?

Secretary RICHARDSON. Except to the extent that they may benefit as compared with their present situation by purchasing coverage under the health insurance pools that would be established under Title II.

Mrs. GRIFFITHS. You have objected to the costs of my bill, and it is true that my bill contemplates spending $68 billion to $70 billion, but, Mr. Secretary, that is what we are spending now.

Is your bill cheaper because it contemplates reducing charges or reducing care?

Secretary RICHARDSON. Our bill is cheaper and, if you are comparing not the tax impact of these various proposals but the total cost recognizing, as you pointed out, that there are transfers under your bill from private health insurance to a federal system of collecting costs, still there is an additional cost as we estimate it under your legislation of about $8½ billion which we have identified as the induced cost, namely, the cost that is brought about by the fact that for all practical purposes free care is available to substantially the entire population.

The conclusion that there would be this induced cost rests in part on the experience of Medicare and Medicaid, as well as the experience of some other countries in which there has been an upsurge of spending associated with taking off any cost-consciousness on the part of the consumer.

Mrs. GRIFFITHS. Out in Michigan, which is run now by Republicans, last weekend we ended Blue Shield and Blue Cross as carriers, and one of the reasons that we did it is because it will be cheaper to have the State do the carrying.

One of the things they discovered after the Federal Government issued the information, was that a doctor in Benton Harbor, a town of about 25,000, during 1968 had collected $169,000 from the Government. Now, the State stepped in and negotiated the fee downward. They reduced that fee by about $40,000, but the Blues hadn't done anything. They had made no effort to correct this situation, and one of the points that one of the Republican Senators made was, "You can't expect an organization run by doctors to object to the fees of doctors."

With that we kicked out the insurance companies, and I congratulate the Republican Governor and the Republican Senators on kicking them out.

Why are you putting them back?

On page 17 of your statement you say that, "Effective insurance regulatory mechanisms are already in operation in many States," but you told the Finance Committee on April 26, "There is no comprehensive system of regulatory mechanisms in the private insurance industry in effect now."

Which of these statements is true?

Secretary RICHARDSON. The statement I made to the Senate Finance Committee is true. What we have proposed to this committee, or what I described yesterday and what we plan to submit in the form of legislation is an approach that does create a comprehensive system by, in

effect, creating Federal authority to intervene where the States are not effectively carrying out the various specified regulatory requirements that I set forth in my testimony.

But we have concluded that no useful purpose would be served by creating a total new Federal structure where the States are doing the job or can do it, and many of them are and can do so.

Mrs. GRIFFITHS. Which States are?

Secretary RICHARDSON. Well, I can't give you a breakdown at the moment as between the best and the poorest or what the range is.

Mrs. GRIFFITHS. Will you supply it for the record?

Secretary RICHARDSON. New York is generally regarded as a bellwether for purposes of the regulation of the insurance industry generally, and its lead has been to a large extent followed by other States.

(The breakdown to be supplied follows:)

STATE REGULATION OF GROUP HEALTH INSURANCE

Attached are several exhibits on the major facets of state regulation of Group Health Insurance.

POLICY FILING AND APPROVAL

A review of state group insurance requirements as of January 1971 (Attachment A) indicates that group health insurance policies are required to be filed with insurance authorities in 47 out of 51 jurisdictions. In one of these, the Commissioner has issued an exemption, in two others, the filing provisions are discretionary with the Commissioner. Of the four jurisdictions having no such "De Jure" requirements, one exercises active informal regulation on this point.

RATE FILING AND APPROVAL

Review (Attachment B) showed that filing of group rates was required in 25 jurisdictions. In one of these the Commissioner has issued an exemption. In three of these, filing provisions are discretionary with the Commissioner. At least two of the 26 jurisdictions having no "De Jure" rate filing requirements exercise active informal regulation of this point.

No file and use provisions, such as are common to fire and casualty insurance regulations were found to apply to Group Health Insurance Regulation. NAIC annual meetings discussions suggest that the competitive nature of group health insurance, produces the adequacy and reasonableness in the absence of regulation. The National Association of Insurance Commissioners in 1947 developed a model act relative to unfair methods of competition and unfair and decreative practices in the business of insurance, including group health insurance, which includes provisions under Section IV(7)(b) that forbid premium discrimination.

The primary purpose of rate regulation according to authorities is stated to be to provide rates which are adequate, reasonable, and nondiscriminatory or to require that rates must be reasonable in relation to benefits.

GROUP LAWS OR RULINGS

Attachment C shows the references for state insurance law or rulings which define "Groups" under "Group Health Insurance," in 45 jurisdictions.

REQUIRED STANDARD POLICY PROVISIONS

As Attachment D shows, some 43 jurisdictions prescribe some standard policy provisions for group health insurance. These usually include such items as: (1) provisions for issuing certificates to employees; (2) provision that statements are representations and not warranties; (3) rules concerning remittance of premiums; (4) provision for adding new employees; and (5) provisions for dealing with proofs of loss and payment of claims.

GROUP HEALTH INSURANCE LAWS AND RULINGS IN EFFECT JANUARY, 1971

(A. Policy Filing and Approval Required by Law)

UNITED STATES

Alabama; Yes; regulations 25.
Alaska; Yes; section 21–42–120(a)(b).
Arizona; Yes; section 21–1110.21–1110A.
Arkansas; Yes; section 66–3209 (1) and (2).
California; Yes; section 10290.
Colorado; Yes; section 10290.
Connecticut; Yes; section 38–165 (*NB* Discretionary with Commissioner).
Delaware; Yes; section 2712, 2713.
District of Columbia; No.
Florida: Yes; section 627–01091.
Georgia: Yes; section 56–2410.
Hawaii: No.
Idaho: Yes; section 41–1812.
Illinois: Yes; section 143, 355, 367 (*NB* Attorney General Ruling Suggests Discretion).
Indiana: Yes; section 39–4251.
Iowa: Yes; section 515–106, 515–6.
Kansas: Yes; section 40–216.
Kentucky: Yes; section 304.14–120(1).
Louisiana: Yes; section 211A, 620.
Maine: Yes; section 2412, 2413.
Maryland: Yes; section 375.
Massachusetts; Yes; section 110 chapter 175, Insurance Laws (*NB* Discretionary with Commissioner).
Michigan: Yes; section 2236 (*NB* Ruling has Terminated procedures).
Minnesota: Yes; section 62A–10, 62A–02.
Mississippi; No; (*NB* Informal regulations of Insurance Departments require Filing).
Missouri: Yes; section 376–405, 376–777,7.
Montana; Yes; section 40–3714(1).
Nebraska: Yes; section 44–710, 44–348.
Nevada: Yes; section 692.030.
New Hampshire; Yes; section 415:18111.
New Jersey: Yes; section 17B:27–49 (*NB* citation effective January 1, 1972).
New Mexico: Yes; section 58–11–2(A).
New York; Yes; section 162, 221.
North Carolina: Yes; section 58–54, 58–249, 58–254.5, 58–254.7.
North Dakota: Yes; section 26–03–42, 26–03–43.
Ohio: Yes; section 3923.02.
Oklahoma; Yes; section 3610, 3610A, 4402.
Oregon; Yes; section 743.006(1).
Pennsylvania: Yes; section 354.
Rhode Island; Yes; chapter 151, section 1.
South Carolina: Yes; section 37–170, 37–538.
South Dakota: Yes; section 31–22–13(1)
Tennessee: No.
Texas: Yes; article 3,42(a).
Utah: Yes; section 31–19–9.
Vermont: Yes; section 4062.
Virginia: Yes; section 38.1–342.1 and regulations dated March 1, 1963.
Washington: Yes; section 48.18.100(a).
West Virginia: Yes; section 33–6–8.
Wisconsin: Yes; section 204–321(3).
Wyoming: Yes; section 26–1–315.

(B. Rate Filing Required by Law)

Alabama: Yes; regulation 25.
Alaska: No.
Arizona: No.
Arkansas: No.
California: No.
Colorado: Yes; section 72–10–2.
Connecticut: Yes; section 38–174 (*NB* Discretionary with Commissioner).
Delaware: No.
District of Columbia: No.
Florida: Yes; section 627, 0539, 0609.
Georgia: No.
Hawaii: No.
Idaho: No.
Illinois: Yes; section 367 (*NB* Attorney General Ruling Suggests Discretion).
Indiana: Yes; section 39–4251.
Iowa: No; (*NB*—Informal Regulations of Insurance Department Require Filing).
Kansas: No.
Kentucky: No.
Louisiana: Yes; section 22:211.
Maine: No.
Maryland: Yes; regulation 5–1–68.
Massachusetts: Yes; section 110, chapter 175, Insurance Laws (*NB* Discretionary with Commissioner).
Michigan: Yes; section 2236 (*NB* Ruling has Terminated Procedures).
Minnesota: Yes; section 62A.02.
Mississippi: No; (*NB* Informal Regulations of Insurance Department Require Filing).
Missouri: No.
Montana: No.
Nebraska: Yes; section 44–710.
Nevada: No.
New Hampshire: Yes; section 415:I.
New Jersey: No.
New Mexico: Yes; section 58–11–2.
New York: Yes; sections 221, 7.
North Carolina: Yes; section 58–254–4.
North Dakota: Yes; section 26–03–42.
Ohio: Yes; section 3923.02.
Oklahoma: No.
Oregon: No.
Pennsylvania: No.

(B. Rate Filing Required by Law—Continued)

Rhode Island: No.
South Carolina: No.
South Dakota: No.
Tennessee: Yes; Regulation 1–1–69.
Texas: No.
Utah: Yes; Regulation 65–2.
Vermont: Yes; section 4062.
Virginia: Yes; Regulation 3–1–63.
Washington; Yes; section 48.19.101(2).
West Virginia: Yes; section 33–6–9(2).
Wisconsin: Yes; sections 204–321(3)(e).
Wyoming: No.

(C.. Group Law (L), Ruling (R) ,or Neither (N))

Alabama: N; region 25.
Alaska: L; section 21.54.060.
Arizona: L; section 21–1401A.
Arkansas: L; section 66–3701.
California: L; 10207.5, (a)(1), 10290.-51, 10270.55, 11512.2, 11512.25.
Colorado: L; section 72–10–16(1)
Connecticut: L; section 38–174
Delaware: L; section 3502.
District of Columbia: N.
Florida: L; section 627.062.
Georgia: L; section 56–3101.
Hawaii: L; section 181–501.
Idaho: L; section 41–2202.
Illinois: L; section 367(1).
Indiana: L; section 39–4260A.
Iowa: L; section 509.1, 1.
Kansas: L; section 40–2209(A).
Kentucky: L; section 304.18–020.
Louisiana: L; section 215A.
Maine: L; section 2802–2812.
Maryland: R; 5/1/68 and L sec. 471.
Massachusetts: L; section 110A.
Michigan: L; section 3601.
Minnesota: L; 62A10.
Mississippi: N.
Missouri: L; section 376.405.
Montana: L; section 40–4101.
Nebraska: L; section 44–760.
Nevada: L; section 692.060.
New Hampshire: L; section 415.18.
New Jersey: L; section 17B.27–26.
New Mexico: L; section 58–11–15(a).
New York: L; section 221.2.
North Carolina: L; section 58–54.4.
North Dakota: N.
Ohio: L; section 3923.02.
Oklahoma: L; section 4501.
Oregon: L; section 743.522.
Pennsylvania: L; section 621.2.
Rhode Island: N.
South Carolina: L; section 37–531.
South Dakota: L; section 31–26–1(1).
Tennessee: N.
Texas: N.
Utah: L; section 31–20–1.
Vermont: L; section 4079.
Virginia: N.
Washington: L; section 48.21.010.
West Virginia: L; section 33–16–2.
Wisconsin: L; section 204, 321(1).
Wyoming: L; section 26.1–432.

(D. Some Standard Policy Provision Required by Law)

Alabama: No.
Alaska: Yes; section 21:54.010.
Arizona: Yes; section 21–1402.
Arkansas: Yes; sections 10116,, 10207.6.
California: Yes; sections 10116, 10207.6. 11512.3, 10207.9, 10270.94.
Colorado: Yes; section 72–10–16(2).
Connecticut: Yes; section 38–174.
Delaware: Yes; section 3503.
District of Columbia: No.
Florida: Yes; section 627.0625.
Georgia: Yes; section 56–3102.
Hawaii: Yes; section 181–505.
Idaho: Yes; section 41–2203.
Illinois: Yes; sections 362a, 367(2).
Indiana: Yes; section 39–4260B.
Iowa: Yes; sections 509.3, 509.10.
Kansas: Yes; section 40–2209(B).
Kentucky: Yes; section 304.18–040.
Louisiana: Yes; sections 221, 215A.
Maine: Yes; section 2816.
Maryland: Yes; section 475.
Massachusetts: Yes; section 110(D).
Michigan: Yes; section 3608.
Minnesota: Yes; section 62A10.
Mississippi: No.
Missouri: Yes; sections 376. 405.
Montana: Yes; section 40–4102.
Nebraska: Yes; section 44–761.
Nevada: Yes; section 692.070.
New Hampshire: Yes; section 415:18T.
New Jersey: Yes; section 178:27–34.
New Mexico: Yes; section 58–11–15(b).
New York: Yes; sections 162, 221.
North Carolina: Yes; section 58–261.
North Dakota: No (ND–Coordination of Benefits is regulated).
Ohio: Yes; section 3917.03.
Oklahoma: Yes; section 4502.
Oregon: Yes; section 743.528.
Pennsylvania: Yes; section 356.
Rhode Island: No.
South Carolina: Yes; sections 37–532 to 536.
South Dakota: Yes; section 31–26–2.
Tennessee: No.
Texas: No.
Utah: Yes; section 31–20–2.
Vermont: Yes; section 4080.
Virginia: No.
Washington: Yes; sections 48.21.060, 48.21–120.
West Virginia: Yes; section 33–16–3.
Wisconsin: Yes; section 204.321(2).
Wyoming: Yes; section 26–1–432, 433.

Mrs. GRIFFITHS. You mentioned that 10 health insurance companies had gone broke. What caused them to go broke, Mr. Secretary?

Secretary RICHARDSON. I don't know.

Mrs. GRIFFITHS. Do you plan on finding out?

Secretary RICHARDSON. We have proposed, as I said, a means of protecting policyholders against any loss consequent upon an insurance company going broke. We have also proposed to require that all insurance companies be audited annually by a CPA.

I go back to the first part of what you were saying about the costs of administration of health insurance. The Social Security Administration has made a very extensive analysis of these csots and for group policies the costs of administration by insurance companies or by Blue Cross-Blue Shield is very comparable to the cost of administration by the Social Security Administration, itself, under medicare.

The 1969 retentions of the group policies are about 1 percentage point higher, about 5.8, as against 4.8 percent of total premium volume, but the Social Security Administration does not reflect some of the costs, such as for example the amortization of buildings, that are reflected in private insurance administration.

Besides, we, as I say, will be requiring insurance companies to file data including rates with State agencies with a requirement that where the rate is apparently out of line that corrective action will be taken.

Mrs. GRIFFITHS. I am interested in how you are going to protect the policyholders against the insurance company going broke. Who is going to do this?

Secretary RICHARDSON. This would be done by the creation of a State fund under which the policyholders would be, in effect, protected against any failure on the part of the company to reimburse their costs of care.

Mrs. GRIFFITHS. Will the Federal Government supply the money or will the State supply the money? Who will supply the money?

Secretary RICHARDSON. This will be done by a Federal mechanism only to the extent that the State does not, itself, adopt the necessary legislation to do this.

Mrs. GRIFFITHS. How much do you estimate the cost will be?

Secretary RICHARDSON. We don't have a firm estimate at this point. It is a comparatively small amount.

Mrs. GRIFFITHS. You are going first, do I understand, to determine how much this policy of insurance is going to cost? Are you going to tell the insurance company that?

Secretary RICHARDSON. No.

Mrs. GRIFFITHS. The insurance company can set that, is that right?

Secretary RICHARDSON. Yes.

Mr. VENEMAN. But he would have to file, Mrs. Griffiths. He would have to file what his rates are. The States then would have the authority, if the rates were too high, to reject the rates established by the company. The companies, themselves, will establish this pool to take care of companies that became insolvent.

Mrs. GRIFFITHS. Will the insurance companies have to show the profits?

Mr. VENEMAN. Yes.

Mrs. GRIFFITHS. They will have to show the profits. To whom are they going to show this?

Mr. VENEMAN. They would have to disclose their administrative costs.

Mrs. GRIFFITHS. And their profits?

Mr. VENEMAN. And their margins. That would be filed. All the accounting procedures, as I understand the proposal, would be uniform accounting procedures that would be established subject to approval by the Federal Government. They then would be responsible to the State insurance commission.

The records and all information would be available, of course, to the Federal Government. So that we would have a uniform procedure. The 10 companies the Secretary referred to, Mrs. Griffiths, it is my understanding, were all in the State of Texas. Apparently Texas has had very lax laws with regard to health insurance companies. These are the kinds of things that I think we would have to strengthen.

Mrs. GRIFFITHS. When are you going to send up the legislation to handle this?

Mr. VENEMAN. We would hope the legislation would be in within a matter of weeks, I hope before the public hearings would be concluded on this particular matter.

Mrs. GRIFFITHS. Would they come to this committee?

Mr. VENEMAN. Yes, they would.

Mrs. GRIFFITHS. I remember that on the social service amendments you promised us that you would send the legislation in early 1970, and we got it in late 1971.

Mr. VENEMAN. Mrs. Griffiths, we had title XX of last year's welfare bill services amendments which we submitted when the bill got over to the Senate. We are in the process again of having services amendments for you for next year.

Mrs. GRIFFITHS. Now let's go back again. The insurance companies are going to publish their rates. They are going to get to set them, themselves, and then people presumably will choose which insurance company they would like to have cover them; is that right?

Secretary RICHARDSON. The employer ordinarily would negotiate the contract with the company.

Mrs. GRIFFITHS. I see. Will this bill wipe out all present negotiated health contracts with employers or not?

Secretary RICHARDSON. No, it would contemplate that there would be an interval in which existing collective bargaining arrangements would continue.

Mrs. GRIFFITHS. I see. This bill is for the weak, those who can't negotiate. They will be paying 35 percent of their health care costs while big unions won't pay any; is that right?

Secretary RICHARDSON. It is possible in some cases that the employer would pay the whole cost.

Mrs. GRIFFITHS. Which employers, for instance?

Secretary RICHARDSON. Normally big employers.

Mrs. GRIFFITHS. Where they have a big union neogtiating the contract?

Secretary RICHARDSON. This may be, but it can also be any other company, small or large. The reason, of course, for this part of our proposal is simply that there are many small companies in which there is no adequate coverage of employees now. So that what we are saying in effect is what has been said in other areas of legislation like

workmen's compensation, for instance, that henceforth every employer is required to make an adequate health insurance policy available to all his employees.

Mrs. GRIFFITHS. Now, supposing a company, an employer, chooses company x. And company x finally says, "I am broke. I can't pay for the health coverage of people already in the hospital."

At that moment is the Federal Government going to step in with money and pay the hospital costs?

Secretary RICHARDSON. No, the State would be required to establish such legislation. The Federal Government would step in only in event of a failure by the state to enact this legislation.

Mrs. GRIFFITHS. Of course it is ridiculous to talk about requiring the State to establish legislation. What are you going to give them to establish the legislation?

Are you going to give them money? Under what circumstances would they establish it? Why would they want to?

Mr. VENEMAN. Mrs. Griffiths, I think we have precedent for it. It has occurred in the past. We have mandated workmen's compensation, for example, where there would be a State fall-back pool. There are other programs where you have a mandated insurance coverage where there are pools or other processes by which, if a company becomes insolvent, the insured does not go without coverage.

Mrs. GRIFFITHS. The way you are going to do this then is that you are going to conduct an investigation. What if you discover that the reason the insurance company went broke was because they invested in the manager's private business? It wasn't because they paid out too much. They made poor investments. They ran up the salaries of the employees too high. What are you going to do then?

Mr. VENEMAN. As I mentioned, I think that all of these kinds of things would be required in the uniform accounting procedures that would be established. You would have a means by which you would be able to determine how much of the insurance company's cost is for administration, how much their retentions are in the premiums. If a State determined that the premium was too high, the State then could step in and require them to reduce their rates or that company would not be able to provide the coverage.

Secretary RICHARDSON. I think it should also be pointed out, Mrs. Griffiths, that in fact health insurance is a very highly competitive business and, since the employer would be negotiating with the insurance carrier, whether nonprofit like the Blues or a commercial carrier, the employer would have the opportunity to compare rates for the same coverage as well as to analyze the financial capability and soundness of the operation.

Mrs. GRIFFITHS. I agree with all of that, but how is he going to analyze the soundness? Who is going to regulate the investments of the insurance company? Are you going to do it?

Secretary RICHARDSON. No; we don't propose to regulate the investments, but the reserves and the financial strength of the company are all going to be matters of public record. The requirement of annual audit will make this information available.

In the rare case where the company does become insolvent, the mechanisms that we have proposed should serve. There are already in effect in 35 States comparable legislative requirements covering

property insurance, for example, and what is involved here is simply an extension of the same approach to health insurance and its expansion from the 35 States to all States.

Mrs. GRIFFITHS. But, if you are going to pick up those that go broke, it seems to me that you have to start now. You have to say in the beginning, "We are going to determine in what you are going to invest. We are going to determine what you are going to pay your management."

Otherwise than that, Mr. Secretary, if the Federal taxpayers are going to pay these bills for those who go broke, as they paid them for the Pennsylvania Railroad, and for Lockheed, what you are really socializing is finance.

Secretary RICHARDSON. Well, I think there are two points that need to be made. One is that the only companies that have gone broke in modern history are very small companies with very, relatively small numbers of policyholders, therefore.

Secondly, the industry itself would be spreading the cost of the failure over the whole volume of business done by the industry in the State. It would not fall on the Federal taxpayer.

When I refer to a Federal mechanism, I mean in effect that if the State doesn't create this kind of a pooling arrangement within the State, then the Federal regulatory legislation would provide for this distribution of costs among the carriers in the State as a matter of Federal law rather than State law.

Mrs. GRIFFITHS. How are you going to keep them from constantly raising their rates?

Blue Cross and Blue Shield have been doing that all the time.

Secretary RICHARDSON. Well, of course, the costs of medical care have been going up all the time, too. The Blues are nonprofit organizations in the sense that no shareholders benefit and the only real question then is whether, as you indicated in the beginning, effectively administered or not, and the record indicates that with respect to group policies they evidently are quite efficiently administered.

Mrs. GRIFFITHS. The Blues? Are you talking about the Blues being efficiently administered? Why would Michigan get rid of them?

Secretary RICHARDSON. I don't know what Michigan's problem was but in the case of the administration of Blue Cross by Blue Cross-Blue Shield plans, the retention rate for group plans as set forth in the Social Security Bulletin of February 1971 is for Blue Cross about 2.2 percent and for Blue Shield about 8.9 percent, as a percent of subscription or premium income.

This compares quite well with the comparable retention rates for the administration of medicare.

Mrs. GRIFFITHS. It is not the percentage, it is the volume on which you are operating the percentage that really counts. I am sure that I have taken up too much time but I would like to point out that in my opinion you have presented nothing that shows that the insurance companies can administer this any more cheeaply than Mr. Ball can administer it. All we are really doing is just picking up the insurance companies.

Secretary RICHARDSON. I certainly don't want to be understood to say that they can do it more cheaply than Mr. Ball. We are very proud of the efficiency of the administration of the Social Security Administration generally under Mr. Ball's leadership, and medicare in particular. So that the issue doesn't really turn on the contention that private

insurance is more efficient. The question really is, is it worth it in order to get at the deficiencies of existing financing of health care to create the enormous Federal structure that is contemplated by your bill and not only in terms of the administration of the insurance side of it but much more important, I think, the administration of the allocation of the appropriated funds within the delivery system.

This is the feature of your proposal that I particularly focused on in my testimony and I did not exaggerate my very real concern that to try to appropriate in the Congress a total amount of money deemed to be sufficient to pay for substantially all health care services for a future fiscal year for all the American people, and then subdivide that money by regions and areas within regions and funnel it down through the areas to each individual hospital and clinic to pay the doctors and dentists in this way seems to me to contemplate a planning capability on the part of the Federal Government that I can not conceive could be brought into being inside of a decade at the very least.

So when I said I hope your legislation is not passed, I hope that we can within that decade have developed effective means of dealing with the acknowledged deficiencies of this system. If we are successful in this, whether the problem is one of the distribution of manpower into remote areas or inner cities, or whether it is ability of poor people to acquire adequate care anywhere, or people of any income to survive catastrophic costs, I think we can deal with those problems by identifying them specifically and developing means directly shaped toward coping with them.

If this is possible, and I believe it is, then it should not become necessary to create the enormous Federal structure that is contemplated by your bill.

Mrs. GRIFFITHS. You are going to have a Federal structure anyhow. You already have somebody out of the Federal Government in every one of these carriers to attempt to get them to handle this thing properly. You will have to have more.

The thing that I think is regrettable is to pay out money that is needed for health care, to insurance carriers that have already proved that they simply can't handle the problem. They are handling it at a very costly rate. It is a waste of money. I don't think that we need 10 years to figure out how to do this. If in Germany under Bismarck such a suggestion as my bill could have been made, it seems to me that in this country 100 years later, we ought to be able to do something.

Thank you, Mr. Chairman.

Secretary RICHARDSON. May I ask, Mr. Chairman, that there be inserted in the record at this point the tables developed by the Social Security administration showing retention rates and overhead costs of various forms of insurance.

Mr. ULLMAN. Without objection, that will be done.

(The material referred to follows:)

CARRIER OPERATING COSTS AND RETENTIONS

Attached are several tables which bear upon private insurance retentions and operating costs.

1. The first is a summarization of the 1969 Social Security Study.

2. The second is information supplied by the Health Insurance Association of America to show relative costs to group size.

3. The third is information from the Health Insurance Association of America showing the make-up of health insurance costs and retentions for several large companies.

(1) FINANCIAL EXPERIENCE OF PRIVATE HEALTH INSURANCE ORGANIZATIONS, 1969

[Amounts in millions]

Type of plan	Subscription or premium income	Claims	Retention		Net underwriting gain
			Total	Operating expense	
Total	$14,657.7	$13,068.5	$1,589.2	$2,133.7	−$544.5
Blue Cross-Blue Shield	6,155.6	5,903.1	252.5	457.7	−205.2
Blue Cross	(4,365.2)	(4,271.4)	(93.8)	(252.3)	(−158.5)
Blue Shield	(1,790.4)	(1,631.7)	(158.7)	(205.3)	(−46.6)
Insurance companies	7,569.0	6,306.0	1,263.0	1,609.5	−346.5
Group policies	(5,685.0)	(5,349.0)	(336.0)	(750.4)	(−414.4)
Individual policies	(1,884.0)	(957.0)	(927.0)	(859.1)	(67.9)
Other plans	933.1	859.4	73.7	66.5	7.2
Community	(375.0)	(349.0)	(26.0)	(27.0)	(−1.0)
Employer-employee union	(490.0)	(450.0)	(40.0)	(35.0)	(5.0)
Private group	(16.3)	(14.2)	(2.1)	(1.1)	(1.0)
Dental Service Corp	(51.8)	(46.2)	(5.6)	(3.4)	(2.2)
Percent of premium income, total	100	89.2	10.8	14.8	3.7
Blue Cross-Blue Shield	100	95.9	4.1	7.4	−3.3
Blue Cross	(100)	(97.9)	(2.1)	(5.8)	(−3.6)
Blue Shield	(100)	(91.1)	(8.9)	(11.5)	(−2.6)
Insurance cost	100	83.3	16.7	21.3	−4.6
Group policies	(100)	(94.1)	(5.9)	(13.2)	(−7.3)
Individual policies	(100)	(50.8)	(49.2)	(45.6)	(3.6)
Other plans	100	92.1	7.9	7.1	.8
Community	(100)	(93.1)	(6.9)	(7.2)	(−.3)
Employer-Employee Union	(100)	(91.8)	(8.2)	(7.2)	(1.0)
Private group clinic	(100)	(87.1	(12.9)	(6.8)	(6.1)
Dental Service Corp	(100)	(89.2)	(10.8)	(6.6)	(4.2)

(2) COST OF GROUP MEDICAL EXPENSE INSURANCE BY SIZE OF CASE, UNITED STATES, 1971

	Group administrative costs as a percent of new premiums earned			
	Total	Premium taxes	Commissions	All other
Size of case (number of lives):				
250	8.7	2.1	1.5	5.1
500	7.9	2.1	1.1	4.7
1,000	7.0	2.1	.7	4.2
2,500	6.2	2.1	.4	3.7
10,000	5.3	2.1	.2	3.0
50,000	5.0	2.1	.1	2.8

Note: Medicare, fiscal year 1969, 4.8 total.

Source: HIAA survey of 14 insurance companies which wrote 52 percent of group health insurance in the United States in 1970.

(3) FINANCIAL EXPERIENCE OF GROUP HEALTH INSURANCE,[1] UNITED STATES, 1970 AND 1968-70

	1970		1968-1970	
	Millions	Percent of total	Millions	percent of total
Net premiums earned	$4,778	100.0	$12,562	100.0
Incurred claims	4,556	95.4	11,781	93.7
Expenses incurred, total	483	10.1	1,270	10.1
Commissions	68	1.4	191	1.5
General administration	299	6.3	780	6.2
Taxes, licenses, and fees	116	2.4	299	2.4
Gain from underwriting after dividends	−261	5.5	−489	−3.8
Transfers from package policies, conversions, and other	136	2.8	267	2.1
Gain from underwriting after transfers and dividends	−125	−2.7	−222	−1.7
Net investment income	81	1.7	220	1.7
Federal income tax	32	.6	91	.7
Net gain from operations after dividends, transfers, investment income, and Federal income tax	−76	−1.6	−93	−.7

[1] Includes disability insurance and medical expense insurance. Medical expense insurance business not available, separately, in annual statements. Inclusion of disability business serves to increase expense ratios.

Source: Schedule H, page 35, and gain and loss exhibit, page 5, of Life Insurance Co., annual statement. Based on sample of 14 companies which wrote 52 percent of group health insurance in the United States in 1970.

Mr. ULLMAN. I wish that you would also make them available to the committee members.

Mrs. GRIFFITHS. Mr. Chairman, include the operating costs, too.

Secretary RICHARDSON. We will add the insolvency data.

Mr. ULLMAN. Without objection, that will be included.

Mr. Broyhill.

(The material referred to follows:)

INSURANCE INSOLVENCIES

The attached report from the National Association of Insurance Commissioners reflects the incidence and impact of recent insolvencies of insurance companies.

Please note that this data applies to all insurers and insurance, not just to health insurance.

Our intention is to assure that those insured under the National Health Insurance Partnership Act will not be denied benefits because of such insolvencies. We recognize that the incidence of insolvencies is not great relative to the total number of firms and total insurance premium volume. However, we are firm in our intent to assure reliable delivery of federally mandated health insurance benefits.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS,
Milwaukee, Wis., April 28, 1971.

Hon. WARREN G. MAGNUSON,
Chairman, Committee on Commerce,
U.S. Senate, Washington, D.C.

DEAR SENATOR MAGNUSON: On December 17, 1970 you requested the following information pertaining to insurance insolvencies since November 1969.

1. Names of insurers declared insolvent
2. State of domicile
3. Date of action
4. Number of states in which the insurer was domiciled
5. The insurers annual premium volume

To provide as up-to-date information as possible, we circulated a questionnaire to every state insurance department commencing in early January. Subsequently, we found it necessary to recontact some states for clarification. From the initial responses we compiled a preliminary summary of insolvencies which was then sent to each state of domicile for checking. From these final returns, we compiled the attached lists. However, we understood from Mr. Sutcliffe that such a delay was not critical due to the press of other matters before the Senate Commerce Committee.

In addition to the information requested above, we sought to determine losses to claimants including both policyholders and third parties. The loss figures shown on the attached exhibits are generally estimates. (Except in a few instances, the period for filing claims has not yet expired on this group of companies.) These figures are based upon the best knowledge of the department personnel responsible. Attached are Exhibits I and II which provide the information on life insurers and insurers other than life companies for the time period November 1, 1971.

In summary, during this period the total estimated losses for life insurers are $3.951.300 and for insurers other than life companies losses are $28,012,115. In addition for 8 non-life insurers listed we have no estimate of losses at this time. To the best of our knowledge, based upon the survey technique with its inherent limitations, the information provided is complete for this time period of approximately 18 months.

Perhaps some perspective on the magnitude of losses attributable to insolvencies can be gained by noting the relative role which such insurers play in the insurance market. For example, in 1969 U.S. insurers wrote life insurance premiums of $20.5 billion. The annual premium of life insurers which went insolvent during the last 18 months amounts to slightly over 5/100 of 1% of the $20.5 billion. The 11 life insurance companies which became insolvent equal ½ of 1% of the total number of life insurance companies in the U.S. All other U.S. premiums for 1969 amounts to $43.7 billion. The annual premium of non-life insurers which went insolvent during the last 18 months amounts to slightly over 17/100

of 1% of the $43.7 billion. The 21 companies in Exhibit II are slightly over 8/10 of 1% of 2800 property and liability companies in the U.S.

Best regards.

Sincerely,

JON S. HANSON, *Executive Secretary.*

EXHIBIT I

LIFE INSURANCE COMPANIES INSOLVENCIES (Nov. 1, 1969, to Apr. 19, 1971)

Company	Date of action	State	Number of States in which licensed	Annual premium	Losses to claimant
Alabama National Life Insurance Co	Mar. 28, 1970	Alabama	9	$2,371,000	[1] 0
Standard Union Life Insurance Co	Apr. 30, 1970	do	1	?	0
Financial Security Life Insurance Co	Jan. 9, 1970	Arizona	1	3,982,000	$3,900,000
National Security Life Insurance Co	Sept. 4, 1970	do	1	14,264	0
Tucson National Life Insurance Co	Oct. 29, 1970	do	1	57,011	50,000
Universal Security Life Insurance Co	Feb. 27, 1970	do	1	1,050	1,300
Continental Investors Life Insurance Co	Nov. 14, 1969	Texas	1	133,170	0
Girard Life Insurance Co	Dec. 30, 1970	do	34	4,884,529	0
Inter American Life Insurance Co	Feb. 18, 1970	do	1	59,013	0
Modern Investors Life	Dec. 22, 1970	do	1	3,861	0
Security National Life	Feb. 6, 1970	do	1	1,727	0

[1] Liens were imposed on cash values in the total amount of $11,000,000.

Note: In 1969 U.S. insurers wrote life insurance premiums of $20,500,000,000. The annual premium of life insurers which went insolvent during the last 18 months amounts to slightly over 5/100 of 1 percent of the $20,500,000,000. The 11 life insurance companies which became insolvent equal ½ of 1 percent of the total number of life insurance companies in the United States.

EXHIBIT II.—NONLIFE INSURANCE COMPANIES INSOLVENCIES (NOV. 1, 1969–APR. 19, 1971)

Company	Date of action	State	Number of States in which licensed	Annual premium	Losses to claimant
Old National Insurance Co	Mar. 28, 1970	Alabama	1	$118,261	[1]
Key Insurance Exchange	Nov. 10, 1969	California	1	3,000,000	$100,000
First American Insurance Co	Feb. 23, 1971	Florida	1	1,500,000	[2] 2,000,000
Fidelity General Insurance Co	Dec. 4, 1970	Illinois	7	10,040,000	[1]
Freedom Insurance Co	Mar. 31, 1970	do	1	1,042,000	[1]
Homeowners Insurance Co	Apr. 18, 1971	do	6	2,000,000	[1]
Prudence Mutual Insurance Co	Feb. 6, 1970	do	14	12,829,000	[1]
United Bonding	Feb. 18, 1971	Indiana	48	5,381,000	1,500,000
Wabash Fire & Casualty	Aug. 25, 1970	do	13	3,881,000	1,000,000
Maine Insurance Co	Jan. 14, 1971	Maine	22	7,563,928	[1]
Sutton Mutual Insurance Co	May 20, 1970	New Hampshire	1	1,000,000	0
Concord Insurance Co	June 12, 1970	New Jersey	[3] 1	3,500,000	350,000
Ohio Valley Insurance Co	Sept. 10, 1970	Ohio	1	3,936,000	[4] 2,500,000
Columbia Mutual Insurance Co	Mar. 16, 1971	Pennsylvania	1	30,776	0
Philadelphia Mutual Insurance Co	Apr. 20, 1970	do	1	81,251	[5] 12,115
Dealers National Insurance Co	Oct. 20, 1970	Texas	6	7,371,810	13,500,000
Liberty Universal Insurance Co	do	do	7	4,745,712	4,000,000
Pioneer Casualty Co	Oct. 14, 1970	do	1	5,809,000	3,000,000
Trans Plains Casualty Co	Feb. 4, 1971	do	12	1,090,000	[1]
Trans Plains Insurance Co	do	do	3	1,886,000	[1]
Forward Insurance Co	Jan. 7, 1970	West Virginia	1	280,000	50,000

[1] Unknown at this time.
[2] Florida guaranty fund will cover all or part of these losses.
[3] And as surplus lines carrier in New York.
[4] Ohio guaranty fund will cover all or part of these losses.
[5] Policies are assessable and department expects all losses to be recovered.

Note: All other U.S. premiums for 1969 amounted to $43,700,000,000. The annual premium of nonlife insurers which went insolvent during the last 18 months amount to slightly over 17/100 of 1 percent of the $43,700,000,000. The 21 companies in exhibit II are slightly over 8/10 of 1 percent of the 2,800 property and liability companies in the United States.

Mr. BROYHILL. Mr. Secretary, under the administration's plan, employers would be required to contribute 75 percent of the insurance costs for their employees. Under existing law, which we amended in 1970, we provide for a 40-percent contribution on the part of the

Federal Government, as the employer, for health insurance programs for Federal employees. Actually, we were late in even inaugurating a health insurance program for Federal employees. I think it was 1959 when the Federal Government reluctantly put through a health insurance program for its employees after industry already had been providing such programs for a good many years. I believe since the Federal program has been in effect, the average contribution on the part of the Government as the employer, has been in the neighborhood of 25 to 30 percent.

The administration opposed the 40-percent program last year. Actually, there was a 50-percent contribution proposed last year, and again this year a proposal for a 50-percent Federal Government contribution, as an employer contribution, was again vigorously opposed by the administration.

My question is, Since the administration feels that it is fair and equitable and proper to require all employers to contribute ultimately 75 percent of the cost of a health insurance program, why shouldn't the Federal Government take the lead and initiative as an employer, to provide a 75-percent, or at least a 50-percent, contribution for its employees? I am sure you feel that Federal employees should be treated equally with other employees.

Secretary RICHARDSON. Well, I can only say, Mr. Broyhill, that your logic is irrefutable. I think the Federal Government should be a model employer, and I think that the recommendation that we make for other employees should cause a reconsideration of the position the Federal Government takes in the cost sharing of health insurance of its own employees.

Mr. BROYHILL. What would be the effective date of the administration bill?

Secretary RICHARDSON. July 1, 1973.

Mr. BROYHILL. At that point, it would be 65 percent, would it not?

Secretary RICHARDSON. Yes.

Mr. VENEMAN. Not to exceed 35 percent for the worker.

Mr. BROYHILL. It might be a great encouragement to industry if the administration would send its people to the Post Office and Civil Service Committee to recommend that a 65-percent contribution be effective around January 1, 1973. I am a cosponsor of the legislation, and I would accept the amendment to make it effective January 1, 1973, and you might find that, since the Federal Government has taken the initiative in that area, the employers throughout the country, along with the big unions that Mrs. Griffiths is talking about, might put this into effect without your requiring it through legislation.

Secretary RICHARDSON. I think that we could certainly pursue this, Mr. Broyhill. As far as the Federal employees are concerned, I would have to, of course, enlist the interest of my colleagues in the administration.

Mr. BROYHILL. There may be some disagrement in the administration, regarding the Federal employee program.

Secretary RICHARDSON. I have no reason to think that the general validity of the point that you have made that we should be prepared as an employer to do what we are asking other employers to do, would be the subject of serious dispute, but I am only saying that that is not a matter that falls directly within my province to say.

Mr. BROYHILL. Thank you, Mr. Secretary.

(The following material was submitted for the record.)

Further exploration of the question raised by Rep. Broyhill indicates the following factors which should be considered concerning pending proposals to raise the Government's contribution to Federal employee health benefits:

It should first be noted that the 40 percent employer's share paid by the Government under the Federal employee health benefits program contributes toward one of the most complete health insurance programs in the Nation; the National Health Insurance Standards Act (NHISA) proposal calls for a 75 percent employer's share of a more modest, basic health insurance package for employees. The NHISA proposal also permits additional benefits to be provided above the required minimum package, but does not specify how employers or employees would pay the added costs involved.

A further consideration is that at the present time, Federal expenditures for employee fringe benefits as a whole amount to slightly more than 25 percent of basic payroll and compare favorably with total private employers benefits expenditures. However, the components of the Federal and private benefits packages vary considerably and, accordingly, it does not necessarily follow that the Federal Government should contribute an employer's share, item for item, that is identical with the share contributed by private employers.

For example, the Government currently provides for more paid leave than private industry, while industry spends more for insurance, unemployment benefits, bonuses and thrift plans.

Moreover, the outlook is that Government contributions to fringe benefits will continue to rise as a percentage of basic payroll because of statutory and other requirements, such as the increase from 25 percent to 40 percent enacted only last year in the Government share of health benefits and the requirement enacted in 1969 that all new unfunded liability in the Federal retirement system be amortized through annual appropriations over 30-year periods.

In the light of the above, the Administration at this time does not believe that additional Federal expenditures for a higher share of Federal employee health benefit costs are warranted in the current stringent budget situation either on the basis of equity or comparability.

Mr. ULLMAN. Mr. Burleson will inquire.

Mr. BURLESON. Thank you, Mr. Chairman.

The insurance companies which went broke in Texas, as you indicate, were small companies.

I think Mr. Secretary that you will find, however, that the losses to the policyholders were negligible, if any, because they were absorbed by large companies.

We believe in the free enterprise system. I do not believe in the nationalization of a great industry which some of these measures would do, particularly the one we just discussed.

Mrs. GRIFFITHS. Mr. Chairman.

Mr. BURLESON. Yes, indeed, if you are asking me to yield, I will be be glad to yield.

Mrs. GRIFFITHS. My bill cuts out all insurance companies. We don't have insurance companies in my bill.

Mr. BURLESON. You nationalize the insurance industry, in my judgment. You eliminate it insofar as the free enterprise operation is concerned.

I am not too sure that some of these other measures don't tend that way and I would be inclined to agree with my colleague from Michigan that with the adoption of some of these measures proposed, depending on their limits, that in time, like all Government programs, your proposal will come as part of our national life, which I regret to see.

Mr. Secretary, I have just one brief direct question.

On page 21 of your statement which you presented yesterday and for which I compliment you, under the title of "Health Provider Regulation" in part 3 you say:

> We will establish on an experimental basis local quality review organization composed of outside medical experts, including nonproviders in some instances, as provided for in H.R. 1.

My question is, who are these outside experts?

I can't imagine their coming from any other place than from the academic medical profession, the colleges, universities, or the military. Where would they come from?

Secretary RICHARDSON. I think what we mean by "outside" is people who are outside of the direct provision of service themselves. In other words, we might include people from outside the geographical area who can bring a more objective perspective than the participants in medical service in the area, but we also have in mind people who might be, for example, experts in epidemiology from a school of public health which could be in the area or experts in whose administration who would be able to review the quality of the services provided.

I would stress the word "experimental." As, of course, this committee is well aware in its own consideration of professional service or review organization, the problem of how to develop these and their methods of operation, their staffing, and so on, will require considerable experimentation before we would be prepared to prescribe a national system.

So I would expect that various approaches will be tried in different parts of the country.

Mr. BURLESON. Under the administration's proposal and others, the private health insurance companies will continue to write the policies.

Do you think that the provision for the pool arrangements which you outlined to us in your statement is a workable provision, a workable structure, and an arrangement which will provide adequate health in quantity and quality to the American people?

Secretary RICHARDSON. The pool is certainly an effective means of providing what is in effect group coverage for individuals who are not part of an obvious group like a group of employees.

We recognize that there are problems of the relative cost to the subscriber to the pool coverage that may result from the adverse election in effect that leaves for coverage in the pool individuals who have disabilities or other costs that mean that the pool cost is higher than other groups.

We have given a good deal of thought to the question of how to deal with that problem and I can only say at this point that, while we are clear that it is desirable to create the pools, the question of how to deal with these costs is a question rather like the one that Mr. Byrnes has dealt with in his version of the administration bill in the case of the subsidy of small employers.

We would look forward to working with the committee on this as an issue in which we are prepared to submit to you the analysis we have undertaken and what we consider the costs are and the relative premium as between the pool and other groups.

Mr. BURLESON. It seems to me that one of the big things, already been referred to in your discussion with other members, is this idea of State participation. If they don't participate, and I think you indicated we have ample precedent for it; in education, health, building sewer lines or whatever it may be the Federal Government says, "If you don't cooperate we will do this, that, and the other," mainly withhold funds, and of course the pressures become so great that they can't do anything else.

That is the way this would work, would it not?

Secretary RICHARDSON. Except that here since the National Health Insurance Standards Act does not contemplate the use of Federal money except to the extent that small employers might be subsidized, the sanction that would be applied would be the disapproval of the policy that was sold by the company in that State.

In other words, if the company did not meet the regulatory requirements or if the State failed to enforce them or to establish them, then in effect what we would be saying is that we could not approve the policy sold by the company in that State as complying with the requirements of the act.

Mr. BURLESON. I have no quarrel with that, if this legislation goes in the direction you suggest.

Of course, you have to have uniformity. I think that would be obvious. The idea is that the Federal Government has to bring pressures on a State to comply with anything. I suppose that is inevitable if we are going to get into this business.

Thank you, Mr. Secretary. Thank you, Mr. Chairman.

Secretary RICHARDSON. Thank you.

Mr. ULLMAN. Mr. Collier?

Mr. COLLIER. I have just one question. How would you propose to integrate the scores of existing insurance programs with the proposal that is before us?

Secretary RICHARDSON. In two ways basically.

First, by permitting an interval during which an existing collective bargaining medical insurance coverage arrangement could remain in effect without being superseded by the policies required by the Health Insurance Standards Act but also by recognizing that in the case of a given group of employees the policy covering them may supplement or go beyond the coverage required by the act.

So, in effect, in the course of time there would be the minimum coverage contemplated by the act and in some cases supplementation of it, but there would remain a degree of variance from one employee group to another.

Mr. COLLIER. Would this eventually lead to abolishing the existing programs where possibly the union and/or the employer are participating or where the company is presently providing a substantial percentage of the payment of premiums under group policies?

Secretary RICHARDSON. No. In effect the legislation would establish a floor of health insurance protection for all employees, but the collective bargaining process could build on that floor and either provide additional benefits or contemplate the employer's assumption of a larger share of the cost or both.

There would be required however, and I think this is an important thing to reemphasize, the option on the part of the employee to elect coverage under a health maintenance organization, that is, a comprehensive prepayment plan.

Mr. COLLIER. What then would be the opposition to permitting the employee to have the option of continuing his existing program if he felt that it were more advantageous to him than what is proposed with the limited coverage under the proposal before us?

Secretary RICHARDSON. The employee could in any case choose. He could choose indeed not to be covered at all.

Mr. COLLIER. Then there will be an option here.

In other words, if he doesn't want to participate in this program he doesn't have to.

Secretary RICHARDSON. Yes; the employer must offer a policy that would provide the benefits set forth in this legislation. The employer could offer more than that but, insofar as the employee would be expected to contribute in the long run at least a maximum of 25 percent of the premium, the employee would be free to choose not to participate at all.

Mr. COLLIER. That is fine. I wasn't under any impression that this would have an optional provision in it but indeed then it would.

Secretary RICHARDSON. As to the employee, yes. The employer would not have the option of providing no coverage. He would have to provide at least this much coverage.

Mr. COLLIER. Would there be some restriction that would prevent participation in two where there would be actually duplicate or excess payments of medical bills such as presently can be done if you maintain two medical policies?

Secretary RICHARDSON. This problem could arise in a situation, for example, where both the husband and wife were working but for different employers and somewhere each was covered then under an employer policy or where, for example, medicare coverage might be available to an employee over 65.

As I mentioned, I think, yesterday we intended that the legislation shall provide effective means of preventing duplication and this is probably not something that can be prescribed for in detail in legislative terms but we would like to see the legislation contain a provision at least that the Secretary shall by regulation prescribe methods to minimize duplication.

Mr. COLLIER. There certainly would be no justification for the Federal Government getting involved in a program that provided duplicate or duplicating benefits. That is not the intent and purpose of the program and I could see no justification under these circumstances for the Government to participate in a program that would pay duplicate benefits.

Secretary RICHARDSON. No; we agree with that.

Mr. COLLIER. Yet it could happen, could it not?

Secretary RICHARDSON. It could happen but it is a problem that can be minimized by the carrier itself in identifying the insurance status of personnel covered by a plan.

Mr. COLLIER. I certainly wouldn't want the responsibility of trying to administer this type of complex arrangement where, in consideration of the numerous policies presently in effect some of which did not,

for example, eliminate the first 2 days as is proposed here, I just see a maze of administrative problems that could develop in trying to prevent duplication or integrating existing medical health policies with what is proposed.

Secretary RICHARDSON. Of course, Mr. Collier, this is not a new problem. It is a problem that exists now to the extent that there are employee group plans and to the extent that even now a husband may be covered under one employer's plan and the wife under another and each plan provides for the coverage of dependents.

The medicare situation could exist now. Insurance companies do make some effort to iron out this kind of problem. What we would be doing here, in effect, is to build upon the most effective means that have been developed to this point to do that and to require that it be done.

Mr. COLLIER. If the basic purpose of this program, and it is certainly a laudable and necessary purpose, is to see that every one has coverage for medical care, I can't by any stretch of imagination see the necessity for involving anyone in this program that already has that coverage because, if everyone had it, there would be no need for the program.

So it seems to me that something ought to be worked out where it would either be optional, so that if that coverage is there, if the employee is protected presently, that he should not be required to participate in this program unless it were done entirely on a voluntary basis.

Secretary RICHARDSON. We agree with you, Mr. Collier. I would like to call to your attention the provision of the bill on page 11 which says that a basic health care plan to be approved must provide for appropriate arrangements with carriers and other providers of services under such plans to avoid overlapping or duplicative coverage.

Mr. COLLIER. If that is going to be a policy why has it not been possible to successfully do this in the Government health program. They have never been able to accomplish this and they have apparently been working at it some way unsuccessfully for quite some time.

Why would it be any easier here than it has been in the Federal employees medical insurance program?

Secretary RICHARDSON. We don't think it would be easier but we think that increasingly it is being done successfully under the Federal employees coverage.

Mr. COLLIER. I would have to disagree with you if you say that it is being done successfully under the existing Federal employees medical program because that is really not quite the fact. That is all I have, Chairman.

Mr. ULLMAN. Mr. Secretary, yesterday I didn't get to quite complete my inquiry.

I would like to just make a brief statement at this place in the record because I think it is pretty important that somebody state at some time what the prime objectives of national health insurance should be.

In your statement you covered a lot of matters but it has never been summarized. It seems to me that national health insurance at this point in time should encompass, No. 1, the matter of delivery of services relating here not just to the spreading of services to get to rural areas but the matter of the ordering of the services through outpatient care, home care, adequate but not duplicated hospital and nursing home care.

Second, a national health insurance in my judgment should involve a basic change in incentives. If we are to continue private participation in health services as I think we should, we need to shift the emphasis in terms of the profit motive.

Today, the private health industry today profits from sickness. It seems to me that the profits, if they are to continue, should come from keeping people well. I recognize that in your health maintenance organization you are talking about this. However, we need a specific program of national health insurance to do something far more definite about the incentive problem than you have recommended.

Thirdly, it would seem to me that we need a definite cost-control mechanism. I see nothing in your program that would establish the kind of cost controls that are going to be necessary if we are to be successful in providing for health services within the scope of the private and public resources available in this Nation.

Fourthly, I would think that any system of national health insurance should involve full coverage and your program falls far short in that regard.

Today we are pushing the average American out of health care. There are a lot of reasons why that has happened, but the health industry has been the most inflated in America, and it can't continue. It has to be turned around. I see nothing that you would advocate to do that.

We need full coverage, as I have said, utilizing public and private resources.

We need further, fifthly, a consolidation of Federal programs. I see in your program a continuation of the kind of hodge-podge that is currently in such problems. It would seem to me that if we are to gain our objective we have to put it all together some place. We are not doing it now and I see nothing in your program that would do it.

Finally, I think we need an equitable financing program for the public part of a national health insurance program, and here again I see great gaps in your program.

Looking, for instance, at the part of your program that mandates private health insurance, you have a 65–35 participatory program that involves great problems with respect to employer-employee relationships.

You give the employer the incentive to hire people who either do not require private insurance coverage or who might opt not to take it. The cost factor for the employer of this Nation under your program, in my judgment, is prohibitive, particularly in view of the fact that you're mandating insurance that does not include the cost-control mechanisms that are so basic to any national health insurance industry.

There are certainly other factors involved but those in my judgment come to the very heart of any basic solution to the problem of national health insurance.

I, for one, have some reservations about Mrs. Griffiths' program of nationalizing at this point in time. I had hoped that we could accomplish these objectives by coordinating the public and private effort in this Nation. I had hoped that you might come up with a far more comprehensive scheme that involves these basic matters to which I have referred. Hopefully, during the course of the public hearings

over the next month we can broaden the scope of our consideration so that somehow we can put it all together.

I don't expect you to comment on this now, Mr. Secretary, but I think these objectives should be clearly stated in the records at this point.

Secretary RICHARDSON. Thank you, Mr. Chairman.

We certainly agree with that last point. I would like if I may to make one brief comment and that is on the cost-control aspect of the total problem. I offered for the record yesterday a listing of the cost-control measures that we are advocating. They fall under the heading of hospital and extended care facility charges, physician fees, delivery system generally, carriers, and patients and they total some 26 different items or aspects of a total coordinated approach.

I would just say briefly that there is no reasonable and in our view feasible means of dealing with the problem of costs of health care or of insurance coverage that we have not incorporated into our proposal that we know of or that has been brought to our attention.

If there are better ways of dealing with the problem than those we have proposed or than those we have heard of to date, certainly we will be receptive to them.

Mr. ULLMAN. I think you would agree and I agree with Mrs. Griffiths that the insurance industry has been greatly at fault. It is not necessarily the profit industry. The nonprofit industry has also been at fault in going down the road of paying bills without regard to coverage or duplication or the quality of service, or, to the other factors that go into a good health program.

This certainly has to be turned around and as we get into executive session I certainly will want to explore it.

I hope you will put all of these cost control mechanisms together in some kind of form that can convince some of us at least that we won't be going down the same old road we have been going down toward ultimate disaster. That is why we have to have a national health program today.

I think there was a time when we could put our head in the sand, but we have passed that point. By the mid-seventies it is mandatory, in my judgment, that we have a viable national health program far beyond the scope of what you have talked about here today.

Mr. VENEMAN. Mr. Chairman, may I just briefly inject one comment and that is that when you said that you felt that this should be the prime objective of a national health insurance policy I would have to disagree with that. I think the six or seven items that you pointed out should be the objective of a national health policy.

What this committee has before it is the administration's health insurance aspects of a national health policy which was outlined by the President on February 18 of this year. Portions of these bills are in other committees. We do have the health maintenance organization proposals up. We do have cost-control measures in H.R. 1. We are taking cost-control initiatives administratively and through other means.

We do have manpower bills before another committee of the Congress. So that I really think what we are talking about is the ability to distinguish between our objectives for a national health insurance

policy and what we are trying to provide there is financial access, reasonable financial access to health care for all Americans.

Now, we can't write all of it in one bill. I would hope that as we go through this that we do understand that the administration has proposed a national health policy.

I think this is the first time that an administration has looked at all the parts that go into a national health policy. I can't disagree really with what you have outlined. I think the objectives that you have outlined are the appropriate objectives.

We may have disagreement but I don't think that we should simply conclude that all of these objectives can be met in a national health insurance bill and the only way you are going to make them meet this objective in a national health insurance bill is to federalize the system in a manner similar to what Mrs. Griffiths and Senator Kennedy have proposed.

Mr. ULLMAN. Mr. Secretary, I don't agree with that conclusion of yours that there aren't ways of putting it together without federalizing it. I am hopeful that as we go into the executive session following the hearings that we will be able to move in that direction.

I think your comments point up one of the basic problems in this Congress. That is that in spreading the responsibilities around among different committees we may very well wind up in exactly the same place we have been in welfare, in exactly the same place we have been in education and other programs, labor training programs, where we have a proliferation all over the lot.

We are all going to be going in different directions and somewhere along the line it has to be put together and I think in this matter of national health policy now is the time and this is the place. We can no longer afford the route of proliferation which I think you will inevitably find if you start spreading this responsibility around among the different committees.

I have taken too much time.

Mr. Conable?

Mr. CONABLE. Thank you, Mr. Chairman.

Mr. Secretary, in view of your fine and comprehensive statement here I have only one short inquiry and that is about the chart we have before us this morning. I wonder if we could go into again what constitutes induced costs.

You have a chart which sets out in full the medical expenditures in this country under any of these systems including the present system and presumably these are each comprehensive and you pick up in direct payments what you don't pick up otherwise.

You have from $105 billion under the present system, to $113 billion as the projected cost in 1974 of a fully federalized system under the Griffiths' bill, a difference of more than $8 billion of induced costs.

Did you say that was cost-push or demand pull or a disruption factor or what adds that additional amount?

Secretary RICHARDSON. Well, I think perhaps demand pull is the most apt of the phrases you have suggested. There is a discussion in the committee print of August 1971 headed "Analysis of Health Insurance Proposals Introduced in the 92nd Congress" beginning on

page 81 that describes the concept of induced cost and also describes how induced costs were estimated.

It says, and I might read it, because I think it is put better than I could do it off the cuff, at the bottom of page 81:

> 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.

What this means is that where an employee regards a health service as totally free that he would make demands that he wouldn't make if he had to think of some cost out of his own pocket and, since the Griffiths' bill which is shown on the second column on that chart would in effect make all health services free, the result then is an estimate that there would be this surge in demand having an effect therefore on costs including an inflationary factor as well as an actual increase of consumption.

Mr. CONABLE. How do you measure this with any degree of accuracy if you don't have any experience though?

Secretary RICHARDSON. Well, the committee report I think is quite candid indicating that the estimates are tentative.

It says on page 83—

> The existence of induced costs has been demonstrated, and to some degree quantified in earlier studies. 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.

What the Social Security Administration Chief Actuary has done has been to assemble these data and develop projections which are at least applied consistently for all the proposals before the committee. There has been no pleading of the results as between one of the proposals and another.

Mr. CONABLE. Have you made any assumptions at all about the impact of these various plans on the medical delivery system, the number of people participating for instance in the health industry, and are these any part of your estimate of cost?

Secretary RICHARDSON. They are in the sense that part of the induced cost is a result of pressures on the available supply of health care personnel.

In that sense therefore there is a reflection of the result to be anticipated if people can demand services of health care professionals without having to consider the cost to themselves.

Beyond that we have to look at the problem of health manpower in terms of how to develop it more rapidly and how to use it more efficiently through the use of allied health manpower and so on.

Mr. CONABLE. Wouldn't the Griffiths' bill result in a very substantial restructuring of the medical delivery system?

Secretary RICHARDSON. It probably would, yes, although we think it is an extremely clumsy mechanism to wheel up in order to bring about what I think we would all agree are desirable improvements in the delivery system especially through the availability to a larger extent

of health maintenance organizations and reliance to a greater degree on allied health personnel.

Mr. CONABLE. Hasn't the advent of a comprehensive medical system in some of the other countries that have adopted them on a nationalized basis had a demonstrable impact on the medical delivery system in terms of what doctors decide to do, what kind of services they decide to perform and where they decide to perform them.

Secretary RICHARDSON. It certainly has.

Mr. CONABLE. That is really very difficult to quantify, isn't it at this point?

Secretary RICHARDSON. It is difficult.

Yesterday in my prepared statement I think Mrs. Griffiths feels that I was unduly harsh but I tried to put what I really think about it in, it seemed to me, measured terms that there is a real risk I think when you put fee for service at the end of the line in distributing appropriated sums to pay for health care. There is a considerable risk that doctors will simply not choose to participate in the system on a capitation or salaried basis and the result is also likely that many people who can afford it will buy service outside the system on an out-of-pocket basis. This has happened to a large degree in the United Kingdom.

Mr. CONABLE. It is happening to a substantial degree right now, is it not?

Secretary RICHARDSON. Yes.

Mr. CONABLE. Mr. Collier, I yield.

Mr. COLLIER. I think there is probably one very fundamental factor that perhaps has been overlooked in most of the proposals that I have reviewed in conceiving a public health program. Relating health care as a necessity, a human necessity to the three basics, food, clothing and shelter, what percentage of his income would you say the average wage earner should be expected to pay for this fourth and very vital necessity?

I think we could arrive at, No. 1, the fact that this is a necessity for which he has certainly an obligation to pay part of his income just as he expects to pay it for food, clothing and shelter. It should be in reason, as we agree, and this is why we have the bill before us, because in some cases it is out of reason.

But establishing a percentage, of course taking into consideration income and not affecting those who can't pay at all, in which event there is certainly an obligation to see that they get health care, what part of a man's income should he expect to pay just as he expects to pay a part of that income for food, clothing and shelter?

If we arrived at that, it seems to me that we get away from this idea that this should be a program that is totally free and yet it would be kept within the realm of reason and meeting the human necessity involved.

Secretary RICHARDSON. I think that is a very significant line of thought, Mr. Collier. I can't give you a carefully considered judgment on what I think the ratio should be. One of the problems, of course, is that it is important to distinguish between the share of a family's income that is devoted to insurance coverage——

Mr. COLLIER. That is medical expense?

Secretary RICHARDSON (continuing). In situations where the family is not sick or in which there is no serious illness in the family and the extent to which the family should be, in effect, immunized against any increased cost in the cases where there is illness.

Now, a program that protected the family against any share of the costs of actual illness would be one, of course, with no element of copayment or coinsurance, and such a program would be possible to design. We have calculated, for example, that the costs of the program that we have advocated for all workers and dependents is about $490 a year premium cost, of which the employee would pay $171.

If you eliminated all the coinsurance features in our proposal, it would just about double the cost. That would raise it then to about $975 or $980. That means, then, that I would be talking about, let's say, roughly $1,000 as of fiscal 1974. The cost would be flat as income rose.

It wouldn't cost a family any more money than that for this coverage. You could expand the coverage some more. Let's say you could easily add systems such as psychiatric care, dental care that might bring the total premium cost to $1,500, but still it would be flat and not rise as income rose because a family's health care needs would not, of course, be dependent upon its income level.

Then you have the question what share of this should the individual pay or the employer and, of course, again one has to recognize that maybe after all the employer's share could be considered in some sense as reducing what the individual might otherwise get in the form of direct cash salary.

So what you really have, then, is a constant dollar amount representing total insurance protection to be divided in some way between employer and employee or between the Government and the individual family, and you also have then the question how much less than total indemnification should the package provide, and this brings us back to the cost considerations that we were talking about in the context of induced costs.

We think that it is desirable for the family, the employee, to pay some of the cost for the reasons of reducing undue pressure on the system that tends to arise where he feels that all health care is entirely free. These are just some of the elements of the problem that you put.

Mr. COLLIER. All I am trying to arrive at is, since medical costs would basically be reduced to payments for medical insurance, then again it brings me back to the necessity of having some basic percentage involved here. It is not new in terms of what has been developed over the years as to what a family of four with four children should pay for rent, for food, for clothing, and it is not my intention to raise the question of restriction, but to arrive at what is a fair figure for a wage earner to pay toward his medical care which would be in terms of insurance premium payments rather than on the basis of any direct payment to a physician or to a hospital.

I think if we could develop a percentage figure and move from there, we would be in a much better position to determine, No. 1, the amount of coverage based upon the $490 figure you have mentioned, based upon the number in a family, and based to some degree upon

that man's income, because therein lies what appears to me to be the crux of the whole problem, the necessity of adequate medical care to be paid for out of incomes that vary for families with different numbers of family members to require this.

Somewhere it just strikes me as being what would be necessary to establish in order to establish a program that was economically feasible for those who are wage earners and yet, as I said before, kept within the realm of his physical ability to pay, on the one hand, and his health needs, on the other.

Secretary RICHARDSON. Well, this is essentially what we have tried to do. I think I must repeat what I have said, that it is difficult to develop an abstract measure of this. Of course, there is the distinction between health care and, say, shelter that as people earn more money, they tend to live in bigger and more expensive homes, and so they may be spending more or less the same share of total income for shelter at a $50,000 income as at a lower level of income.

Mr. COLLIER. And their taxes proportionately go up?

Secretary RICHARDSON. In the case of health care, however, we would hope that this was not so, that the quality and accessibility of health care to the $5,000 income earner was just as good as the $50,000 income earner could buy, which means therefore that the costs are the same irrespective of the income level of the family.

Mr. COLLIER. We then would spread the cost, which is the basic concept of group health insurance, notwithstanding the fact that there are different risks involved within the broad group that is covered. I don't want to press this. I am just raising the point because I think it is important.

Thank you, Mr. Chairman.

Mr. ULLMAN. Mr. Vanik will inquire.

Mr. VANIK. Mr. Chairman, there has been a question raised on the testimony that was given yesterday on page 52 of the reported testimony. This relates to the assignments by physicians.

Secretary RICHARDSON. Would you repeat the page number again?

Mr. VANIK. Page 52 of the stenographic report. Don't you have that?

Secretary RICHARDSON. I am sorry, I don't have that.

Mr. VANIK. I will refresh your memory. We were dealing with the reimbursements of physicians on the basis of medicare and Chairman Mills had asked: "You would require that all the basic health policies in the entire Nation must reimburse physicians on the same basis as medicare; is that right?" And you responded in the affirmative.

Then the chairman said:

> Now, even if this is good policy, and I guess you think it is, how would the hundreds of health insurance carriers obtain access to all the physician charge profiles which Medicare carriers maintain now and how would we know who should pay for the data?

And your response to that was:

> We believe, Mr. Chairman, that for this reason and also in order to make patients aware of the physicians who have agreed to accept assignments at the published rates, that these should be published for the areas to which they apply.

The whole subject area dealt with cost control. My question is this: I have been trying for a long time to get the Social Security Admin-

istration to make available in my community the list of those doctors who took the social security assignments on the fee schedule that was recognized in the community, because the average person has no way of knowing whether his doctor will take an assignment or not. He usually is deeply involved in his professional and contractural relationship with his doctor and is very often surprised after the services are completed that his doctor will not take the assignment.

Now, do I understand your reply to that question to imply that it would now be at least your policy that we would have available in communities the list of physicians who accept assignments so that the consumer, the person in need of medical services, could have ready access to at least a list of those doctors who take assignments as distinguished from those who do not?

Secretary RICHARDSON. We believe that such a list should be available in the community and we have thought about various ways whereby doctors could make known the fact that they will accept patients at the published fee rates, which of course in the case of medicare means that they are reimbursed at their customary charge up to the 75th percentile of the range of rates charged in the area for a particular procedure.

I might ask Mr. Ball, who is administering this policy right now, to answer that.

Mr. VANIK. I understand that he opposed making this information available or said it couldn't be done. I will be glad to have your response under these circumstances.

Mr. BALL. Mr. Vanik, I think the situation under the administration's proposal is quite different than the situation today in the medicare program. Part of the problem that exists today is the typical situation is that a physician does not in general take assignments or, on the other hand, in general has decided not to take assignments. The typical situation is that he takes assignments for some patients under some circumstances and then for other patients he does not take assignments at all.

This is related to how large the bill is, to the income of the patient and so on. So that the idea of having under the present medicare program a list of physicians who agree to take assignments is not too practical because most of them don't do it all one way or another.

Another problem on the publication of reimbursement amounts, if I can complete the thought here, Mr. Vanik, is that medicare as you know does not reimburse on the basis of a set fee schedule. The reimbursement is on the basis of the customary charge of the physician, what he customarily charges with a ceiling and the ceiling relates to the prevailing charge for that locality for that particular procedure.

But most physicians will be under the ceiling. It isn't as if the prevailing was what governed the reimbursement. Mostly what governs the reimbursement is a customary fee which is below the prevailing. So if you are going to say we are now going to have a fee schedule under medicare, defined as the prevailing, that is as the 75th percentile of customary charges, all the physicians who are now below the 75th percentile have a good reason to come up to that amount and you make the program more expensive rather than less expensive, because we are now reimbursing below the prevailing in most instances.

Then you go beyond that and say, now we have to have a list of those who will pledge always to take an assignment regardless of how much income the patients have and you have introduced an entirely different element into the program. So that I am merely saying that I believe the Secretary was replying to a new approach under the administration's proposal rather than to the way medicare could operate under present law.

Mr. VANIK. I don't know how it would differ from medicare. I thought it was based on the same idea. Am I right, Mr. Secretary?

Secretary RICHARDSON. I think the underlying approach to the reimbursement or payment of fees utilizing a ceiling at the 75 percentile and so on is basically the same and I think the considerations that lie to the patients' understanding of whether or not he is receiving a service at the cost which will be reimbursed in full by the insurance system is also the same.

The difference, I think, essentially is that the case of the insurance plan that we are proposing we would be seeking to enlist the medical society for the area on a broad base cooperatively in peer review, utilization review and other measures that are designed to keep costs down for the population generally as part of a broad effort to attack what is undoubtedly one of the most troublesome areas of concern to people today as they see their bill for health care going up faster than any other of the costs they pay.

Mr. VANIK. Well, as I have studied your proposal, everything seemed to be exactly the same as it operates under medicare, so that it would seem to me that at least we ought to have a list of those physicians who refuse to make assignments of any kind.

In my community we have a substantial number of physicians who refuse to take assignments in all or part or any case. They just refuse to do it. At least we ought to be able to have some way in which the individual citizen can be aware of this without having to make an individual inquiry of each and every doctor.

Today he goes into a hospital and before he is through, there are eight different doctors that deal with his illness. It is very difficult for him to decide and determine, particularly under emergency conditions, which one of them take assignments and which one of them does not.

I think he would be well advised if he at least could tell which refused to take any assignments. That would be a very helpful thing and might serve to bring about some cost control. I have had a great deal of concern on this issue. From what I have been able to determine, the reasonable doctors, those that are low in their charges, if they charged $10 would get reduced by medicare to $6, and if they charged $100, they would be awarded an $80 fee by medicare.

I find no balance in this thing. It seems to me that we have penalized hard-working, diligent doctors in favor of the society doctor with big fees.

Secretary RICHARDSON. We agree with you, Mr. Vanik, and we are very clear on the proposition that in the regulatory legislation shortly to be submitted to you, there would be a requirement for the publication of providers' charges for standard items and other patient access matters.

Mr. VANIK. And could that be amplified to include a public listing somewhere of those doctors who refuse assignments of any kind under the system?

Secretary RICHARDSON. I am not sure I would be prepared to say that we should publish the list of those who won't as distinguished from the list of those who will, but certainly we agree in principle that the patient should have the opportunity to be informed in advance whether or not he is going to be stuck with an extra bill beyond what his insurance coverage meets.

Mr. VANIK. The average patient is hardly able to enter into a fair negotiable arrangement with the doctor who is providing the services. He is pretty much at the mercy of his problem. At the time he must contract for these needed services, he is fighting to save the life or protect the life of someone he loves. He is hardly in a bargaining position.

Very often the patient is already in an institution, which has a limited number of doctors who designate themselves as the doctors of that institution who provide the special services in that institution. He doesn't have a free market choice on who should render the services for his patient.

Mr. WAGGONER. Will the gentleman yield?

I wasn't aware that people who needed medical care shop on the basis of price with doctors.

Mr. VANIK. They hardly have a chance. I think that if their doctor is one who absolutely refuses to accept any claims under this program or under medicare they ought to know that, so they could find a doctor who might accept an assignment. Many people, by reason of their own income in life, might have very little choice but to try to select that kind of physician.

Mr. WAGGONER. If the gentleman will yield further, he might get one of his secretaries to work with the Yellow Pages and compile the list himself.

Mr. VANIK. I think this kind of service ought to be provided nationally, on a uniform basis by the Government to help those who are providing services have some idea of what they might get into.

Mr. WAGGONER. The gentleman must not think it is worthwhile or he would do it.

Mr. COLLIER. Would the gentleman yield?

What is the difference whether he looks at a list and sees who will? Why is it better that he gets a list of those who won't?

If there is going to be a list of those who will, he looks on the list for one who will.

Mr. VANIK. He wants to select a doctor who is going to take an assignment. I think he ought to know which doctors are taking assignments and which doctors are not.

Mr. ULLMAN. A point of order. Does the gentleman yield?

Mr. VANIK. I certainly don't yield for argumentative purposes. We will do that in executive session.

I would like to ask the Secretary a further question. In your statement, Mr. Secretary, you talked about "virtually" all people having health coverage. In that answer you deal with those who have hospital

insurance. If you talk from the standpoint of hospital insurance, the statement is substantiated. But when you get away from hospital service and go to physician services, then we find that over one-half of the people are not included.

You don't dispute the chart that we have in the Ways and Means Committee report on the number of people that are excluded from medical services covered by insurance?

Secretary RICHARDSON. No, indeed. I think we furnished the data on which that was based.

Mr. VANIK. Now let me ask you this. By your definition how many and what people remain excluded under the age of 65 in the Administration's health proposals?

Secretary RICHARDSON. I would have to furnish for the record the age breakdown on this. Basically the coverage is most limited in the case of people under 65 with respect to unemployed single individuals and couples without children.

On the other hand there is included in that total a large number of students.

(The material referred to follows:)

THE POTENTIAL IMPACT OF NHISA ON THE LOW-INCOME POPULATION AND ON THE WORKING-FORCE POPULATION AND ON EMPLOYMENT CHARACTERISTICS OF THE MANDATED POPULATION

In theory, only persons eligible for Medicare or the Family Health Insurance Plan are ineligible for NHISA.

Part A of NHISA would apply to virtually all private employers of one or more persons. Governments and religious orders and those immeasurably few employers who hire only transient part-time help would not be mandated.

Section 605 of Part B of NHISA would offer coverage to all unmandated individuals not eligible for Medicare or Family Health Insurance, (Title II) through pool arrangements.

NHIPA does not require any worker to obtain insurance. Hence we would only assume that all those eligible would take advantage of the large employer contribution, unless alternative coverage was even more favorable to him.

It is estimated that 57 million workers out of the total age 18 to 64 civilian employed labor force of 79 million would have coverage offered under NHISA's mandate by virtue of their own employment. Nearly 7 million workers not directly mandated would have this opportunity by virtue of their spouses' employment.

Among this civilian employed labor force, the residual 15 million would include some eight million government workers, nearly two million farm owners, four million other self-employed, and one million unpaid family workers. (It may be of interest that 70% of the unpaid family workers whose spouses were not mandated are spouses of self-employeds). There would also be an estimated four million unemployed heads of families most of whom would be public program eligibles.

Data was adjusted to eliminate from the mandated worker totals, spouses who work less than 13 weeks per year in mandated employment. No such adjustment was made for household heads, because reviewing combination data, we find less than 0.5 million families (and 0.8 million working-force individuals) in the situation of neither head or spouse employed more than 13 weeks. Like the unemployed, many of these would be public program eligibles.

Over time, as mandated workers become eligible for Section 603(f), approximately half of the unemployed would receive the opportunity to continue self-sufficiency for their health insurance, during transitional periods of unemployment.

Attached are several tables illustrating NHIPA's potential effects on the low income population, the adult population, and an estimate of the unaffected population according to their work characteristics. Estimates in the tables were de-

rived from the SSA data tapes which have adapted the March 1969 Current Population Survey to simulate H.R. 7741 assuming H.R. 1 for 1972. They are essentially, therefore, projections ultimately based upon the 1960 census and its interim updates. Estimates using the 1970 census as the ultimate basis will be developed as soon as it is technically possible.

The estimates in Table 1 suggest that the under age 65 low-income population, not eligible for adult assistance, will total 27 million persons, 21.8 million in families with children and 5.2 million in other families.

Of the 21.8 million in families with children, NHIPA would impact on all but 0.5 million persons in some 138,000 families whose heads are not employed 50 or more weeks each year but whose assets exceed FHIP requirements. FHIP would protect some 14.6 million and NHISA would be available to another 6.8 million through the employer mandate.

Of the 5.2 million in childless households, NHISA would be available to over 0.9 million through the employer mandate. The remaining 4.2 million would include some student headed families.

The combined 4.7 million persons who are neither FHIP eligible or mandated would be theoretically eligible for NHISA pool coverage. This sum would be reduced should H.R. 1 coverage of disabled worker beneficiaries be enacted by approximately 150,000 persons.

1. NHIPA IMPACT ON THE LOW-INCOME (FHIP LEVELS) POPULATION UNDER AGE 65

	Units (thousands)	Persons
Within low-income levels	9,022	27,024
Expected eligibles for FHIP	3,362	14,600
Expected ineligibles	5,660	12,424
Mandated NHISA [1]	1,963	7,709
Families with children	1,297	6,774
Other	666	935
Eligible for NHISA pools	3,697	4,715
Families with children [2]	138	466
Other [3]	3,559	4,249

[1] Represents heads of households employed 50 or more weeks. Assumes all such low-earnings positions are in private sector. This possible understatement of the mandated NHISA in terms of weeks worked, is offset by the overstatement possibly arising from unmandated employment.

[2] Families whose assets disqualify them for FHIP.

[3] Childless households—including student headed—whose heads are not full-time employed. Some to these may also be eligible for public programs such as those for veterans, and others may be aided by pending medicare for the disabled.

Tables 2 and 3 consider only adults age 18 through 64 of several types. Individuals (working and not-working) and couples with various combinations of work experience. Several hundred thousand adults, not spouses or heads, but attached to families, are not included because their type of occupation is not known.

Table 2 shows that of this 116.7 million adults, 79.1 million will be offered mandated coverage, while 37.6 million will not. All of this latter population is theoretically eligible for "Pool" NHISA coverage. The pending Social Security coverage of disabled worker beneficiaries under Medicare would eliminate a large portion of the 1.5 million persons that would be covered should those provisions be enacted.

Table 3 gives work characteristics of the unmandated population. Nearly 16.7 million are not working, and have no working spouse. Many of these would be public program eligibles, including over 4 million adults under FHIP. Nearly 21 million are working in unmandated employment or are spouses of such persons (not themselves mandated). About 10 million of these most likely will be eligible for group health insurance as government workers, or their spouses. The remaining eleven million receive earnings through the heads of self-employment, and could obtain "Pool" NHISA coverage as individuals.

2. POTENTIAL IMPACT OF NHIPA ON ADULT (18-64) POPULATION

[Thousands of persons]

	Total	Affected by mandate	Not affected by mandate
All persons 18-64	116,759	79,121	37,638
In HW families	95,456	69,420	26,036
Both working	45,356	[1] 38,438	6,918
Head only working	38,660	29,066	9,594
Spouse only working	3,196	1,916	1,280
Neither working	8,244	.....	8,244
Individuals	21,303	9,701	11,602
Working	12,877	9,701	3,176
Not working	8,426	.....	8,426

[1] Husband and wife both working, and one or both work more than 13 weeks per year in mandated employment.

3. EMPLOYMENT CHARACTERISTICS OF ADULT POPULATION NOT AFFECTED BY NHISA MANDATE

Total	37,638
Reason for no mandate:	
Not working	[1] 16,670
Individuals	8,426
Heads and spouses	8,244
Employment not mandated	20,968

	Type of employment	
	Government	Other (self)
Total	10,008	10,958
Individual	3,176	2,162	1,014
Both working	6,918	2,404	4,514
Head only working	9,594	4,764	4,830
Spouse only working	1,280	680	600

[1] Includes students and many persons eligible for public programs such as those for veterans. Others may be aided by pending medicare for the disabled.

Mr. VANIK. The couples without children you definitely exclude?

Mr. VENEMAN. Unless they are employed.

Mr. VANIK. Yes, unless they are employed. What do we do with them? What can they do? There are quite a few people in that category.

Secretary RICHARDSON. They could elect to purchase coverage under the pool that would be set up for their area under the legislation we propose.

Mr. VANIK. That isn't an assigned risk pool, is it?

Secretary RICHARDSON. It is not an assigned risk pool, but it is a pool which, in effect, provides the equivalent of group coverage for small groups of employees and single individuals and couples who are not part of any group.

Mr. VANIK. And there would be no public contribution to the cost of their coverage?

Secretary RICHARDSON. Not as we have proposed it to this point, although as I indicated earlier, this is a question which we think is

going to have to get a considerable amount of further consideration by the committee. We don't have a firm view of the question of how best to deal with the higher costs of coverage in the pool than would be likely in the case of many employer plans.

Mr. VANIK. Have you any estimate as to the number of people that would fall into that category?

Secretary RICHARDSON. Yes, we do have these figures and the total that we estimate of the individuals nationally falling into this category is about 4.2 million persons.

Mr. VANIK. Let me ask this further question. With respect to those covered under your plan, where a person seeking coverage has had a previous record of an illness, would the insuror be allowed to exclude that particular person with his record of illness or would it have to embrace everyone, regardless of their medical record?

Secretary RICHARDSON. No. The individual with a previous illness or existing illness would have to be covered within six months of his becoming employed.

Mr. VANIK. Without any increase in premium?

Secretary RICHARDSON. Without any increase.

Mr. VANIK. Would that include physically and mentally handicapped children?

Secretary RICHARDSON. As members of the family, yes.

Mr. VANIK. One other thing concerns me. That is the matter of uniform eligibility nationally with respect to FHIP income eligibility. Wouldn't that discriminate against the higher cost communities and in favor of the lower cost communities geographically distributed throughout the United States?

Secretary RICHARDSON. There would be a degree of variance, certainly, in this. This is a problem which we have come up to in other connections, for example, with respect to the minimum level of welfare reform benefits. It turns out that the variances as between, for example, urban and rural living can be wider even within a narrow geographic area of the country than regional differences are.

But today take the poor and it is difficult to factor in that kind of variance into a basic national plan. We said on the Senate side that we were prepared to initiate studies of ways of trying to do this, but that we did not believe that we had sufficient data or good enough yardsticks to go by to do it at the outset of any program.

Mr. VANIK. I have one final question concerning the exhaustion of catastrophic coverage. What do you propose could be done for people in that dilemma?

Secretary RICHARDSON. In the case of an individual when the total medical bills exceed $50,000, then he would, in effect, be started over again by the restoration of catastrophic coverage at the rate of $2,000 a year. In other words, it would build back up again.

It could be done in other ways. Of course, you don't have to have the $50,000 limit or you could build it back up faster. These are questions essentially of cost and there is also involved in the case of catastrophic coverage generally the problem of potentially skewing the system toward high-cost procedures or the payment of costs in situations where resources are unduly devoted to long-term and elaborate procedures at the expense of other forms of care.

Mr. VANIK. I have no further questions, Mr. Chairman.

Mr. ULLMAN. Mr. Pettis will inquire.

Mr. PETTIS. I will very quickly ask the question and maybe it isn't a question as much as a statement. I have a feeling as we have been going into this problem that maybe we don't have as much interagency communication about not only the problem, but the solutions. Let me use another area of our society in which we have problems.

For example, if a military installation is phased out of a community and it results in economic loss, every agency of Government has an input into helping solve that economic problem in that community by a newly developed interagency committee.

Now it is my impression that, for example, in the area of creating health personnel, or I should say medical and paramedical personnel, that we have some agencies of Government that are building hospitals, for example, that do this without any regard to whether that hospital might be helpful in the training of doctors and paramedical people.

The Veterans' Administration is a very good example of this. I wonder if we couldn't bring all of these people together, whether they are military hospital builders or the Veterans' Administration, so that when these hospitals are built, they are built next to an existing medical school. All of these schools now are going broke.

They need help and, rather than build a veterans' hospital out in the middle of a cornfield in Iowa that is 60 miles from the nearest medical school, it would be better to put it next to a medical school where there could be a benefit to the medical school as well as to the veterans.

I am not sure that you are not doing this, but I am not sure you are either. What I am really saying is, why can't we get all of these agencies of Government to collaborate on the problem? Let's say the one problem of producing more medical and paramedical personnel when they are spending millions of dollars in the building of institutions like hospitals.

Secretary RICHARDSON. I think you have pointed up a very real problem and a very real need. We can and should do a better job across the Government and, indeed, we need to do a better job within communities to anticipate needs and coordinate planning. Planning has historically, I think, in the United States been a dirty word and we have lagged badly in developing even the most rudimentary planning base and capabilities not only within the Federal Government, but within communities and in regions throughout the country and we simply do not have the resources for the health care system that would permit us any longer to waste them in duplication or overlap or to allow unconscionable gaps to develop.

With all of this in mind, I have urged the creation in the Office of the Assistant Secretary for Health and Scientific Affairs in HEW of a deputy who would develop this planning capability. I would like to ask Dr. DuVal, the Assistant Secretary now, who is here, to perhaps supplement this because I know he is very much aware of the problem you identify.

Dr. DUVAL. The specific question, of course, focuses on misoriented Federal development such as the military and Veterans' Administration, which do not fall within our jurisdiction. They do, of course, fall within our concern.

The Veterans' Administration since the so-called policy recommendation No. 2 of 1946 or early 1947 has shown an increasing awareness

of the possibilities that exist and the benefits that accrue to having made a decision to locate their hospitals in juxtaposition to the academic medical centers, to enhance their training capacity and contemporary legislation less than 2 years old not only makes that an even more desirable policy for them to implement, but actually gives them authority to begin training in the paramedical fields and this year with legislation currently before the Congress may actually get them into the business of joining States—I think it is five in number at this time—to start medical schools.

So that the VA has shown already a very real interest in pursuing the same objective that you just articulated. The military institutions are, of course, somewhat different in that their missions are highly specific and concrete and they do not have the same latitude in decision-making that the other Federal establishments do, although they are also showing by certain pilot examples in the United States that they too can enter into a compact-type arrangement and participate at the community level.

From the viewpoint of the Department of Health, Education and Welfare, our concern is that we bring into being a much stronger local community health planning capability with some guidance to the extent necessary from the Department, such that the total facility development in a community can be rationalized and to the extent that the Federal Department can participate with the community, this is an effort that we not only consider worth pursuing, but we are going to develop the capacity in my office to focus on that.

Mr. PETTIS. May I pursue this one step further?

Would there be any harm, say, here locally where we have Bethesda and Walter Reed, in having affiliations, let's say, with the two medical schools here because they are in dire financial straits, I understand.

This would be so that some of the expensive equipment and facilities at those two major hospitals could be made available to medical and paramedical students studying in those two universities.

Mr. DUVAL. Mr. Pettis, I am sure that you know that this is a concept that has appeared in legislation such as, I think, the present H.R. 2 every year for some years, and this year it has gone through the House and will be, if I am correct, subject to further treatment. I would only add the parenthetical note that to the extent that the medical schools in the District are having financial difficulty, it is not due to absence of availability or access to the resources such as at the Bethesda campus.

Mr. PETTIS. Thank you.

Mr. ULLMAN. I would advise the committee that we are going to attempt to conclude the hearing with the Secretary this morning and would ask unanimous consent that all members have 5 days in which to submit questions to the Secretary to round out the record.

Without objection that will be done.

(Supplemental questions and answers follow:)

From Mr. Mills—Question No. 1

In the Medicare program the hospital inpatient deductible, the coinsurance amounts and the part B premium all rise automatically as health costs rise. Why didn't HEW follow this same general policy in H.R. 7741?

Would you recommend that same policy be applied to the Medicare program by eliminating the present automatic increases?

Answer

In the Medicare program, the hospital inpatient deductible, the coinsurance amounts and the part B premium all rise as health costs rise so that beneficiaries continue to pay the same share of their medical costs. If this were not done, it would be necessary to increase the income to the program or cut back on the benefits.

For the most part the same is true with respect to the deductibles, coinsurance, and premiums in H.R. 7741. Under the National Health Insurance Standards Act employers and employees would be responsible for specified shares of premium costs. Since private insurance companies would underwrite employer sponsored plans, there is every reason to believe that premiums would increase as medical costs rise. Further, beneficiaries would pay for the first 2 days of hospital care, plus 25 percent coinsurance on additional days of care. Since each of these beneficiary cost-sharing responsibilities will rise as health costs rise, beneficiaries would continue to pay the same share of the expense.

Under the Family Health Insurance Plan, beneficiary cost sharing varies in accordance with the income class of the eligible family. Premiums are a fixed amount, but deductibles and coinsurance whenever applicable are similar to those under Medicare. With the Family Health Insurance Plan, it seems necessary to consider the ability to pay as the primary determinant of the amount to be paid.

From Mr. Mills—Question No. 2

Private health insurance covers about one-quarter of all health care expenditures. What will the proportion be in the event your bill became law?

Answer

The proportion of all health care expenditures paid through private health insurance is projected to rise from approximately 25% to 20% under the Administration proposal. The proportion of expenditures for acute care (excluding public health expenditures, research, long term custodial care in nursing homes of mental hospitals, etc.) would rise from approximately 35% to approximately 41%.

From Mr. Mills—Question No. 3

On page 13 of the Secretary's testimony it is stated that family health insurance "would prevent a sudden loss of all health financing benefits when earnings rise." I think Mr. Ullman's chart illustrates that the bill does not completely get rid of the problem. Certainly if the income which the family has is unearned income, like Social Security survivor benefits, for example, there would be a notch with a resulting inequity. Moreover, if the earnings are received from employment which is not covered under the basic employer plan, then you also retain a serious disincentive to work. This would certainly be true in the case of a domestic worker who works regularly for five days for five different employers and has a Social Security survivor benefit for several children.

What other alternatives did the Department consider before this approach was chosen? Is there no possibility of some other approach which avoids these serious problems?

Answer

There will be a small number of cases where unearned income or income of domestics carries the income above the cutoff. In these cases, the individual would be able to purchase pool coverage.

The Department did consider numerous alternatives including a higher income cutoff for FIHP with a reducing subsidy and would want to discuss further possibilities with the Committee in Executive Session.

Alternatives to extend coverage would require additional commitments of Federal funds.

From Mr. Mills—Question No. 4

During the course of the Secretary's testimony, reference was made to a figure of $490, which apparently is the estimated value on an actuarial basis of the complete benefit package proposed in the employer-employee program. In comparable dollar terms, what is the estimated annual actuarial value of each of the benefit components (hospital services, physician services, routine exams, etc.) in the package? If the 2-day inpatient hospital deductible were eliminated, what additional value would be assigned to the inpatient hospital benefit? If no patient cost-sharing features were in the bid, what would value of the benefit

package be? What would the $490 figure be in an area like New York City or Los Angeles?

Answer

The average component cost of the mandated coverage for an employee with a family is as follows:

Mandated coverage—average for families

	Amount
Hospital room and board—nonmaternity	$127
Hospital services—nonmaternity	113
Physician and other professional nonroutine services—nonmaternity	169
Maternity	34
Routine services (physical exams and immunizations)	50
Well child care and vision care for children	17
Total	490
Average for families in New York	745
Average for families in Los Angeles	769
No deductibles or coinsurance—average for families	985
Elimination of 2-day room and board deductible—average for families, add	65

From Mr. Mills—Question No. 5

How many workers will not be eligible for employer-financed basic health benefits at any point or time because they do not meet the length-of-work requirement? Also, please furnish estimates of the number of unemployed workers who would be covered under the 90-day rule at the same point of time?

Answer

Under the proposal, employers must make basic health insurance 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 have to 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).

1. The accompanying table projects that about 6.2 million workers will be employed for less than 14 weeks during 1972. This amounts to about 12 percent of those who will work during the year. The data here are restricted to nongovernment workers not eligible for FHIP.

Most of the 6.2 million workers would not have sufficient employment to meet the 10–13 week waiting period for basic health insurance, or for continued coverage for 90 days when unemployed. This group is largely made up of women (of the 6.2 million workers, 58% are women) and students who are not full-year workers for a number of reasons, including going to school and taking care of the home, and who probably will obtain health coverage from the head of the household.

2. An estimated 18.9 million persons will have worked 14–49 weeks and most would have sufficient employment to meet the 10–13 week waiting period for health insurance coverage. Most of these will have no unemployment or unemployment of less than 15 weeks. It is estimated that about one out of 10 (or 1.9 million workers) of the workers who will work 14–49 weeks will be unemployed for 15 or more weeks and therefore may not be fully covered by a 90-day extension of coverage requirement. Another 46.7 million would have no unemployment.

3. It should be noted that under current practices many employers have voluntarily, or as the result of collective bargaining, decided to make health insurance coverage immediately available upon employment rather than after a waiting period. Furthermore, in the future, it may be expected that unilateral employer action and collective bargaining will also exert an influence in the direction of immediate coverage or short waiting periods. Continuation of coverage upon termination of employment likewise would be open to negotiation, so employers and unions may very well develop more liberal continuation rules than visualized in the proposal.

4. The estimates presented are from SSA data tapes derived from the March 1969 CPS to simulate H.R. 1 for 1972.

WORK AND UNEMPLOYMENT EXPERIENCE OF PERSONS AGED 18 TO 64 IN NONGOVERNMENT JOBS, EXCLUDING FHIP ELIGIBLES BY EXTENT OF UNEMPLOYMENT [1], BY SEX, 1972 ESTIMATE [2]

[In thousands]

Work experience	Total	Extent of unemployment		
		None	1 to 14 weeks	15 or more weeks
BOTH SEXES				
Total	71,614	61,658	7,456	2,499
Worked	70,836	61,658	6,884	2,294
1 to 13 weeks	6,243	[3] 4,947	883	413
14 to 49 weeks	18,921	[3] 11,039	6,001	1,881
50 to 52 weeks	45,672	[4] 45,672		
Did not work but looked for work	778		572	205
MEN				
Total	42,768	36,588	4,605	1,576
Worked	42,573	36,588	4,483	1,502
1 to 13 weeks	2,115	[3] 1,492	400	223
14 to 49 weeks	9,428	[3] 4,066	4,083	1,279
50 to 52 weeks	31,030	31,030		
Did not work but looked for work	195		121	74
WOMEN				
Total	28,845	25,071	2,852	923
Worked	28,263	25,071	2,401	792
1 to 13 weeks	4,128	[3] 3,456	483	190
14 to 49 weeks	9,493	[3] 6,973	1,918	602
50 to 52 weeks	14,642	14,642		
Did not work but looked for work	582		451	131

[1] Includes persons with more than 1 period of unemployment during the year.
[2] The estimates presented are from SSA data tapes derived from the March 1969 CPS to simulate H.R. 1 for 1972.
[3] Part-year workers who did not have unemployment.

Note.—Because of rounding, sums of individual items may not equal totals

From Mr. Mills—Question No. 6

While there is this problem of the employer modifying his hiring practices so as to give preference to those categories of workers with the lowest cost, there is also the basic problem of assuring that employers would not in some way screen applicants for employment so as to consider only those who indicate they would not choose the insurance offered. I wonder how you could keep an employer who naturally wants to keep his labor costs to a minimum, from screening applicants in the interviewing process so as to accomplish this result. He might, for example, give preference to those who indicate that they already have insurance coverage as a member of another worker's family. How much snooping into employer hiring practices would be required to be assured that this kind of activity was not going on?

Answer

Naturally, it would be our goal to keep our activities in the area of employer monitoring to the absolute minimum consonant with responsible program administration and integrity. We would rely on the employee or prospective employee to alert us to such practices on the part of the employer, coupled with random and selective monitoring of the employer. We would look to active help from employee unions in this area as well.

It is our estimate that such practices by employers would be attractive and successful only for a very small number of employers in marginal enterprises employing non-skilled and non-unionized labor. As a result, we would weigh whatever Federal compliance efforts we mount toward these companies.

From Mr. Mills—Question No. 7

Mr. Secretary, on the average, how much would employer payroll costs be increased in fiscal year 1974 when the employer share is 65% of the total premium cost? Can you express that as so many cents of wage costs per hour? My rough

calculations indicate that it is about 11¢ per hour per employee based on the national average.

Would you give a comparable figure for calendar year 1977, when the employer share is 75%, assuming that medical costs went up only 6% a year between fiscal year 1975 and calendar year 1977?

Is it not true, Mr. Secretary, that your requirements on employers would increase employer costs, particularly in low wage employment and would result in economic pressure in the direction of lowering employment, in much the same way the opponents of higher minimum wage legislation have been claiming over the years?

Answer

The actual cost of the Administration bill to an employer would depend on how much that employer would have been spending otherwise on health insurance for his employees. Many employers are presently paying for health insurance benefits that are more expensive than the mandated coverage. For many employers, a shift in emphasis may be required from first dollar coverage to insuring against large health insurance bills (as caused by long hospital stays or physician and hospital services of more than $100 in a year)—in order to avoid spending more. For employers with no health insurance coverage, the additional cost of the employer share would be around 12 cents per hour (more if the average work week is less than 40 hours, less if greater).

By 1977, if the average medical prices increase six percent per year and the deductible is held constant at $100 (thus increasing the effective coverage since the deductible will eliminate fewer services in terms of 1977 prices and utilization), the required employer share would be around 18 cents per hour for an average work week of 40 hours.

It does not seem likely that an increase of 12 cents per hour to the employer's share would generate substantial unemployment. While some marginal employers might have difficulty paying for health insurance coverage, this amount is considerably less than recent increases in the minimum wage rate. By "phasing-in" the employer share, we will enable the employer to plan for the added expenditures.

From Mr. Mills—Question No. 8

Perhaps the most serious weaknesses in the Administration's proposal for requiring employers to have basic health insurance I find are the problems arising when employers attempt to keep their labor costs down by either:

1. hiring those whose average cost for health insurance would be lower, or;

2. hiring only those who indicate that they will not choose to be covered under the employer health plan.

Mr. Secretary, could you break down the 11¢ per hour increases in payroll costs that you gave us? What would this figure be for the single worker? Is it between 4¢ and 5¢ for the male single worker? What would the figure be for the single female worker? Is it about 6¢?

What is the figure for the married worker? Is it about 14¢?

What would these figures be in calendar year 1977 under the assumption of 6%-a-year increase in health costs?

I believe that these figures illustrate one of the most serious weaknesses in your approach. They illustrate the tremendous incentives for an employer to hire the categories of worker who will have less than average costs. If an employer can hire a single male worker, it will cost his less than ⅓ of the payroll costs associated with a married worker.

What is your response to this criticism?

Answer

Based on an average work week of 40 hours, the cost per hour of the employer share would be as follows:

	Fiscal year	
	1974	1977[1]
Adult male	$0.06	$0.10
Single female	.06	.11
Average for employees with dependents	.15	.23
Married male or female with spouse and 2 children (assuming only 1 covered by mandated coverage)	.16	.25

[1] Assuming 7 percent per year increase in hospital costs and 5 percent per year increase in physician fees.

The cost of the mandated plan is a very small part of overall compensation to employees, and much less than the differences in overall costs resulting from variation in employee performance. Further, around 20% of employees have spouses who are employed by an employer who would be obligated by the bill to make the mandated plan available.

From Mr. Mills—Question No. 9

In his health message when talking about regulating private health insurance the President used these words, "including the introduction of sufficient disincentive measures to reinforce the objective of creating cost consciousness on the part of the consumers and providers."

Does this mean that you might not permit Blue Cross to pay first dollar costs but instead institute some deductibles and coinsurance? Would you require HMO's to have deductibles?

Answer

Under the mandated employer-employee plan, which each employer of a mandated firm must offer, Blue Cross (or another carrier) would be required to institute a number of cost-sharing features. Hospital care would be subject to a two-day deductible and 25 percent coinsurance. Most other persons would be subject to an annual deductible of $100 per person, with a family maximum of three, plus 25 percent coinsurance.

There are several exceptions to the cost-sharing provisions, however. After a person has received $5,000 of services in a year, all cost-sharing would be waived for him and his family for that year and the next two years. An employer plan would have the option of reducing or eliminating the cost-sharing requirements but the employee would not be required to accept (or pay for) this. Therefore, while the mandated policies are required to have deductibles and coinsurance provisions, these could be lowered by optional plans containing more than the required benefits.

Employees who enrolled in health maintenance organizations would be required to pay, in addition to the regular premium, the actuarial value of the deductibles and coinsurance as maximums. As with the basic health care plan, these could be eliminated by a more generous employer plan using health maintenance organizations.

From Mr. Mills—Question No. 10

The Committee on Ways and Means has been receiving a good deal of mail about the provision in the present Maternal and Child Title of the Social Security Act which would convert direct Federal grants to State allotments. Could you tell us what HEW has done to provide for an orderly conversion? Does HEW have any position on whether changes should be made in present Title V provisions for the short run, long run or both?

Answer

The Administration is proposing a one-year extension of the project grant authority in Title V. We feel these projects have brought high quality services into urban ghetto areas for mothers and children. If the project grants would be folded back into the formula grants, there is a good possibility that many of these projects would close in the absence of third party payments from NHHSA and FHIP, since there is a time lag in the effective dates of the financing legislation.

In the interim, we are taking the following steps to insure the continuation of this service capability.

1. Implementating service payments from Medicaid for all eligible recipients and other third party payments. Many mothers and children served by these programs are not eligible for Medicaid, but will be for FHIP and NHHSA.
2. Encouraging the absorption or conversion of these centers into HMO's.

From Mr. Mills—Question No. 11

Would HEW be prepared to administer H.R. 7741 by July 1, 1973, or would you recommend a later date as you did with FAP?

Answer

No, we would not be prepared to administer H.R. 7741 by July 1, 1973, because of the uncertainty of the final provisions of the bill, the dependence of FHIP administrative arrangements on those of Welfare Reform, and the time that has elapsed since the legislation was originally submitted.

Our best current estimate is that it would take a minimum of six calendar quarters from the date of enactment before we would be ready to put the program into operation. It is not possible to provide a more definite answer at this time.

From Mr. Carey—Question No. 1

The Administration's Phase II program regarding the economy calls for, among other things, the creation of a Committee on the Health Services Industry. To date, not much information regarding this committee's activities has been published.

In announcing the President's Phase II program regarding the economy, a Committee on the Health Services Industry was created either as part of or to work with the Pay Board.

Would you explain for us in detail what this Committee is supposed to do, how it is organized, and who will serve as its members?

Answer

The President on November 10th appointed Barbara (Mrs. William C.) Dunn, Commissioner of the Department of Consumer Protection for Connecticut, as Chairman of the Committee on the Health Services Industry, an advisory panel to the President's Cost-of-Living Council, Price Commission, and Pay Board.

The President has appointed 20 members to serve on the committee, representing the public, the medical profession, consumers, hospitals, related health occupations and industries, and the health insurance industry.

The Committee is part of the post-freeze apparatus the President outlined in his October 7 message on the Economic Stabilization Program. The creation of the Committee reflects the Administration's concern over the rising medical costs which represent a growing share of the family budget. The Committee will concentrate on advising the Cost-of-Living Council on ways in which the President's program can be applied in the health field and to enlist the full voluntary cooperation of the industry in restraining cost and price increases. The Committee also will advise the Pay Board and the Price Commission.

The Committee will be assigned a small permanent staff in performing its advisory functions and had its first meeting early in the week of November 14th. At that time the Committee began to come to grips with many of the complex issues associated with the administration of Phase II in the health industry.

COMMITTEE ON THE HEALTH SERVICES INDUSTRY

Barbara (Mrs. William C.) Dunn

Commissioner of the Department of Consumer Protection for the State of Connecticut. She is a member of the Governor's Cabinet, State Advisory Council on Aging, State Drug Advisory Council, Connecticut Comprehensive Health Planning Council and the Executive Committee on Human Rights and Opportunities. Mrs. Dunn is a director of the University of Connecticut. She lives in East Hartford, Connecticut.

Karl D. Bays

37, President and Chief Executive Officer, American Hospital Supply Corporation. He is a director of the Northern Trust Company of Chicago; an Associate Trustee of Northwestern University; a member of the Advisory Council of Northwestern University's Graduate School of Management; the President's Council of the National College of Education; and the Business Advisory Council of the Chicago Urban League. Bays lives in Lake Forest, Illinois.

Earl W. Brian, M.D.

29, Director of California Department of Health Care Services. As Director of the biggest Medicaid Program in the country, he has implemented a number of innovative cost reduction programs. He lives in Sacramento, California.

Rita R. Cambell

A Senior Staff member of the Hoover Institute on War, Peace and Revolution at Stanford University. She lives in Palo Alto, California.

Brooks Chandler

Senior Vice President of Provident Life and Accident Insurance Company. He lives in Chattanooga, Tennessee.

Mrs. Jane Claflin

Hospital and health programs volunteer. She is Chairman of the Voluntary Services Committee, Massachusetts General Hospital and a member of the Social Services Advisory Committee, Ladies Visiting Committee, and the Hospital Administration Committee. She is a Trustee of the Faulkner Hospital and of the Massachusetts Division of the American Cancer Society. She lives in Boston, Massachusetts.

James R. Cowan, M.D.

55, Presently Commissioner of Health for the State of New Jersey, member of the Medical Committee on Human Rights, New Jersey Chapter and Chairman of the Committee for the establishment of the Comprehensive Health Care Facility of East Orange, New Jersey. He resides in Maplewood, New Jersey.

Theodore E. Cummings

63, Director and Chairman of the Executive Committee, Pacific Coast Properties, Inc., Beverly Hills, California. He is Senior Vice President and member of the Board of Directors of Cedars-Sinai Medical Center, Los Angeles, and a member of the Governing Committee of the Jules Stein Eye Institute of U.C.L.A. Center. He is a member of the Board of Regents, University of California, and a Charter Founder of the Eleanor Roosevelt Cancer Foundation. He lives in Beverly Hills, California.

Miss Rosamond C. Gabrielson

Executive Director, Nursing Services, Good Samaritan Hospital, Phoenix, Arizona. She is Treasurer, American Nurses Association Board of Directors, and President of the Arizona State Nurses' Association. She received an R.N. in Nursing from the Hotel Dieu School of Nursing, El Paso, Texas and a B.S. in Psychology and an M.A. in Guidance and Counselling from Arizona State University. She lives in Phoenix, Arizona.

James W. Haviland, M.D.

Practicing physician since 1946 and educator. Received his M.D. from Johns Hopkins in 1936. He has been Assistant Professor, Assistant Dean, and Acting Dean of the University of Washington School of Medicine. He also serves as President of Trustees of the Seattle Artificial Kidney Center. Dr. Haviland lives in Seattle, Washington.

John A. Hill

64, is President of the Hospital Corporation of America ; a chain of proprietary hospitals headquartered in Nashville, Tennessee. He is a member of the Committee on Aging, U.S. Department of Health, Education, and Welfare. Hill is a Director and on the Executive Committee of Owens-Illinois Glass Co. and Arrow-Hart, Inc. He lives in Nashville, Tennessee.

Mrs. Alice K. Leopold

A member of the Technical Committee on Employment and Retirement and the 1971 White House Conference on Aging. She served as Assistant to the Secretary of Labor and Assistant to the Secretary of Labor for Women's Affairs. She holds a law degree from Rutgers University. Mrs. Leopold lives in San Francisco, California.

William E. Lotterhos, M.D.

57, President of the American Academy of General Practice; formerly vice chairman and chairman of the American Medical Association Section on general practice. He is an assistant clinical instructor at the University of Mississippi Department of Preventative Medicine and an instructor at the Southwestern School of Alcoholic Studies. He received his M.D. from the University of Mississippi. Mr. Lotterhos lives in Jackson, Mississippi.

Kenneth M. McCaffree

52, is a Professor at the University of Washington School of Public Health and Community, Medicine, Seattle, Washington. He is a past President of the Group Health Association of America, and has served on the Board of the Puget Sound Health Program, a health maintenance organization. McCaffree was born in Wichita, Kansas. He lives in Seattle, Washington.

J. Alexander McMahon

50, President of Blue Cross-Blue Shield of North Carolina. He heads one of the few combined Blue Cross-Blue Shield plans in the Nation. McMahon presently serves on the Committee on Health Education. He lives in Durham, North Carolina.

C. Joseph Stetler

54, has served as President of the American Pharmaceutical Manfacturers Association since 1965. From 1963 to 1965 he served as Executive Vice President and General Counsel of that organization. From 1951 to 1963 he was with the American Medical Association, serving first as its General Counsel, and Director of its Socio-Economic Division. He was a member of the staff of the Second Hoover Commission from 1953-54. He is the co-author of "Doctor, Patient and the Law," and of the "Handbook of Legal Medicine." He is a member of the D.C. and Illinois Bar Associations and lives in Bethesda, Maryland.

William Thoms

45, is Administrator, Greenbriar Nursing Home, Nashua, New Hampshire. He also supervises the operation of two other New Hampshire nursing homes. He lives in Nashua, New Hampshire.

Samuel John Tibbitts

Has been President of Lutheran Hospital Society of Southern California since 1966, and Assistant Secretary since 1969. He received a masters degree in Hospital Administration at the University of California at Berkeley in 1950. Tibbitts, 47, has served several hospitals in administrative posts in California. He lives in San Marino, California.

John F. Tomayko

Director of Insurance, United Steelworkers of America, Tomayko, 54, has served on various study groups for the U.S. Government, i.e., Surgeon General's Consultant Group on Nursing, White House Conference on Aging, and Labor-Medicine Liaison on Medicare. He lives in Bethesda Park, Pennsylvania.

Donald G. Walden, D.D.S.

A dentist, he is trustee of the Delta Dental Plans Association and holds a Doctor of Dental Surgery Degree from the University of Indiana. Walden, 47, resides in Denver, Colorado.

John Colman Whitwell

62, Research Associate for the Textile Research Institute, Princeton, New Jersey. He is a member of the Governor's Advisory Commission on Health Costs. Formerly, he was Acting Chairman, Princeton University, Department of Chemical Engineering. Mr. Whitwell is the author of numerous chemical engineering studies and analyses. Mr. Whitwell lives in Princeton, New Jersey.

From Mr. Carey—Question No. 2

As you know, the Federal Government now pays millions of dollars through State Medicaid programs for dental services for poor children. Under your bill this Federal support would be totally withdrawn. How can you justify this policy when your own HEW studies show the great unmet need for dental care among poor children particularly?

Answer

We agree that dental care for poor children is a serious unmet need and we have continued to provide financing for these services through other authorities. As we previously stated, in later years, when the priority benefits are in place and as resources become available, we would hope to be able to add to the list of minimum benefits.

We believe many states will supplement the basic FIHP package, just as 32 states supplement basic services under Medicaid by supporting optional dental services.

Because the Federal Governmental will pay the total cost of the basic FIHP package, the states will save the money they are now spending for Medicaid services for AFDC families. If all states supplement the FIHP package to maintain current Medicaid benefits to recipients they will still realize a savings of at least $500 million beginning in FY 1974.

From Mr. Carey—Question No. 3

The Administration's bill would impose, in connection with any basic health care plan, a requirement that each insured person incur in any calendar year, a deductible amount equal to the reasonable costs of two days of room and board in a hospital and a coinsurance of 25% applicable to remaining hospital charges. The use of such cost-sharing features is usually justified in two ways. First, it is often held that deductibles help control the utilization of specific health services. And, second, that cost-sharing reduces the liability of the insurer and hence the premium charges for the protection provided.

A number of experts, however, fail to see how deductibles of the kind envisioned in the Administration bill act to deter hospital utilization. Hospital care, from the point of admission through the provision of specific services to the point of discharge, involves physician, rather than patient, initiated decisions. It is doubtful, therefore, that a 2-day room and board deductible will effectively work to control the utilization of hospital resources. A similar argument can be raised against the coinsurance feature with regard to the use of ancillary services while the patient is institutionalized.

As to the second justification for deductibles and coinsurance—that it reduces the liability of the insurer—other issues arise. Would it not be wiser to permit some reduction, perhaps in the duration of the hospital benefit in the overall benefit package in order to pay in full, the costs of those services over which the patient has no control. Considering the average length of stay in hospitals by persons under 65 and in employment, a benefit which spans 365 days may be largely meaningless to most insured persons. The costs for 2 hospital days and for 25% of the remaining hospital charges, on the other hand, may constitute a rather substantial burden for the insured.

Mr. Secretary, once again, we are being asked to consider a health insurance program loaded with deductibles and coinsurance features that, in my judgment, fail to serve any useful utilization control value and only add administrative burdens for the patient, for the provider of service, and for the insurer. It is especially disappointing to see a deductible and coinsurance of no mean proportion imposed in connection with hospital services which are entirely physician- rather than patient- initiated.

Show me the evidence that you have to justify the use of sucharchaic features of the health insurance industry? And what makes you think, just like with the Medicare program, that private insurers wouldn't immediately offer supplemental policies to cover the costs of the 2-day deductible and the 25% coinsurance?

Answer

Several important and seriously disputed issues are raised by the questions on deductibles and coinsurance. As we have said in response to a question by Mrs. Griffiths, the evidence on the impact of deductibles and coinsurance is mixed. However, the Palo Alto Study and the recent work of several econometricians demonstrates that they do have impact in controlling utilization. Also through SRS and SSA, the Department is sponsoring studies which seek to clarify some of the apparent ambiguities. (A summary of several studies is attached.)

The reason for the 2-day hospital deductible was to discourage the use of high cost inpatient facilities for diagnostic purposes and minor surgery that could be provided as well in an outpatient setting. While it is indeed correct that the physician is the main determiner of the use of facilities, most physicans would consider the cost impact on their patient in selecting the mode and site of care as well as the number and type of procedures. Deductibles and coinsurance can also serve the function of alerting the consumer to price considerations and to get consumers to question the necessity and cost of the services. Having recipients share in some costs, allows the limited public resources to serve more recipients.

As we stated in testimony before the Committee, we certainly would be open-minded in discussions in Executive Session of scope of services, cost sharing, premiums and the balances among these factors.

What we have tried to develop was an underlying philosophical base of a public private national health insurance partnership providing basic and catastrophic coverage for the nation with cost sharing on the part of the employer and employee and cost and quality controls on services. Within these parameters,

changes and improvements can be made in benefits, eligibility, etc., and we look forward to these discussions with the Committee.

We are not relying on patient cost-sharing alone, but also upon improved utilization review and administrative controls, and the meaningful development and acceptance of health maintenance organizations. As these demonstrate desired results, the present need we see for cost-sharing should be reduced.

Regarding the question of supplemental benefits, we would expect as in Medicare, that individuals would be free to purchase supplemental insurance as would employers and employees to negotiate for this coverage. While we would prefer the retention of some cost sharing, we do not intend to interfere with individuals rights to supplement their protection. We would require that every worker have the option to select only the NHIHSA Basic Health Insurance.

Appendix

The deductible and coinsurance features of the Administration's health care program represent a balanced approach. Cost-sharing is not applied indiscriminately across the board. Under the Family Health Insurance Plan (FHIP), the very poor would be exempt from deductibles and coinsurance (as well as from premiums), deductibles would be applied selectively for the next two classes of families, and coinsurance would be applicable only to the two top family classes, and then at a substantially lower rate than for employed persons. FHIP beneficiaries, regardless of income class, would pay no deductible nor coinsurance for maternity care family planning, nor for check-ups, immunization and similar treatment for children up through five years of age. We recognize the importance of these preventive services to the health and well-being of the low-income population and have not imposed any deterrents to their use.

For the employed population the National Health Insurance Standards Act (NHIHSA) places a maximum on deductibles of three per family, sets a ceiling of 25 percent coinsurance on covered services, waives deductibles and coinsurance for at least two years for families with heavy medical costs, and also exempts the employed population from sharing the cost for well-child care. Moreover, the bill would not prevent unions and management from negotiating contracts in which cost-sharing should be reduced or wiped out entirely.

Cost-sharing gives a program flexibility to influence and guide the use of medical services. This flexibility can become increasingly important as the program gains experience in utilization and effectiveness. We recognize that present knowledge of the extent to which deductibles and coinsurance reduce costs, relieve inflationary pressures, and deter persons from seeking necessary attention is limited. Surveys and studies on cost-sharing present qualified conclusions and they caution that there often are other factors that influence the findings.

The Blue Cross Association and National Association of Blue Shield Plans recently surveyed all United States Plans on the effect of deductibles, coinsurance and copayments on utilization of health services. The survey was conducted to determine whether the two organizations should continue their traditional emphasis on first dollar coverage or if there were indeed some beneficial aspects of deductibles, coinsurance and copayments. The results of the survey are presented in a report, entitled "The Effect of Deductibles, Coinsurance and Copayment on Utilization of Health Care Services—Opinions and Impresisons from Blue Cross and Blue Shield Plans," dated September 28, 1971.

The Survey showed that Blue Cross and Blue Shield Plans believe deductibles, coinsurance and copayments do have a definite impact on utilization but the nature of that effect is hazy. The following are several pertinent excerpts:

"The survey results, not surprisingly, were mixed and emerged without a clear-cut picture or prevailing pattern of how coinsurance, deductibles and copayments affect utilization" (p. 2); or "These comments, plus the experience of other plans, indicate that deductibles, coinsurance payment have a definite impact on utilization—by at least the amount of the deductible, coinsurance and payment . . . However, there is little real evidence to demonstrate the overall result of these features, i.e., whether they result in over-, under- or optimum utilization." (p. 6).

Thirty-four plans of the 60 plans that participated in the Blue Cross-Blue Shield survey had definite opinions or impressions about the effect of cost-sharing on utilization. The following tabulation of their replies demonstrates their lack of consensus:

	Plans			
	Deductibles	Coinsurance	Copayment	1 or more provisions
Does curb utilization	[1] 13	[2] 11	[2] 9	[3] 20
Does not curb utilization	12	9	6	[3] 15

[1] 6 of these plans specified that a large deductible would have an effect on utilization.
[2] 4 of these plans specified that a high coinsurance or copayment would have an effect on utilization.
[3] These 2 figures add to 35 plans because 1 plan felt a deductible does not curb utilization while coinsurance does and is, therefore, included in both columns.

Findings of other studies are surveys on cost-sharing, some of which are referred to in the Blue Cross-Blue Shield survey are summarized below. In addition, the Department is taking steps to help improve the state of knowledge and understanding about cost-sharing and its consequences. For example, the Department has approved a demonstration project in California and has waived for an 18-month period starting January 1, 1972, the prohibition against cost-sharing in Medicaid so that a token copayment may be introduced into the State's Medi-Cal program in order to test its effects.

The Social Security Administration also is funding a study of the effects that the introduction of coinsurance had on the use of medical services by Stanford University faculty and staff who participate in a comprehensive prepayment plan offered them by the Palo Alto Medical Clinic. Some preliminary results appear below in number one.

1. GROUP HEALTH PLAN OF THE PALO ALTO MEDICAL CLINIC

Since 1954 a comprehensive prepayment plan of medical care has been offered by the Palo Alto Medical Clinic to the faculty, to other professional and technical personnel, and to other staff members, including clerical workers and blue-collar workers of Stanford University. Dependents of subscribers also are covered. On April 1, 1967, coinsurance was introduced. Premiums remained unchanged but members now must also pay 25 percent of scheduled fees for medical services. A study, conducted by Mrs. Anne Seltovsky, is being funded by the Social Security Administration to appraise the effect of coinsurance on medical care utilization.

Results and evaluation

Preliminary data show that the per capita number of physician visits declined 24.1 percent between 1966, the year before coinsurance was introduced, and 1968, the year after coinsurance started—dropping from 5.7 visits to 4.3 visits. Except for "other professionals," the rate of decline was larger for female members than for male members. A distribution of members according to number of visits indicates that 20 percent did not see a doctor in 1968 compared to only 13.4 percent without physician visits in 1966. At the other end of the spectrum, only 20 percent of the members visited a doctor more than six times in 1968 in contrast to about 30 percent in 1966. Changes in the per capita number of annual physical examinations showed no consistent pattern on the basis of sex or occupation.

A comprehensive interpretation of the trends revealed by the statistics is not yet available.

SOURCE: Correspondence with Mrs. Anne Seltovsky.

2. MEDICAL CARE INSURANCE PLAN, SASKATCHEWAN, CANADA

The plan, started in 1962, is financed by annual premiums and by Provincial general revenues to which Federal contributions are made under the Federal Medical Care Act. Since April 15, 1968, most insured medical services were subject to a copayment of $1.50 for an office visit and $2.00 for a home, emergency, or hospital outpatient visit. The copayments were rescinded on August 1, 1971.

Results and evaluation

The per capita use of covered services rose annually until copayments were introduced. In 1968, utilization fell three percent below the previous year. By 1970, however, the annual increase in per capita utilization was 8.91 percent. Officials of the Medical Care Insurance Commission believe that a significant

factor in the increase might have been the larger number of specialists in 1970 and, perhaps, economic conditions as well. They stated that "While the increased per capita utilization in 1970 may also have been contributed to by a lessening in the effect of utilization fees, it might at this point be unwise to draw definite conclusions."

SOURCE: Annual report of the Saskatchewan Medical Care Insurance Commission, 1970, and correspondence with the Director, Research Branch, Medical Care Insurance Commission.

3. HEANEY-RIEDEL STUDY OF CONNECTICUT BLUE CROSS

This study compares utilization of indemnity coverage with cost-sharing features to full coverage.

Results and evaluation

Cost-sharing held down admissions and length of stay but the introduction of full service benefits did not result in significantly higher utilization.

SOURCE: Charles T. Heaney and Donald C. Riedel, "From Indemnity to Full Coverage: Changes in Hospitalization Utilization," *Blue Cross Reports*, Research Series 5, October, 1970. (Summarized in secondary source)

4. INSURED PRESCRIPTION DRUGS, SASKATCHEWAN, CANADA

A 20 percent coinsurance charge that had been imposed in 1948 was raised to 50 percent in 1959.

Results and evaluation

Effect varied with age, sex, and degree of urbanization. Utilization actually increased for males, age 25–44. According to the Royal Commission on Health Services, "It is worth recording that these co-charges have not had the deterrent effect originally hoped for, even though they were followed by an overall reduction in drug utilization."

SOURCE: "Methods of Patient Cost-Sharing," *Approaches to Drug Insurance Design*, Task Force on Prescription Drugs, February, 1969.

5. VIRGINIA BLUE CROSS PLAN

A $50 deductible and an additional copayment were imposed if hospital room charges exceeded $12 per day.

Results and evaluation

Hospital admissions rate dropped 6.7 percent and those paying deductible and daily copayment remained in hospital longer than those fully covered (8.20 days vs. 8.13 days). It was suggested that the decline in admission was not greater because some members purchased supplementary insurance to cover the deductible and that longer hospital stays might reflect the fact that the illness reached a more serious state before members entered the hospital and that members wanted to make up for their $50 loss.

SOURCE: "Problems in Measuring the Effect of Deductibles Upon Hospital Utilization," *Blue Cross Reports*, October, 1968.

6. MICHIGAN BLUE CROSS PLAN

In 1965 the "Deductible Contract Study" was made to compare membership and utilization differences between comprehensive and deductible contracts in both group and conversion contracts.

	Group		Conversion	
	Comprehensive	Deductible	Comprehensive	Deductible
Percent of contract charges to earned income	94.3	69.5	123.6	75.5
Admission rate	162	122	234	138
Average length of stay	8.3	7.0	11.3	10.3
Patient day rate	1,344	857	2,633	1,432
Contract charges per case	$339.66	$249.37	$433.58	$363.02
Contract charges per day	41.06	35.57	38.48	35.09

The study pointed out that whether the deductible in itself or whether individual election is more important as a deterrent to utilization cannot be determined from the available data. (Only 10 percent of the total membership of Michigan Blue Cross had elected the deductible contract.)

SOURCE: *Blue Cross Reports*, "Problems in Measuring the Effect of Deductibles upon Hospital Utilization," October, 1969.

7. SWIFT CURRENT HEALTH REGION PROGRAM

A medical care plan that was established in 1946 for an area in the southwest corner of Saskatchewan, Canada increased coinsurance payment for home and office calls.

Results and evaluation

In the early years, the coinsurance payment was collected and there was "a dramatic reduction in home visits" and "a significant reduction in office visits," especially in cities and towns. The reduction was partially offset by an increase in hospital visits and "a significant increase in minor surgery." . . . "But in later years (when lower utilization was not so obvious) there are grounds for suspecting that the listed coinsurance charges are more theoretical than real deterrents, because the patients have come to realize they are not always collected." (Evaluation is that of Byron W. Straight)

SOURCE: Charles P. Hall, Jr., "Deductibles in Health Insurance: an Evaluation." Journal of Risk and Insurance, June-July, 1966.

8. WILLIAMS STUDY OF FIVE BLUE CROSS PLANS

Based on data obtained from a survey of five Blue Cross Plans in 1964, Robert Williams examined the relationship of full pay, deductibles, and co-pay coverage to utilization and to costs. In each plan an alternative type of coverage to full pay was offered so it was possible to compare use and cost of members with different coverage in the same plan.

Results and evaluation

Deductibles had a minimal effect in reducing utilization and practically no effect in reducing amount of benefits paid by Plans. Chief deductible effect was longer length of stay compared to members with full pay coverage. This may be partially due to the elimination of one-day cases and stays whose costs did not exceed maximum deductible. However, both utilization and benefit payments were lower for members with co-pay coverage.

SOURCE: Robert Williams, "A Comparison of Hospital Utilization and Costs by Types of Coverage," *Inquiry*, Vol. III, No. 3 September, 1966, pages 28–42.

9. WEISBROD-FIESLER STUDY

The study compared two groups of subscribers before and after an increase in prepaid hospital services was offered to one group.

Results and evaluation

While the group electing broader coverage increased its use of hospital service more than the other group, the increase was mainly for older females, suggesting that "the extension of hospital care services—whether through private or public programs—may have significantly different impacts among the sexes and among persons of different ages." The authors also suggest that up to some point "a reduction of benefit charges—but not to zero—may have little or no incentive effect on utilization."

SOURCE: Weisbrod, BurtonA. and Robert J. Fiesler, "Hospitalization Insurance and Hospital Utilization." *American Economic Review*, March, 1961, vol. 51, pp. 126–132 as summarized by Anne Scitovsky.

10. QUESTIONNAIRE TO INSURERS IN MICHIGAN

Questionnaires asking their opinions on the effectiveness of deductibles and coinsurance in controlling excesses were sent to the leading writers of hospital and medical expense coverage in Michigan in 1959.

Results and evaluation

65 insurance companies and two prepayment plans responded as follows:

	Deductibles	Coinsurance
Are effective	28	34
Are not effective	18	12
Effect not known	21	21
Total	67	67

Source: Walter J. McNerney, et al., Hospital and Medical Economics, v. 2, p. 1092.

From Mr. Carey—Question No. 4

I assume that one of the reasons mental illness is not covered under your bill is the lack of cost experience. Have you examined carefully the experience under the Federal employees program and under Medicare? What has been the experience under these programs? Has it been so bad that you decided against such coverage on grounds of cost? Would you recommend reducing such coverage under Medicare?

Answer

The coverage of mental health by some of the Federal Employees plans and Medicare is very limited, and hence has not proved to be very expensive. For example, if a Social Security beneficiary has been confined for 180 days in a mental institution upon reaching age 65, he received no coverage from the hospital insurance program. Otherwise, benefits are limited to 180 days. These provisions eliminate most institutional care for mental illness. Only 3% of the hospital days furnished under the HI program are for care in psychiatric institutions. Under the SMI program, benefits for psychiatric care are limited by a 50% cost sharing (after the deductible has been met) and a maximum payment of $250 in a calendar year. Under these limitations, SMI psychiatric payments have been limited to 0.2% of benefits. It is estimated that removing these restrictions would increase SMI benefits by 1%.

Coverage in private health insurance programs is normally limited to 90 days while confined in a hospital per illness. Although experience with health insurance benefits for mental illness is very limited, this is not the main reason for the Administration decision not to include such care in the mandated package. The cost can be estimated although the chance for error in estimating this component may be large.

We do not propose discontinuing present financing for these services under other authorities. As we previously stated, in later years when the priority benefits are in place, and as resources become available, we would hope to be able to add to the list of minimum benefits.

From Mr. Carey—Question No. 5

It was agreed that the Administration bill would require the coverage of all services of a podiatrist, including the trimming of toenails.

Do you consider that coverage more important than coverage of mental conditions?

Answer

Obviously not. A special problem relating to the provision of coverage for mental conditions is the difficulty of predicting costs. While significant advances have been made during the past several years in the treatment of mental illness, particularly on an outpatient basis, there is insufficient experience with large group coverage to adequately predict the fiscal impact of nearly universal coverage of mental illness. We are continuing to study the problem of devising effective approaches to the coverage of services required in the treatment of mental conditions.

However, we were attempting to stay within a specific, affordable premium amount for coverage and preferred to emphasize child health services as well as basic medical and hospital services. We look forward to continuing discussion with the Committee on details of all benefits.

The podiatry coverage arises from the definition of physician, cross referenced to the Medicare definition. Inadvertantly, we did not include the Medicare ex-

clusion of routine foot care and will be submitting a technical amendment to correct the error.

From Mr. Carey—Question No. 6

Health insurance companies receive a substantial, but undisclosed, amount of income from their reserves. As a matter of fact, as you know, a company can seem to have a loss when benefits and administrative expenses exceed premium income and still make a substantial profit. Will your regulations get into disclosure of income from invested reserves and the relationship to premiums?

Answer

As the Secretary pointed out in his statement before the Committee on October 19, 1971, the Administration will propose minimum standards for regulation of health insurance under which States will require annual independent audit of participating insurance companies, and require disclosure by insurers of their administrative expenses as a percentage of premiums, under standard accounting procedures to be proposed by the industry and the States for the Secretary's approval.

In general, we will rely on State regulatory authority and mechanisms, with Federal standby authority only where States do not act promptly to adopt the needed authority to meet Federal standards.

From Mr. Carey—Question No. 7

Your bill would permit the Department to agree to administer any benefits which the state wished to have added to the basic health benefits at its own cost. Suppose a state wanted to set higher income limits, paying the deductibles and coinsurance your benefits would require. Could it do so?

If a state wanted HEW to administer a drug program, when would HEW be ready to do it, assuming all the administrative costs as well as responsibility?

If HEW required the state to continue to administer the drug program how could effective utilization review procedures between the Federal and State program be coordinated, like, for example, the relationship between physician and drug utilization?

Answer

1. FHIP is designed to provide that financial assistance which is most needed for obtaining necessary medical care. Accordingly, priorities for *Federal* financing have been given to assisting families with the lowest incomes to obtain basic health benefits. It is hoped that states will continue to supplement the basic health package. They are encouraged to do so by the fact that the Federal Government will pay the cost of the administration of this supplementation. Furthermore, fiscal relief will have been provided to the States by the Federal assumption of the total cost of providing medical assistance to the poor. The States, through their Medicaid programs for AFDC, are currently paying at least $1.6 billion in such medical assistance. States may, therefore, find themselves better able to supplement the FHIP and NHIHSA packages.

In specific response to your question:

(a) There is no restriction against states paying the deductibles and coinsurance. If the conditions under which states pay such cost-sharing satisfies the Secretary's requirements, the Federal Government will pay the cost of administering such supplement. There would not be Federal matching of the state supplementation.

(b) On the other hand, if a state wished to establish different eligibility standards than those called for in the proposed statute, i.e. if not all FHIP eligibles are eligible for the state supplementation, then the Secretary would have to agree to administer such a program only if its eligibility criteria were not inconsistent with those of FHIP. (It is emphasized that most families earning income above the FHIP standards would probably be eligible for the employer-employee health plans, where employers would be covering at least 65%, of the premiums for the basic health insurance package. However, higher income eligibility criteria in a given state would not per se bar federal assumption of administrative costs for FHIP eligibles.)

2. As you know, we have been working on the administrative problems of drug benefits in relation to a future possible drug benefit under Medicare. We think we would need about 18 months after enactment of the National Health Insurance Partnership Act to gear up to administer the programs including

supplemental benefits that may be offered by the state. HEW would be willing to administer a drug program for the state for the eligible FHIP population.

3. It would be very difficult for either to institute effective utilization review procedures between physician and drug utilization with split Federal-State administration. This is one of the major reasons the Federal Government would be willing to administer state supplemental benefits, provided that state eligibility criteria are not inconsistent with those for FHIP.

From Mr. Carey—Question No. 8

The low-wage employer paying his 300 employees at or around the minimum wage of $1.60 an hour faces considerable increases in his payroll costs, if his employees choose to participate in a significant way in the basic plan contained in your proposal. Since the employer's obligations in this regard depend on the employees' options only, won't he have a great inducement to pressure or persuade his workers not to participate in the program? Where in the bill, for example, is the employer prohibited from firing or laying off workers who are participating?

Would it be permissible for the employer to offer a small increase in cash wages on the condition that the employee not participate in the plan?

Answer

The National Health Insurance Partnership Act contains no provision specifically prohibiting employers from attempting to dissuade their employees from participating in the program. However, certain kinds of conduct by an employer would constitute a violation of his obligations to provide his employees an opportunity to obtain NHISA coverage. Precisely what conduct constitutes such a violation must be determined on a case by case basis.

The bill would permit the Government to sue an employer in the Federal courts when the Secretary finds that he is not meeting this requirement, if efforts have failed to secure voluntary compliance. Moreover, an employer who willfully and knowingly failed to adopt an approvable basic health care plan could be found guilty of a misdemeanor and, if convicted, fined $1,000 for each employee affected.

In addition to these provisions, the law would allow any employee to bring suit in Federal court, regardless of the amount involved, to compel his employer to make available a basic health care plan, and to recover any expenditures necessitated by the employer's failure to do so.

From Mr. Carey—Question No. 9

In order to meet the definition of a health maintenance organization under the employer plan, would the HMO have to cover the services of a Christian Science Practitioner, a Christian Science nurse and Christian Science Sanatoria?

Answer

Section 604 (a)(2) of the Administration's health insurance proposal would require, as a condition to the approval of a health maintenance organization enrollment plan, that the health maintenance organization provide all of the services and benefits described in Section 603 which are required to be made available under a basic health care plan. These would include the provision of all covered physicians' services except maternity care by a Christian Science practitioner (sec. 603(a)), and the provision of all covered hospital services by a Christian Science sanatorium to the extent that the sanatorium ordinarly provided such services, and subject to certain limitations imposed by regulations of the Secretary of Health, Education, and Welfare (sec. 608(6)).

In essence, if there is demonstrable demand for Christian Science practitioner, nurse or sanitoria services, an HMO would have to provide these either directly or by satisfactory arrangement.

From Mr. Carey—Question No. 10

The Administration bill would require the employer basic plan to cover Christian Science practitioners, Christian Science nurses, and Christian Science sanitoria. Now I would not for a moment entertain the thought these provisions are included because certain key members of the White House Staff happened to be of that faith. But I would like to know why you require this coverage in the employer plan, but do not include it in the Family Health Insurance Plan?

Answer

Christian Science practitioners would be treated essentially like any other eligible provider under NHIISA, while FHIP, as a fully Federal program, would provide for their involvement on the same basis as under present Medicare.

Basic health care plans made available to employees under the proposed National Health Insurance Standards Act would include the provision of all covered physicians' services (except maternity care) by a Christian Science practitioner (sec. 603(a)), the provision of all covered services of a registered nurse by a Christian Science nurse (sec. 603(a)), and the provision of all covered hospital services by a Christian Science sanatorium to the extent that the sanatorium ordinarily provided such services, and subject to certain limitations imposed by regulations of the Secretary of Health, Education and Welfare (sec. 608(6)). The proposed Family Health Insurance Plan would cover the provision of inpatient hospital services by a Christian Science sanatorium, subject to the same limitations described above, but would not cover physicians' services of a registered nurse provided by a Christian Science nurse.

We are prepared to discuss the differences in this area between NHIISA and FHIP with the Committee.

From Mr. Carey—Question No. 11

(a) The Administration bill permits employees to pay as much as 25% of the costs of health insurance protection provided under the basic plan, is that correct?

(b) What do you estimate as the value of the basic benefit package set out in the bill?

(c) Well, then, if your estimate is correct—and I understand that non-HEW experts may not agree with the derivation of that figure—but assuming it's correct then employees could be asked to pay one-fourth of that. How much would that be annually?

(d) I'm sure you know that there are at least 8.5 million workers in this country who are paid less than $2.00 an hour. How many of these people do you really think are going to voluntarily reduce the amount of these pittance wages to obtain coverage under your plan?

Answer

(a) The bill does provide a limit on how much employees could be asked to contribute. At the outset, this ceiling amount would be 35%, but would drop to 25% after 2½ years. These rates might be set even lower in some cases—for example, through union-management negotiations. They would also pay 25% coinsurance for most eligible services.

(b) In response to question no. 4, from Mr. Mills, it was indicated that the average cost of the bill's basic benefit package would be $490 in fiscal 1974 for coverage of an employee with a family. If there were no deductible or coinsurance provisions, this figure would rise to $985 a year.

(c) The amount of the employee share at the 35% contribution rate would average $171.50. If the plan had no deductible and coinsurance provisions, the employee share would be 35% of $985, or $344.75, i.e. about twice as much.

(d) The question whether people with low wages will choose to enroll in a health program that requires that they pay a portion of the premium arose when supplementary medical insurance under Medicare was first proposed. The experience has been that more than 90% of eligible persons over age 65, by and large people with limited incomes, have enrolled in the program.

The employee's share of the cost of the mandated coverage for family coverage will be approximately 8¢ per hour out of the posed $2.00 wage. This expenditure will purchase health insurance which will to a large extent replace present direct expenditures for health services. Most such employees would clearly be better off with the insurance and most can be expected to purchase it.

Question No. 12—From Mr. Carey

The Administration bill provides that a basic health care plan may not exclude for a period exceeding 6 months coverage of a health condition which exists on the date the employee initially secures coverage under the basic plan with that employer.

Let's consider the employee with a wife who enters the first job and secures coverage under the basic plan. During the second year of his employment, the wife develops a serious health condition. What's more, because the Administra-

tion's economic policies continue to be a failure, the poor man is laid off. He is out of work for more than 90 days and loses his protection under the original plan altogether. One month after his coverage terminates, he finds new work and immediately signs up for the basic plan offered by his second employer. The carrier says, however, I'm sorry, but no coverage of your wife's condition is possible for the next six months, since it existed on the date you initially secured coverage under our basic plan. What would you have me tell the man if he complains about the Nixon health program?

Answer

The proposed waiting period could sometimes result in this kind of problem. Although NHISA might often be supplemented in this respect, your concern is valid. During further deliberations with the Committee, the Department may want to discuss possibilities for assuring greater continuity of coverage during transition periods.

From Mr. Carey—Question No. 13

Department officials have repeatedly emphasized the magnitude of mental health problems in the United States and have urged Congress to support programs that will remove the barriers to mental health care. Dr. Bertram Brown, for example, Director of the National Institute of Mental Health, in testimony before the Appropriations Committee, commended the work of psychiatrists and particularly the time they spend on community service activities.

The Administration's bill, however, would prohibit any payments under the basic plan for the services of psychiatrists and indicates, in my view, a traditional insurance industry bias against the health needs of the mentally ill. Why have you failed to take steps to remove the financial barriers to competent and professional psychiatric help?

Answer

Secretary Richardson announced that once the primary benefits are in place and as resources become available, we would hope to add to the list of covered benefits. The reasons for the proposed benefits were two-fold.

1. The Administration wanted to keep benefits within a specified premium range for the first several years to minimize the initial impact of the expenditures on employers and the consequent employment situation. We therefore sought to provide protection for basic needs first.

2. There is mixed experience with insurance for mental health care and other areas of personal health care and consequently, substantial questions as to the impact on demand and cost. We are studying the experience under the other services of a few large insurance contracts, with the view of over time adding to the priority benefits.

Through other authorities, the Administration is continuing to develop and support community mental health centers and has expanded its programs in Narcotics Addiction and Alcoholism prevention and treatment through project grants.

From Mr. Carey—Question No. 14

How would you explain to an AFDC family in New York City, which has recently had its welfare payments reduced, that the medical protection now available under Medicaid will be substantially reduced under FHIP?

Answer

It is not necessary or axiomatic that medical assistance to an AFDC family in states like New York be reduced after passage of FHIP. Indeed, MSA is confident that in the case of New York and many other states present levels of support for health care for the poor will essentially continue. Currently, benefits under Medicaid vary from state to state. New York is one of the states which supports a relatively high level of health care under the program. It now supplies a number of services for the poor which are not part of the basic FHIP package, i.e., dental services, eyeglasses, drugs. A majority of states provide a variety of services not included in the basic FHIP benefit package.

If the states continue to cover, for Medicaid family recipients, those services not provided under FHIP, then they would have to supplement the FHIP program with expenditures, not Federally matched, totalling almost $1.4 billion. However, even with supplementation most of the states would spend less on medical care for their AFDC population than they currently expect to spend under

Medicaid. In fact, 34 states and jurisdictions would spend about $525 million less than their current AFDC-Medicaid budgets. The costs of supplementation would exceed current state/local Medicaid for AFDC costs only in 18 states and aggregate less than $50 million. These include primarily those states with extremely favorable Medicaid matching. New York is not one of these.

Thus based on the pattern of state participation in the Medicaid program to date, the savings for states which no longer would have to carry the basic Medicaid-AFDC costs; and the Federal assumption of administrative costs of supplementation, we believe that states like New York will continue to offer a level of health care for the poor similar to that which is presently provided. Some states, in view of possible increased discretionary income for cash recipients under proposed welfare reform, or of lost Federal dollars formerly attributable to high matching ratios, may not supplement.

From Mr. Carey—Question No. 15

The Administration bill provides that employers will eventually pay up to 75% of the premium costs for making available basic plan coverage for their workers. The greater the risks represented by his employee population, the greater the overall costs of making available such protection to workers.

Under your proposal, employers eventually will assume as much as 75% of the premium costs required to cover their workers. Considering the skyrocketing costs of health care, these premium costs, as you well know, can represent a significant and crucial cost of doing business.

It seems likely to me that private insurance carriers would advise employers that high risk employees or high risk families of such workers necessarily mean higher premium costs and a greater dollar outlay for the employer. In fact, employers might simply refuse to employ workers with health conditions or those whose family members have serious conditions. Once the pre-existing condition exclusion washes out, the health care costs for these people could be enormous. Don't you think the bill discriminates against the sick and against workers with family members who are ill?

And doesn't this permit the employer to tell a potential employee that he might get the job, on the condition he not join the basic plan?

Answer

As pointed out in answer to Mr. Carey's question 8, attempts by employers to dissuade employees, or potential employees, from exercising their right to participate in a mandated basic health care plan could violate the law requiring that such a plan be made available by the employer to his employees.

The National Health Insurance Standards Act also contains several civil and criminal enforcement provisions to discourage lack of compliance.

The purpose of the state regulated pools under NHISA's section 605 would be to assure coverage to all employees of small employers and self employeds and individuals not in the regular workforce, and ineligible for FHIP or Title XVIII, of the opportunity to purchase coverage.

The bill would greatly improve health service financing for millions of workers and their families, especially the sick and workers with family members that are ill.

From Mr. Collier—Question No. 1

A representative of the AFL-CIO, appearing before our committee on Tuesday, October 26th, charged that a wage earner participating in the health insurance plan under the Administration's national health care program would be denied any coverage if he lost his job and was unable to continue paying the premiums. Under what circumstances would an employee lose his coverage and what provision would take care of his medical requirements if he were either discharged, laid off, or resigned from his job and was then without employment for four or five months?

Answer

The Administration's proposal would ensure that some form of health care plan was always available to an individual from the time that his employment was terminated until he was eligible to participate in the health care plan offered by a subsequent employer.

First of all, if the employee had been covered by his prior employer's health care plan for 13 weeks before termination of his employment, he would be eli-

gible to obtain a 90-day extension of coverage under that plan. Alternatively, if the individual had a family and met the other eligibility requirements, he could receive benefits under the Family Health Insurance Plan. Application could be made immediately upon termination of the employment or at any time thereafter, and coverage would continue as long as the individual continued to be eligible. Finally, if coverage under a 90-day extension was not available to the individual or he had already used the 90-day extension, and he was not eligible for the Family Health Insurance Plan, he would be able to purchase coverage under a basic health care plan under section 605.

From Mr. Karth—Question No. 1

I have two related questions. First as I understand it, employers are to afford their workers "an opportunity to secure coverage under a basic health care plan approved under this part . . ." of the bill. What action by an employer would satisfy the provision of "an opportunity to secure coverage . . ."?

Now let me move to the second point. Suppose, for example, that an employer and his employees who are organized into a union, sit down to consider their options in the health insurance area. Suppose further that the cost of a basic plan with the exact benefit structure and cost-sharing features set out in the bill carries a price tag of $400 per worker per year. The employer's liability would then be $300 of this amount per worker.

Let us also assume that there is available another benefit package with full hospital coverage—no deductibles or coinsurance carrying a price tag of $300. The duration of such coverage in any one year, however, is only 180, rather than 365 days as in the bill. The employer is prepared to put up the full $300 premium cost for the second plan, or apply the $300 toward the costs of the basic plan. The union, after considering the needs of its members, decides that the 180-day program without cost-sharing features is the program they want. What's more, they now see that their members will have no premium charges for the second plan. The employer says—"I offer you the basic plan." The union replies—"We don't want the basic plan." The employer says—I also offer a second plan." The union replies—"We'll take it." What would you do in a situation like this, Mr. Secretary?

Answer

Under the Administration's bill, an employer's basic obligation would be to "provide an opportunity" to his employees to secure coverage under a health care plan. To meet this obligation, he would have to arrange for such a plan to be available to his employees, take reasonable steps to ensure that all eligible employees were aware of the availability of the plan, the benefits it provided, its costs, and the manner in which coverage could be elected, and give each qualified employee a reasonable opportunity to elect to be covered by the plan. In the situation you describe, the alternate non-NHISA plan could be selected instead.

From Mrs. Griffiths—Question No. 1

I am amazed that you would propose in this legislative package such a variety of cumbersome and administratively nightmarish group of deductible and coinsurance provisions. I wonder if you might listen to this statement by Blue Cross of Northeastern Pennsylvania to the state insurance commissioner on the matter of deductibles and coinsurance:

> ** * * we believe coinsurance and deductibles are without merit in affecting the use of medical care. We believe further that their popularity and the continued emphasis on their use proceed from the fact that they are easy answers" . . . Blue Cross, commercial insurance companies, and government spokesmen espoused the concept of deductibles, hoping that they would rationalize and influence patterns of medical care, rather than contend with the much more difficult challenge of affecting medical care at the point from which it proceeds: that is, the doctor and his style of medical practice. Even at this point in time, we would all rather believe that devices such as deductibles can accomplish the task of controlling hospital and medical care costs which we all face. I submit that the sooner we drop this notion, the quicker we can all address our energies to the difficult task we face. (Memo from Blue Cross and Blue Shield; Subject: Survey on Deductibles. Coinsurance and Copayments, September 28, 1971.)*

Mr. Secretary, why and on what basis do you disagree with the statement?

Answer

The statement by a representative of Blue Cross of Northeastern Pennsylvania reflects the views of only one Blue Cross plan submitted in response to a survey entitled "The Effect of Deductibles, Coinsurance and Copayment on Utilization of Health Care Services—Opinions and Impressions from Blue Cross and Blue Shield Plans. The survey represented a poll of 146 organizations, of which 60 responded. In our view, the results of the survey could be termed at best as mixed, without providing a clear-cut picture or prevailing pattern of how deductible and coinsurance provisions affect utilization. The responses received were sprinkled liberally with comments such as "no specific evidence," "no valid statistics," or "some effect but unable to measure it." It appears to us that the survey findings reflect, in large part, ideas and opinions on deductibles and coinsurance and do not provide a solid data base.

The quoted statement implies a certainty and universality of knowledge about the effects of cost-sharing which, unfortunately, are not available. Research studies of the effects of cost-sharing on utilization, program costs, service costs, and administrative costs are surprisingly scarce and sometimes contradictory. Through SRS and SSA research, the Department is currently supporting studies aimed at eliminating some of the ambiguities.

In fact, the source survey would seem to confirm our belief that empirical evidence on this matter is somewhat limited. Data from the survey indicate that a few Blue Cross plans have experienced lower utilization rates with (or after conversion to) deductibles and copayments for hospitalization policies. In Indiana, for example, Blue Cross' experience with a nongroup contract that covered roughly 30,000 people, showed that when this contract was converted from full coverage to a 75 percent -25 percent coinsurance basis the inpatient admission rate dropped about 10 percent and average length of stay increased about six percent. Another source of data shows that the introduction in 1968 of copayments for physicians' services in the Saskatchewan Medical Care Insurance Program was followed by a reduction in utilization rates. Also, a Stanford University study shows dramatic reduction in utilization rates followed the introduction, in 1967, of a coinsurance provision applied to medical services under the Group Health Plan of the Palo Alto Medical Clinic in California. Some medical economists like Dr. Mark Pauly of Northwestern and Dr. Martin Feldstein of Harvard have written and spoken widely on the deleterious impact of removing all price constraints on demand and costs.

What evidence there is on the effect deductibles and coinsurance have on utilization of health services seems to support the position that while factors such as phychological, personal, and family considerations all come into play when a decision is made regarding utilization, the economic factor is still an important one and cannot be disregarded. Of course, an equally important consideration in the imposition of deductibles and coinsurance is the manner in which they distribute the cost burden among beneficiaries. By leaving unreimbursable the "early" costs of covered health care—and a percentage of other costs—the NHIHSA Basic Health Care Plan can provide more comprehensive coverage of the higher and more catastrophic expenses which are more likely to devastate individual family finances. Similarly, a portion of the FHIP premium savings resulting from cost-sharing has been directed toward full payment for maternal family planning and well-child services for all FHIP eligibles.

We do agree with the implication of the statement that cost-sharing is not the only, or necessarily best means for controlling medical care costs or inefficient utilization nor for improving the delivery of needed services. But while cost-sharing is not a panacea for *all* of the difficulties in our Nation's health system, we will argue that cost-sharing is sensible in most circumstances, as a means of distributing scarce funds to those with the greatest medical expenses. Further, we believe that as improved utilization and peer review mechanisms evolve and as significant numbers of Health Maintenance Organizations increase their role in the Health Care System, the present needs we see for cost-sharing should be reduced.

From Mrs. Griffiths—Question No. 2

On page 18 of the Secretary's testimony it is stated that where the States do not act promptly to adopt authority meeting Federal standards, the Federal Government will be forced to exercise standby authority.

Would the Federal Government exercise this authority if the states do not administer their regulations effectively? Will the States receive any Federal

money for carrying on these activities? If the Federal Government should exercise its standby authority in a single State, isn't it likely that those Federal standards would apply to the whole nation since most health insurance companies do business in all of the states? Would you require the states to use more, or even all, of the proceeds from the typical 2% premium tax to regulate health insurance?

Answer

Minimum standards will be in effect throughout the country, even without the Federal presence in each state, since each state will be required to carry out the regulations set forth in the legislation establishing the National Health Insurance Standards plan. We do not anticipate that this regulation will require state funds in excess of that collected under the 2% premium tax.

From Mrs. Griffiths—Question No. 3

The price freeze now applies to health care prices as well as other prices. I have read that the Phase II program will have a special group just working on health costs. Since hospitals are paid on the basis of reasonable costs under government programs as well as under most Blue Cross plans, payments to hospitals can keep going up during the freeze period. What are you going to do about that in Phase II?

Answer

The President on November 10 appointed Barbara (Mrs. William C.) Dunn, Commissioner of the Department of Consumer Protection for Connecticut, as Chairman of the Committee on the Health Services Industry, an advisory panel to the President's Cost-of-Living Council, Price Commission and Pay Board.

The President has appointed 20 members to serve on the Committee, representing the public, the medical profession consumers, hospitals, related health occupations and industries, and the health insurance industry.

The Committee is part of the post-freeze apparatus the President outlined in his October 7 Message on the Economic Stabilization Program. The creation of the Committee reflects the Administration's concern over the rising medical costs which represent a growing share of the family budget. The Committee will concentrate on advising the Cost-of-Living Council on ways in which the President's program can be applied in the health field and to enlist the full voluntary cooperation of the industry in restraining cost and price increases. The Committee will also advise the Pay Board and the Price Commission.

The Committee will be assigned a small permanent staff in performing its advisory functions and had its first meeting early in the week of November 14. At that time the Committee began to come to grips with many of the complex issues associated with the Administration of Phase II in the health industry.

It would be premature at this point to speculate on how the Committee will address the issue of hospital reimbursement.

From Mrs. Griffiths—Question No. 4

An HEW audit report shows that 26 Medicare intermediaries have claimed over $100,000 in government funds for travel, meetings, entertainment, and other expenditures which HEW auditors found to be unrelated to the Medicare program. For example, one intermediary charged Medicare for a share in the printing and mailing costs of more than 3 million contracts for its regular subscribers. Other chrges made by intermediaries were for entertainment, donations, and personal expenses of employees. This all added up to a total of more than $1 million in questionable costs identified in just one 12-month period.

In view of this kind of experience with private insurance organizations acting as agents of the government under Medicare, what assurances can we have that this type of problem would not be even worse under your program where there is little or no accounting for expenditures?

Answer

The Administration's proposed National Health Insurance Standards Act provides that employers must make an approved basic health care plan available to their employees, and must pay a substantial portion of the applicable premium. Under this plan employers would have the opportunity to compare the costs and services available from a number of competing health insurance carriers. The insurance carriers would be impelled to avoid incurring unnecessary costs in order to maintain a competitive position. The question of what types of

costs are allowable would not be as significant as the premium the carrier charges compared to the premiums of other carriers in the market place. As further protection, we are proposing amendments which will provide "file and use" procedures for National Health Insurance Standards Act premium rates under National Health Insurance Standards Act insurance contracts, with authority for the States to disapprove extraordinary rates.

In contrast, Medicare and Medicaid fiscal intermediaries negotiate agreements which provide that certain costs not related to the agreement will not be reimbursed to the intermediary. Medicare and Medicaid intermediaries should be reimbursed only the necessary and proper costs of administering the program. These costs are reviewed in advance and monitored throughout the year in order to assure that unallowable costs are not claimed by the intermediary. Finally, the costs are typically audited in order to assure that only necessary and proper costs are paid to the intermediary, regardless of the amount claimed.

It should be noted that the Medicare problems you mention occurred early and have been largely corrected.

Under FHIP, the use of carriers as fiscal intermediaries is not required by the legislation. Rather, the Secretary would have the option of engaging in such arrangements "to the extent found appropriate to carry out the plan established in the most efficient and effective manner . . ."

Thirty-two State Medicaid Plans are administered at least in part through carriers acting as fiscal intermediaries. The HEW audit agency has detected problems in some of these, not unlike those encountered under Medicare. Yet, the vast majority of those States admit advantages to their program through using fiscal intermediaries including:

(1) the long-standing rapport between the intermediaries and the providers and vendors and their societies enures to the program;

(2) intermediaries share their experiences in reimbursement methods and techniques for quality review and utilization analyses; and

(3) fewer State facilities and personnel are required.

To help insure effective performance by fiscal intermediaries under Medicaid, a model management information system has been delivered to the States, and regulations have been developed which would provide improved definitions of responsibilities and clearer standards and conditions for participation and Federal approval of State contracts with intermediaries.

From Mr. Gibbons—Question No. 1

Data from the Special Analysis of the Budget (published by OMB) show that government agencies during the period FY 1967 through the current fiscal year have invested nearly $1 billion ($987 million) in programs to improve the organization and delivery of health services. In this fiscal year (FY 1972) the bulk of this money (82.1%)—about $4 out of every $5—will be obligated by HEW through its component agencies, such as the Health Services and Mental Health Administration.

Aside from the HMO concept, the President's bill appears to contain little, if anything at all, to suggest that this massive research effort influenced the design of the bill. The proposal continues to rely almost entirely upon the existing "system" of resource allocation and organization.

HEW has invested all this money to conduct research and carry out studies on the best way to provide health care to the public in an efficient and effective manner. And yet, you bring to us a bill that simply relies on the same old fragmented health delivery system.

I would like to know, and in concrete terms, rather than in generalities, exactly how you arrived at this proposal without consideration of everything you should have learned from your research efforts? Didn't we learn anything from spending this $1 billion? What did we learn exactly?

Answer

The budget category, organization and delivery of health services since FY 1967, has included expenditures for comprehensive health planning, regional medical programs, maternal and child health project grants, neighborhood health centers programs, both OEO and HEW centers as well as the research activities of the National Center for Health Services Research and Development.

These expenditures have enabled us to establish State health planning agencies in all the States and areawide health planning agencies, covering half the country which are necessary to implement the capital planning provisions in

H.R. 1 and the new provision proposed by the Administration. Rational planning is a necessary ingredient of improvements in the efficiency and economy of the health service system.

The various centers programs, neighborhood health centers, comprehensive children and youth centers, maternity and infant care centers, have brought organized service capability to urban ghetto areas and rural areas where services were not available. These centers are forerunners of HMO's and have shown the value of organized one-stop services, with emphasis on prevention and early diagnosis. As you know, the experience with these centers and the studies of the prepaid groups provide much of the base for the Administration's Health Maintenance Organization proposal and the dual choice option for all the financing programs.

In addition, in these centers programs, there has been experimentation with and development of new types of health personnel such as the pediatric nurse practitioner who will be a qualified provider under the National Health Insurance Partnership Act.

The HMO's and the use of pediatric nurse practitioners, nurse midwives and medics are substantial departures from the same fragmented health delivery system.

The Regional Medical Programs are designed to provide linkages for physicians and community hospitals with regionalized sophisticated methods of treatment and continuing education. The improvements in treatment for cardiovascular illness are in large measure attributable to RMP.

In addition to these examples, there has been experimentation with communications technology to provide improved services to remote rural areas.

The Administration's proposals reflect what we have learned from the expenditures of these funds. For example, the health manpower legislation would expand the training of physicians' extenders like the pediatric nurse practitioners. It would establish area health education centers, extensions of the RMP concept.

The HMO assistance act provides grants and loan guarantees for the planning and development of HMO's with high priority for the expansion of the existing centers programs into HMO's. The National Health Insurance Partnership Act and H.R. 1 would require offering an HMO option to enrolees in the program.

H.R. 1 and the Administration's proposal expand the functions of comprehensive health planning in relation to rational distribution of health service resources.

The use of physicians' extenders is encouraged in H.R. 7741.

From Mr. Gibbons—Questions Nos. 2 and 3

(2) About 43% of Americans under 65 have insurance against the cost of physician home and office visits. How many more would have this protection under the employer-required health insurance in the Administration bill?

(3) About 4 out of 5 Americans under age 65 have private hospital insurance. How many more Americans would get hospital insurance as a result of the requirement that all employers offer such coverage to their employees?

Answer

Virtually all Americans would be eligible for some form of insurance against the cost of hospital services and physician visits under the Administration proposal. We have estimated that 80% of the employed civilian labor force between ages 18 and 64 would be mandated either directly (57 million) or through their working spouses employment (7 million). Including all spouses and children under 18, approximately 140 million persons under age 65 would be eligible through the mandate.

From Mr. Gibbons—Question No. 4

Based on the consultations you no doubt had with such groups as the National Association of Insurance Commissioners, the Health Insurance Association of America, what would you say are the most serious problems they find with your bill and with the regulation bill you have talked about?

Answer

Three major problems which have been of on-going concern to these groups are:

1. the relative roles of the States and the Federal Government in the regulation of health insurance companies;
2. the establishment of stable "pools" within each State; and

3. protection against insolvency for employees of "self-insurers".

While we didn't seek this agreement on every aspect of our regulation strategy, we did seek to obtain from their professional organization their best technical advice on how the regulatory mechanism should be established to insure that they would operate.

From Mr. Gibbons—Question No. 5

The Administration's health "white paper" states that the present health insurance industry "is essentially unregulated." Do you mean by this that State insurance commissioners are not doing their jobs? What are some of the factors which contribute to this poor performance?

If the present State agencies are all that bad, why do you propose continuing to use them?

Answer

The *White Paper* was referring to the lack of Federal regulation. Our careful analysis indicated to us that in an overwhelming number of States the performance of the States in regulating the group health insurance industry was quite adequate. We, therefore, decided to build on this strength and introduce new legislation only where some additional controls seemed desirable.

From Mr. Gibbons—Question No. 6

I get quite a bit of mail from Medicare patients complaining that Medicare actually pays considerably less than 80% of physicians' charges because the Medicare reasonable charge is less than the physicians' current charge. If your bill should be approved the whole population would be in that situation. Is that right? Would you expect private insurance to write policies covering the difference between the Medicare reasonable charge and the actual physician charge?

Answer

All purchasers of National Health Insurance Standards Basic Health Care Plans and all FHIP eligibles would have physician service benefits determined in accordance with the Medicare methods of determining reasonableness and may include such approved experimental methods as may be initiated and approved should H.R. 1 be enacted.

As with other types of extra or supplemental benefits, private policies could cover the excess charges you describe so long as they are part of an optional benefit plan. All employees would still have the right to choose only the NHISA Basic Health Plan.

From Mr. Gibbons—Question No. 7

HEW testified that the increase in premiums for private health insurance under the Administration bill will amount to about $3.6 billion. Since the States now tax such premiums at a rate of about 2%, they will have an additional $75 million in tax revenue.

As your own analysis no doubt was shown, one of the problems of more effective State regulation has been the low amounts spent on such activities, usually much less than the 2% premium tax which is supposed to support that activity.

Are you going to require that the States use this additional $75 million to support their regulatory activity or will it merely be a Federally mandated increase in State taxes.

Would you support a small carmarked Federal tax on premiums to support the Federal regulatory activity?

Answer

We have not specified a fixed sum of money to be spent by the States to regulate the industry. We feel the 2% premium tax will provide sufficient revenue for the States to carry out the Federal requirements and that no new State or Federal funds will be necessary. Our concern is not with how much they spend, but with their performance in carrying out these new regulations.

From Mr. Gibbons—Question No. 8

The Social Security Administration determined some time ago that it was impossible to satisfactorily supervise intermediary and carrier operations throughout the country from its central office or even from its regional offices, so it has been placing its own on-site representatives in the offices of intermediaries and carriers around the Nation. If the operation of private insurance organizations is really so bad under the Medicare program as to require this kind of close day-to-

day governmental supervision, how can we depend on these same companies to do a good job with the billions of dollars in increased premiums they would receive under your employer plan?

Answer

The situation of private insurance companies under the National Health Insurance Standards Act would be different from that of intermediaries and carriers under the Medicare program. Under Medicare, intermediaries and carriers can be paid no more than their costs in administering the Government program, and therefore have little direct financial incentive for improving either their efficiency, or their degree of compliance to those directives aimed at achieving National uniformity in Medicare benefit delivery.

In some respects, the purpose of the on-site SSA Representative is to provide a substitute for this lack of direct financial incentive and the tendency toward inefficiency which cost reimbursement often precipitates. SSA believes that the general level of intermediary and carrier performance is acceptable, but could and should be improved in areas influencing efficiency, uniformity and improved administrative technique.

Whereas the elderly have few alternatives to Medicare for their basic health insurance, the working population will have many alternatives and opportunities to compare carrier costs and premiums.

The National Health Insurance Standards Act would provide a strong economic incentive for better management in the form of greater profits and market shares. There would be competition among insurance companies to keep costs down by providing good service efficiently. There would be more tolerance of administrative variations and innovations than present Medicare realizes.

From Mr. Gibbons—Question No. 9

Although the employer-employee proposal contained in the Administration plan provides some protection against so-called "catastrophic" health care costs, no comparable protection is available to the presumably higher-risk population that would be covered by FHIP. With the limitations imposed on benefit days, the application of coinsurance and deductibles, it is entirely possible for a level V family under FHIP to incur a cost-sharing liability well in excess of $1,000 for the first 30 days of hospital confinement. Beyond 30 days, the costs become catastrophic. How do you justify this posture toward the poor protected under FHIP? Do you really expect that a family of four with $4,100 in gross income can afford $1,000 of that for health care?

Answer

It is not expected that the exceptional circumstances described in the question would occur with any serious degree of probability. Admittedly, it is possible for a family with an income of $4100 to pay $1000 in hospital costs. However, this would certainly be the exception rather than the rule. In the Income Class 4 category ($4001–4500) a family is liable for 10% coinsurance on all services except hospital room and board. While this cost-sharing requirement will not impose hardships in the vast majority of families in Income Class 4, it is possible that a few of these families could be liable for sizeable medical bills. For example, if a family member is in an uninsured automobile accident and incurs $20,000 of hospital expenses, he is liable under FHIP for 10% of those expenses, or approximately $2,000.

Income Class 5 families ($4501–5000) are liable for 25% coinsurance costs. Thus, using the same example of a family with a $20,000 hospital bill, the family in Income Class 5 would be liable for approximately $5,000 of the bill.

It must be stressed that families with such sizeable medical expenses are a distinct minority. Department studies indicate that fewer than 5% of all families have medical costs in excess of $2,000 per year. It should also be recognized that State and local governments will often supplement FHIP.

The Administration feels the costs of providing financial coverage against catastrophic illnesses for FHIP families is less urgent than providing basic health benefits for this population. The added costs of catastrophic coverage for this population would benefit a very small portion of this population, while the basic family planning, maternal and well-child benefits, provided to all families will be of benefit to virtually all of this population.

From Mr. Gibbons—Question No. 10

The President in his health message said that his program would require the establishment in each State of special pools which would offer insurance at a

reasonable group rate to people who did not qualify for other programs including the self-employed and the poor risks. I don't see this in your bill. Are you still proposing such a provision?

How would this work in detail?

If you include both the self-employed and the poor risks in the same group, won't the self-employed be required to help pay the costs of the poor risks?

If you put the poor risks in one group and the self-employed in another won't the rates for the poor-risks have to be so high as to be unaffordable?

As you know, individually written commercial health insurance pays out in benefits only a little over 50¢ of the premium dollar. Individual premium collections and sales costs account for most of the higher retention rates in individually written plans and you would still have these costs for the self-employed even if you call it group coverage. What is there in your plan that makes the coverage for the self-employed and the poor risks available at retention rates as low as group insurance?

Answer

Our proposed legislation will include a requirement that such special pools as you refer will be established in each State. Exactly how these pools will operate is still being worked out, but we can assure you that your concerns about cross-subsidization are being carefully considered.

The major savings that will result under mandated coverage which will substantially reduce the administrative costs of insuring the self-employed and the small employer are that:

1. Mandated coverage will be required of all employers of one or more—thus substantially reducing carrier selling costs.
2. A standard benefit package will exist for all plans, thus allowing fuller realization of economics of scale.

From Mr. Gibbons—Question No. 11

Under the Administration's proposal, the employee appears to have all of the options regarding enrollment or disenrollment in the basic plan. What do you propose to do about adverse selection against these plans by employees who refuse to pay 25% of the premium costs during periods in which they and their families are healthy, but would participate when they or their families are ill? Would an employee only have one chance to enroll? Under what circumstances would he be permitted to change his option, either to disenroll or reenroll?

Answer

Given the uncertain nature of the incidence of illness, the high cost of care, and the well-known benefits of insurance, it is unlikely that the number of employees who would gamble on buying insurance only during times of illness would be more than a very tiny fraction of those covered, hardly sufficient to alter program costs.

Administrative necessities might lead us to a concept, whereby employees (other than new employees) may be periodically given the opportunity to change their coverage or to enroll if they have not done so. We might specify by regulation or guideline the minimum frequency for such periods. Of course, an employee would be allowed to disenroll at any time.

The Secretary would assure, by regulation, that the circumstances surrounding "the offering" of mandated coverage be reasonable.

From Mr. Gibbons—Question No. 12

HEW promulgated a new inpatient deductible of $68 which Medicare patients will have to pay when they enter a hospital. This is according to the Medicare law and takes into account the steep rise in hospital costs during 1970. But if we have gotten hospital costs under control as a result of the freeze and your activities in Phase II, don't you have the authority under the economic powers you have been using to suspend the $8 increase in the amount these sick old people have to pay?

Answer

Under the law the Secretary of Health, Education, and Welfare is required to review hospital costs each year. If he finds that these costs have increased substantially, he must increase the inpatient hospital deductible for the following year. The law provides a specific formula for determining the amount of the

increase, which requires that it be in direct proportion to the rise in hospital and medical costs experienced the previous year. When this formula is applied to current data, the inpatient hospital deductible for 1972 must be set at $68. The Secretary has no discretion in applying the law and no power to rescind this increase once promulgated.

The method of computing increases assures that Medicare beneficiaries will continue to pay the same share of their hospital and skilled nursing home care costs as they did when the Medicare program started. The intent of the law in this regard is that as the cost of Medicare services goes up, the beneficiaries' share of such costs must go up proportionately. If this were not done, it would be necessary either to find other ways of getting the additional money needed to meet the rising costs or to cut back on other Medicare benefits.

The Administration is firmly committed to dealing with the problems of inflation in health care cost. Not only does Phase II of the President's new economic policy directly address this problem, but the Administration has already proposed, under H.R. 1, a series of important cost control measures for Medicare and Medicaid. If Phase II is as successful in controlling inflation as we hope and expect, there would be no necessity for an increase next year. However, to suspend or rescind the current increase would disrupt the relationship between hospital costs and the inpatient hospital deductible.

From Mr. Gibbons—Question No. 13

The Administration bill provides that carriers will notify the Secretary that it has offered and that an employer has subscribed to a basic health care plan. The carrier is required to advise on the contents of the plan, the class of employees covered, and such other information to determine whether the employer is in compliance with sec. 602(a).

Sec. 606 of the bill provides for a reporting mechanism to establish compliance with the provisions of your proposal. Certain information is required in connection with these reports.

Nothing is mentioned in the bill, however, regarding the premium costs of the protection involved. Who is going to assure that these private carriers are not taking excess profits out of the Federally-mandated program?

Are you going to monitor their reserve policies, the profits, the expenses, and other financial matters?

Answer

The States would be responsible to insure that the premium rates charged for NHISA coverage are not unreasonable in relation to the benefits offered. The carriers would also be required to have an independent annual audit of its financial status. The results will be available to the public. Also, the Secretary will prescribe the manner in which the relationship of each carrier's retentions bear to premiums for basic NHISA health care plans would be disclosed.

From Mr. Gibbons—Question No. 14

There have been some press reports, as you know, about the relationship between the Electronic Data Systems Company owned by Ross Perot and the Medicare and Medicaid programs. I am informed that the Domestic Council at the White House has given this outfit a contract or grant for $60 or $70 thousand to look into utilization review ideas for national health insurance. Can you describe just what you hope to learn from this contract that you don't already know?

Answer

The Domestic Council has the specific charge of assisting the President to develop Administration policy in domestic areas. In the course of its work on the national health strategy, it became apparent that any national strategy should contain significant controls on rapidly escalating health costs. In order to understand the operations of the present cost control measures better and to get the best outside, consultative advice on new measures that might be proposed, the Domestic Council turned to Electronic Data Systems.

EDS is a major factor in the financing of health care since it operates payment mechanisms for more third party payors than any other company. EDS held meetings with Social Security Administration staff, interviewed specialists and health economists in the field, and analyzed data from its own customers to bring to bear the best available knowledge on the subject. EDS also

did a state of the art analysis which provided ideas beyond those already present in the EDS and other systems. In addition, EDS had staff resources and support time which could be made available immediately.

The final report discussed a number of cost control measures, including utilization review. The proposed cost control measures are integrated into a total cost review and control system. Specifically in the area of utilization, EDS had more private post-payment utilization review data available than any other source. Other aspects of the system are prospective utilization control, duplicate checking, eligibility checking, establishing reasonable charges, and peer review. The characteristics of these cost controls are fully analyzed and documented, and the impact of these controls on the national health bill is estimated.

In addition, the contract provided an independent check on forecasts of health costs which became available for the formulation of the Administration's health insurance program, as presented to the Ways and Means Committee.

The contract has been completed and the analysis has been used in the development of the Administration's cost control strategy involving both long-run and short-run proposals. The analysis can also be used to anticipate problems which might be encountered in any extension of present utilization review and cost control measures into a more comprehensive cost control system.

From Mr. Gibbons—Question No. 15

The Administration bill would require that each of the 1,000 companies which would write your basic health care benefits to reimburse physicians, hospitals and other providers of health services on the same basis as does the Medicare program.

(1) How would each of these organizations obtain all the information about the customary charges of over 200,000 physicians. Wouldn't that be an administrative monstrosity? Would we actually wind up with a national fee schedule for all physicians?

(2) How would all these carriers obtain information about the reasonable costs of seven thousand hospitals?

Answer

It is doubtful that anywhere near today's 1,000 carriers will qualify to underwrite the National Health Insurance Standards Act benefit packages. At present, fewer than 100 carriers write about 90 percent of the commercial group coverage in force. Some of these companies and virtually all Blue Cross and Blue Shield plans have already had experience in administering the "reasonableness" criteria under the Medicare program. Those not now involved with Medicare will have to demonstrate to us their ability to perform reasonable cost and charge determinations within our guides.

With respect to charge determinations, the regulations and guidelines developed by the Social Security Administration for use under the Medicare program would provide a uniform basis for determining reimbursement amounts under the various employer-sponsored plans and the Family Health Insurance Plan. These criteria have the dual advantage of establishing a uniformity of approach and, by relating determinations to individual customary charges and prevailing charges in the area, responding to the economic, social and geographic variables which influence patterns and costs of health care services in various sections of the country. We believe that such an approach is preferable to a uniform national fee schedule and, by standardizing the determination process, will serve to reduce much of the current confusion on the part of physicians and other suppliers as to the basis for reimbursement under the various insurance plans carried by their patients.

The same benefits of uniformity of reimbursement approach will also accrue to institutional providers of services reimbursed on a cost basis. The Department has developed a uniform financial report for use by providers of services receiving reasonable cost reimbursement under more than one Federal program; ultimate use of a single standardized report for all plans would not be an unrealistic expectation and would significantly simplify the reimbursement mechanism with concurrent reductions in provider administrative costs.

The Department has also recognized that a reimbursement system which stresses retroactive adjustment based on actual costs incurred lacks incentive to contain costs or to provide services in the most efficient and effective manner. We have therefore recommended that the Medicare program move toward a system of prospective reimbursement under which providers would be encouraged to

innovate and improve the effectiveness of delivery of services. H.R. 1, the Social Security Amendments of 1971 as passed by the House of Representatives, would authorize experimentation with various types of prospective reimbursement. We are hopeful that a workable prospective reimbursement system can be rapidly developed.

From Mr. Gibbons—Question No. 16

The Secretary made several references to pool arrangements within States to provide protection for certain high-risk or otherwise ineligible persons who could not obtain coverage through an employer-employee plan. Such pools may be more trouble than they are worth to carriers and the latter may not want to underwrite any portion of the risks associated with this population. Do you propose to require carriers to participate in these pools? Would you specify the proportion of the risk that each must assume? If not, how would you underwrite that portion of the risk that would be beyond the financial capacity of participating carriers in the pool to assume?

Answer

Every carrier writing insurance for employee groups under the National Health Insurance Standards Act will be required to participate in the pool arrangements, in every State in which any of the employees it insures are located.

From Mr. Gibbons—Question No. 17

Under FHIP, eligible persons would be entitled to 30 days of inpatient hospital care annually. Presumably, the States could supplement this benefit with additional coverage days. But what do you propose to do for that person living in a State which does not supplement who requires during the course of 12 months more than 30 days of inpatient care? Who pays for that care? Would you require all hospitals which have a nonprofit tax status to keep patients beyond 30 days?

Answer

Since all States but two now provide Medicaid benefits and FHIP would provide basic protection, federally financed, the States will be relieved of much of their Medicaid burden. A very small number of people exceed 30 days of hospital care a year. In these cases, we would expect most States to supplement.

In addition, FHIP extends coverage to many low income families (mainly male-headed families) who were not eligible for Medicaid or other Federal and State supported programs. These families often received all their hospital care from county hospitals and through philanthropy. FHIP would therefore lift some of this burden, reducing local funds needed for basic health services.

In many communities, United Givers Funds or similar funds are used to supplement hospital payments for the medically indigent and probably would continue to supplement in these cases, particularly since some of the care these funds finance now would be paid for by FHIP.

It is recognized that the 30 days inpatient hospital benefits under the Family Health Insurance Plan will not meet all needs. However, Family Health Insurance Plan benefits were designed to meet the most pressing needs of poor families with children, while keeping the entire cost of the program within reasonable limits. In States which fail to supplement the hospital benefit, public hospitals—city, county, and State—generally are maintained for care of indigents and would be available. We would, however, expect Federal financing of administrative costs to move many States to supplement the Family Health Insurance Plan, since they otherwise would have to bear the costs of indigent care in many cases anyway.

Coverage of additional hospital days, however, is not the only solution to the 30-day limitation since relatively few patients require hospital stays of this duration. In many cases, in fact, patients are kept in costly hospital beds when ambulatory care would be medically appropriate. It is therefore important in hospital utilization and reimbursement to ensure that patients are receiving the most appropriate level of medical care, either in a hospital, extended care facility, home health, or on an ambulatory basis.

The question of requiring hospitals with a nonprofit tax status to keep patients beyond 30 days is a complex one which requires additional study before we can give you a definitive response.

We do think nonprofit tax-exempt hospitals should provide a certain amount of care on a charitable basis, as indeed they generally do. But it would be unreason-

able to expect hospitals to provide unlimited amounts of free care, and regulating just how much is required would be difficult. For these reasons we are not now proposing to change the current revenue rulings under which tax-exempt status for hospitals is determined.

From Mr. Gibbons—Question No. 18

How many workers in the United States already are protected by health insurance programs, the benefit of which has an actuarial value equal to or greater than the value of the structure proposed in your program? In the aggregate, what percentage of premiums for private health insurance are now paid by employers in the United States? What is this in dollar terms? How many additional dollars would employers pay, over and above what they now pay, to comply with your program, if every eligible employee elected the coverage you propose?

Answer

(a) This information is not known with certainty. However, one approach to estimating the number of workers with protection equal to or greater than that proposed by the Administration program is to look at the number of persons with comprehensive major medical and supplementary major medical policies of commercial insurers, as well as comprehensive extended contracts of Blue Cross-Blue Shield plans. While not a perfect measure, it is a start in the direction of estimating the impact of the proposal in terms of numbers of workers involved.

In 1969, approximately 24,500,000 workers were covered by commercially insured group major medical expense policies. An estimated 6.5 million workers were included in extended contracts of Blue Cross-Blue Shield. To this total of 31.0 million workers should be added those included in comprehensive private group practice plans—estimated at less than 3 million workers—for a total of about 34 million workers included in what may be considered the more comprehensive protection through employer-sponsored plans.

At the end of 1969, it is estimated that 57 million workers had some type of medical care protection through their place of employment. Therefore, the more comprehensive policies would have included about 6 out of 10 workers with some medical care protection through the workplace.

(b) As the table below shows, in 1969 it is estimated that employers paid about $8.0 billion toward group health insurance premiums, or about 55 percent of total voluntary health insurance premiums (individual and group) in that year, and about 70 percent of group.

Preliminary estimates for 1970 show that employers contributed about 9.6 billion, or a little over 55 percent of total health insurance premiums, and still about 70 percent of group.

	1969	1970 (preliminary)
Total voluntary health insurance premiums	$14,660	$17,185
Employee-employer contributions to group plans	$11,465	$13,645
Percent of total	78	79
Employer contributions to group plans	$8,025	$9,550
Percent of total	55	56
Percent of group	70	70

(c) In fiscal year 1974, projectng current outlays and trends, employers are expected to be spending around $18.4 billion dollars for health insurance (including workmen's compensation), which is approximately 59% of private health insurance premiums. If the Administration proposal were in effect, employers' expenditure for health insurance would rise by $4.7 billion to $23.1 billion, which would be 64% of private health insurance premiums.

From Mr. Gibbons—Question No. 19

The Secretary indicated in his testimony that no additional Federal financial assistance would be provided to the States to fund the costs of regulation of private insurance proposed by the Administration. What additional financial

burdens would the States be required to assume to comply with their new and broadened regulatory responsibilities?

Answer

See answer to your question 7.

From Mr. Gibbons—Question No. 20

The Secretary stated that the Federal Government would step in to regulate private carriers only where the States failed to do so. Describe precisely the conditions under which the Government would take such steps and what would constitute the failure of a State to carry out regulatory responsibilities? What organization in the Federal Government would make these decisions? What agency would actually do the regulating under these circumstances?

Answer

In the near future the Administration will submit to the Committee, in the form of amendments to H.R. 7741, its proposals for the regulation of insurance carriers under the National Health Insurance Standards Act.

From Mr. Gibbons—Question No. 21

Under the Administration bill an individual who is laid off is allowed to keep his insurance up to 90 days.

Let's say a man who is laid off decides to keep his insurance for 90 days. Now if he can't get another job within four weeks he may have a gap in his protection because his new employer doesn't have to offer the coverage until he has been on the job for more than eight weeks. What is the poor fellow going to do if he can't get a job for six or eight weeks?

Answer

One of the purposes of the pool is to enable individuals in the situation described to obtain coverage during employment gaps. In addition, most group insurance has conversion provisions, where when group coverage ceases, the individual can elect to continue coverage on an individual basis.

The Administration's proposal would ensure that some form of health care plan was always available to an individual from the time that his employment was terminated until he was eligible to participate in the health care plan offered by a subsequent employer.

First of all, if the employee had been covered by his prior employer's health care plan for 13 weeks before termination of his employment, he would be eligible to obtain a 90-day extension of coverage under that plan. Alternatively, if the individual had a family and met the other eligibility requirements, he could receive benefits under the Family Health Insurance Plan. Application could be made immediately upon termination of the employment or at any time thereafter, and coverage would continue as long as the individual continued to be eligible. Finally, if coverage under a 90-day extension was not available to the individual or he had already used the 90-day extension, and he was not eligible for the Family Health Insurance Plan, he would be able to purchase coverage under a basic health care plan under section 605.

From Mr. Gibbons—Question No. 22

In reading reports made by Medicare officials to another Committee in the Congress a year or so ago, I was impressed by the difficulties they had in getting poor-performing private insurance organizations up to acceptable levels of performance. It seems to me that Medicare invested a tremendous amount of time and money in bringing some of these organizations up to the point where they can be considered to be doing an adequate job. This investment was supposed to be justified because the alternative—to drop a poorly performing intermediary and contract with another—would be even more expensive, and the investment already made in the original outfit would go down the drain.

HEW is also on record as stating that private health insurance companies are simply bill-paying mechanisms. I wonder why it would not be more efficient, less costly, and result in a better run over-all health insurance program if a government organization like Medicare which has developed by now considerable experience and expertise of its own in running a benefit paying organization were given the responsibility of tooling up and contracting directly with private insurance firms with widely varying degrees of experience, costs, organizational set-ups and what have you? Would you comment on this?

Answer

(See answer to your question no. 8)

Also, SSA's experience in directly dealing with providers and individual practitioners is quite limited, since only a small percentage of Medicare claims are processed directly. Gearing up to handle every medical expense episode would require many thousands of additional SSA employees and millions in additional space and equipment. It would also result in the displacement of large numbers of private employees and investment. As we have testified, the point is not whether Social Security can operate the program more efficiently than private industry, but the social costs of such a displacement.

From Mr. Gibbons—Question No. 23

The Secretary agreed that the FHIP program would not cover all of the health care expenditures of persons eligible for the program, but that the States could supplement the benefit package provided for under FHIP. If no State supplemented the basic FHIP package, what percentage of total health expenditures of eligibles would not be paid for by FHIP? What portion would be equivalent to the amounts eligibles pay for deductibles, coinsurance and premiums, and what amount from unknown sources?

Answer

1. There does not exist data which would fully answer your questions, since there has never been an adequate study of total health care costs and expenditures by low income persons.

MSA has estimated that FHIP will replace about $2.8 billion of the forecast $4.2 Medicaid for AFDC fiscal 1974 total expenditures for medical services. FHIP for those not eligible under present AFDC definitions, but within FHIP specifications, would cost another $0.4.

Thus, if no State supplemented FHIP, public expenditures for poor families could fall from $4.2 to $3.2. If, on the other hand, all States supplement, public expenditures for this population group would rise to $4.6 or $4.7 billion.

Under FHIP, beneficiaries would contribute income related premiums of approximately $150 million, which add to FHIP outlays. FHIP beneficiaries would also pay approximately $450 million in cost-sharing.

Considering only program outlays, the amount of medical services paid for after FHIP would be:

Federal dollars, net	3.2
Premium contribution	0.2
Gross value	3.4
Less administration	.3
Benefits	3.1
Cost-sharing	.4
FHIP total	3.5

(State supplementation: zero to $1.5) (Total services: $4.9 to $5.0 maximum to $3.5 minimum.)

From Mr. Gibbons—Question No. 24

Under the Family Health Insurance Program, earned and unearned income, including FAP payments, would be counted in determining into which class a family would fall for the purposes of applying deductibles and coinsurance under FHIP. Is it not possible, therefore, that a high-risk family (from a health standpoint) could be placed in a position where a State supplementation payment resulted in cost-sharing requirements for the purposes of FHIP that exceed the value of the State supplementation payments?

Answer

It is possible for a family to be placed in a position where a State supplementation payment results in cost-sharing requirements (for the purposes of FHIP) which exceed the value of the State supplemental payments. This situation will occur, however, only in a family in Income Class 4 or 5; Income Classes 2–3 have no coinsurance and a maximum of $265–$340 of premiums and deductibles* and

*Calculated at $60 per person for hospital room and board in FY 74.

there is no cost-sharing for families in Income Class I. Thus, families in Income Class 1 can receive up to $3,000 ($600 in State supplemental payments) and still be excluded from cost-sharing; families in Income Class 2 receive up to $3,500 ($1,000 in State supplemental payments) and be subject to a maximum $265 in cost-sharing; and families in Income Class 3 may receive up to $4,000 ($1,600 in State supplemental payments) and still be subject to a maximum of $340 of cost-sharing. Thus for families in Income Classes 1–3, the State supplemental will work to their advantage and never will place them in an income class which would force them to assume medical expenses beyond the value of the State supplemental.

The situation changes somewhat when a family in Income Class 4–5 is considered. In the Income Class 4 category, a family is liable for 10% coinsurance. While this cost-sharing requirement will not impose hardships in the vast majority of families in Income Class 4, it is possible that a few of these families could be liable for sizeable medical bills. For example, if a family member is in an uninsured automobile accident and incurs $20,000 of hospital expenses, he is liable under FHIP for 10% of those expenses, or approximately $2,000. This rare instance could more than eliminate the $1,601 in State supplemental payments needed to put the family over the $4,001 dividing line from Income Class 3 into Income Class 4.

The situation with Income Class 5 families is that families are liable for 25% coinsurance costs. Thus, using the same example of a family with a $20,000 hospital bill, the family in Income Class 5 could become liable for approximately $5,000 of the bill, if there were no State supplemental medical benefits to FHIP.

It must be stressed that families with such sizeable medical expenses are a distinct minority. Department studies indicate that fewer than 5% of all families have medical costs in excess of $2,000 per year. The FHIP benefit design devotes dollars that could have been used to provide better catastrophic coverage for those few who may need it, to basic first dollar maternal, family planning and well-child services which will benefit virtually all eligible families.

From Mr. Gibbons—Question No. 25

Why should the working poor enroll in an employer-employee plan which would take more than $170 in premium costs annually when they could fall back on the FHIP at little or no direct and recurring costs to them or their families? Isn't this a big incentive to limit the amount of work activity so that enrollment in an employer plan never occurs?

Answer

We are not unaware that some people may try to adjust their income level in order to take advantage of the lower-cost protection available under the Family Health Insurance Plan. However, we firmly believe that this would be the exception rather than the rule. Most Americans by far prefer to work and earn their living and few would deliberately spend time and effort to manipulate the system.

Even if they could, we have designed the mandating proposal, the Family Health Insurance Plan, and the Family Assistance Program that would be established under H.R. 1, so as to encourage people to work and to eliminate incentives for them not to. As an example, under the Family Health Insurance Plan a family of four with an annual income of $5,000 (which would include both earned and unearned income) would pay an annual premium of $100. Using your example of $170 as an annual premium under an employer-employee plan, it seems to us highly unlikely that a person would stop working or somehow adjust his work hours and income so as to become eligible for protection under the Family Health Insurance Plan.

It is questionable that a $70 annual difference or $6 per month in premium cost for a plan that contains unlimited hospital and physicians' services and catastrophic coverage would act as a work disincentive. In addition, the $170 average reflects the maximum worker share of premium. In unionized industry, it is quite possible that the premium cost to the employee would be lower.

It is, of course, possible to adjust the cost-sharing provisions of FHIP, if a serious work disincentive does exist and we expect to engage in discussions with the Committee in Executive Session on the various schedules of premiums and cost-sharing.

From Mr. Gibbons—Question No. 26

Under the family assistance program we would disregard earnings of school children. Why don't you do that under FHIP?

Answer

The development of FAP and FHIP were somewhat separated in time and the definitions of eligibility are at variance with each other. Our basic intent is to have FHIP eligibility extended to all FAP families who would not be eligible under an employer-employee plan. In Executive Session, we intend to conform the definitions of eligibility between these programs to the extent necessary to achieve their mutual goals.

Mr. ULLMAN. We will continue, hoping to conclude with the members present.

Mr. Waggoner.

Mr. WAGGONER. Mr. Chairman, I will be brief with the three questions I have and I would like to submit some other questions for answers in writing and have the answers included at this point when the hearings are printed.

Mr. ULLMAN. You have that permission.

(Special questions and answers follow:)

From Mr. Waggoner—Question No. 1

Mr. Secretary, on page 11 of your testimony, you refer to those employees who could continue to get coverage for 90 days after being laid off. As I read your bill, the employee would have to be covered under the basic health benefits program for 13 weeks, not just employed for 13 weeks. The result would be that an employee would have to be working for the same employer for at least 21 weeks before they would be eligible for the 90-day provision.

Am I right on that?

Answer

Under the Administration's proposal, the vast majority of employed individuals would obtain coverage for themselves and their families under basic health care plans offered by their employers. The availability of coverage under a particular employer's plan arises out of the employment relationship and must be closely related to it. An employer who must make substantial contributions to the cost of his employees' health care plans should be permitted to assure himself that the employment relationship will have some degree of permanence before an employee becomes eligible for the benefits of the plan. Similarly, eligibility to participate in the plan should end within some reasonable period after the employment relationship is terminated. The Administration's bill (section 602(a) would permit an employer to require that an employee work 25 hours a week for ten weeks or 350 hours in 13 weeks before the employee was eligible to obtain coverage under the employer's health care plan. It would also, under proposed section 603(f)(6), permit an employer to require that an employee be covered under the plan for 13 weeks before he was eligible for an extension of coverage upon termination of the employment relationship and permit the employer to limit the available extension to 90 days.

The Administration feels that the times specified in the bill strike a reasonable balance between the needs of employees and the interests of their employers. There will, of course, be cases in which individuals who are unemployed for an extended period of time will have no coverage under an employer's health care plan available to them. The bill therefore would make coverage available to these individuals under section 605, or, in the case of the neediest families, under the Family Health Insurance Plan.

From Mr. Waggoner—Question No. 2

Mr. Secretary, on page 21 of your testimony you indicated that somehow you were going to require the states to require in turn that providers of health care inform the public of their charges and "other patient access matters . . ." Would you propose that the public be made aware of the deficiencies in providers of health services found by the state health department? For example, would you require that all medicare patients be told publicly what the deficiencies are in hundreds of nursing homes which do not fully meet the medicare standards of participation?

Answer

In our view, public access to relevant information about deficiencies in providers of health service found by state health departments is a desirable objective.

In making such information available, however, it should be borne in mind that in some instances deficiencies may be of a relatively minor nature and would not preclude the provider's participation in Medicare, i.e., the deficiencies represent conditions that *do not* constitute hazards or potential hazards to health and safety. Where nursing homes and other institutions fall in this middle ground, it would be necessary to carefully explain the nature of the deficiencies involved so as not to create unwarranted concern that the institution may be unable to provide adequate patient care. Failure to make explicit the various levels of deficiencies, and their implications for patient care and safety, could severely hamper an institution's efforts to maintain patient loads while effectuating needed improvements.

Thus, an attempt to provide for public disclosure of information concerning provider deficiencies must take into account the need to develop policies explaining and interpreting for the public what the deficiencies mean in terms of quality care and patient safety and, in fairness to the home and the public, ways of keeping the information concerning deficiencies both timely and accurate. I might point out here that one of the principal goals of the President is to improve nursing home conditions and to make sure that nursing home patients are treated with dignity and consideration. At present over 900,000 Americans over age 65 now live in nursing homes, and while many of these institutions provide outstanding care to our older citizens, we are all aware that some nursing homes are in deplorable condition. The Administration is pledged to improve these conditions, and at this moment is engaged in many activities that will assure that all nursing home care provided to the aged is of a high order. These activities take many forms, including better enforcement of standards for participation in Federal programs; improving the traning and professional competence of those engaged in seeing that standards are met; increased funding of state health department services connected with improvement of nursing home facilities; terminating the participation in Federal programs of nursing homes that fail to meet standards; and regular reviews of state health department professional certifications of nursing homes.

From Mr. Waggonner—Question No. 3

Mr. Secretary, on page 21 of your testimony you state that you would require carriers to carry out certain control measures under Federal guidelines such as strict review of utilization of health care services. As you know, we have found in the medicare program that we cannot be sure of effective carrier performance unless a Federal employee is placed on the premises of the carrier. Would you tell us in detail just how your proposal would be different from present medicare practices?

Answer

The problem of assuring that carriers will conduct strict review of utilization of health care services provided under the National Health Insurance Standards Act is quite different from that encountered in the Medicare program where carriers disburse Federal funds as agents for the Government. It is expected in the first place that considerations of self-interest will motivate private insurance carriers to carry out strict control measures to discourage overutilization of services. Nonetheless, we propose to provide that States, under their insurance regulatory mechanisms, would require carriers to install insurance regulatory mechanisms, would require carriers to install utilization control systems capable of detecting questionable or inappropriate utilization.

We would, of course, apply what we have learned in our experience with carrier control systems under Medicare in developing guidelines for systems to be used by carriers under the National Health Insurance Standards Act.

Mr. WAGGONER. Mr. Secretary, you know that many States have laws requiring chiropractitioners' services to be covered as physician services. New York State has just passed such a law and Governor Rockefeller signed it into law.

Is the effect of the administration proposal such that basic health plans must cover chiropractor services or are we going to move to regulate or overrule State laws?

Secretary RICHARDSON. We have not proposed the coverage of chiropractic services. We have, in effect, extended the approach which is presently being observed in medicare.

Mr. WAGGONER. Mr. Secretary, would the self-employed businessman be able to include himself in a group with his employees and treat all his health insurance premiums as a cost of doing business?

Secretary RICHARDSON. Yes.

Mr. WAGGONER. At one point on page 9, beginning on page 9 and continuing on page 10, of your statement, you say:

> The National Health Insurance Standards Act would require all private employers in the Nation to provide basic health insurance coverage for virtually all their employees and their employees' immediate families.

Where is the employer going to be if he is required to provide this coverage for not just the employee, but the dependents of the employee when he is faced with a situation that surely some employers are going to be faced with under today's circumstances. He has an application from two people at the same time for the same job. One man has 10 dependents and the other man has no dependents and just out of pure common business sense, to try to reduce the cost of doing business, he hires the man with no dependents.

What is he going to be subject to in the way of discrimination, or his rights being violated, because he had children?

Secretary RICHARDSON. We haven't thought of proposing a remedy to the man with children in that case, but we think that the true economic incentive to the employer in that case to prefer the single individual over the one with children really is pretty marginal. He has a group plan. It would have two rates, we assume: One for the single individual and one for the family and I suppose if he consistently in every situation kept hiring single individuals and no family members, he could push his group rate down. But this is not a very likely course we think as a practical matter.

Mr. WAGGONER. I think this is the most likely thing of all with the attitude what it is today. Everybody feels their rights are being violated. I think this is going to be a real stickler.

Secretary RICHARDSON. The differences under our proposal is that the ranges we estimate between 5.6 cents an hour for the adult single worker and about 15 cents an hour for the worker with dependents. You are dealing with per year a pretty small cost margin.

Mr. WAGGONER. It is not small when it is three to one in cost. That is a significant cost of doing business when the insurance costs three to one for a man with dependents as compared to one without dependents.

Secretary RICHARDSON. But it is a cost per year of the employer's share, $318 to $117 per worker. Now, given the gross costs of employment including fringe benefits, salaries and so on, that ranges a pretty marginal factor and for an employer to select out in his employment married workers in order to capture that marginal advantage is likely to penalize him in terms of the stability of the work force, the motivation of the worker and a lot of other factors, and I would suggest that as a practical matter that employers who were that chintzy and that concerned wih picking up a few bucks are going to be relatively few.

Mr. WAGGONER. I beg to disagree with you. Let's take your example of $318 a year for an employee with dependents as a cost to the employer as compared to $117 without. You just multiply that for a little businessman with 25 employees and see what the additional cost is to him in a year. That might be more money than his net profit was the year before.

Secretary RICHARDSON. It is an appreciable amount, but I would suggest the he would be very likely to conclude that he would be more than compensated in terms of the quality of the output of the worker by deciding that it was not smart to exclude married men with children.

He might well find that he had lost more than he gained in terms of the turnover.

Mr. WAGGONER. Then you are saying to me that if a man in the operation of his business did choose as a matter of policy openly stated to reduce the cost of doing business by hiring one of these people, he would be subject to litigation for having violated somebody's rights. That is the end result of it.

Secretary RICHARDSON. We haven't so far proposed that anybody would have the right.

Mr. WAGGONER. I don't think you are going to have to. I think the first time somebody does it, they are going to propose it.

Secretary RICHARDSON. Maybe we will have a new class action.

Mr. WAGGONER. That is my point. We are headed for a new class action.

Secretary RICHARDSON. You are bringing out a real issue. This is the situation that led Mr. Byrnes to propose that in the case of small employers that they would receive to the extent of the first 10 employees a subsidy represened by the amount by which their share of the insurance premium, that is, the employer's share, exceeded 4 percent of the payroll for those employees. This would mean, in effect, that small employers as a practical matter with relatively low wages would be able to receive this subsidy in order to reduce the impact you have been talking about.

Mr. WAGGONER. Thank you, Mr. Secretary.

Mr. ULLMAN. Mr. Brotzman.

Mr. BROTZMAN. Thank you, Mr. Chairman.

It seems to me, Mr. Secretary, that our basic mission in whatever bill we come out with has to relate to the extension of quality medical care to the consumers and extend it to them economically.

My question relates to the term "quality." I note in the bill that on page 12 you refer to part B of title XI pertaining to professional standards review organization. I would assume that you are referring to other legislation or legislation to come into existence to provide for some kind of quality review; am I correct?

Secretary RICHARDSON. Yes; we are referring to, among other things, the provisions that are in H.R. 1, as reported out by this committee.

Mr. BROTZMAN. I am also correct, am I not, that HEW is financing some pilot programs in this particular area in the States relative to peer quality review mechanisms, et cetera?

Secretary RICHARDSON. Yes; I believe this is true.

Mr. VENEMAN. I think we can go further than that. I think we go so far as to urge the State under title XIX to put in an effective care

review procedure and we pay half the administrative cost. This is something we are encouraging. We want States to have effective peer review.

Mr. BROTZMAN. I happen to know that one of these is underway out in my State of Colorado and I think that review must come about contemporaneously or at least about the same time as the passage of this law. There has to be some kind of plan or all of the mechanisms that we have been discussing on how we are going to finance it and deliver it really will be somewhat moot.

In other words, I think we have to keep looking at the basic objective of what we are trying to accomplish and that we are talking about not deteriorating the quality of medicine in this country. We hope that it will improve and we are trying to extend it to more people. Isn't that what we are really talking about?

Secretary RICHARDSON. Yes; I think you put it very succinctly.

Mr. BROTZMAN. I have one more question. I think more people are talking about the catastrophic protection than anything else in the country right now. It is graphic, it is understandable, and it is meaningful; meaningful particularly because I think people fear catastrophic illnesses.

Will you just elaborate a little bit on how the plan works under the Byrnes bill, Mr. Secretary? You just touched on it on page 11, I think.

Secretary RICHARDSON. Under the Byrnes bill the mandates insurance package, that is, the plan that each employer would have to have, in effect, would provide coverage up to $50,000 in expenditures applicable to each covered individual. There is a further provision that as soon as total medical bills reach $5,000 that all of the additional expenditures in case of a particular episode of illness from $5,000 up to $50,000 would be picked up by the plan.

As to the first $5,000, the coinsurance or copayment features of the plan would apply so that there could be for that individual out-of-pocket costs as high as $1,400.

In the case of expenditures over $50,000 for that episode, some other means of payment would have to be found. But these would be proportionately extremely rare. We estimate that the $50,000 level would be reached in only about 2 percent of all covered illnesses, and in any event, as I said earlier, the $50,000 catastrophic coverage provision would be restored at the rate of $2,000 a year.

Mr. BROTZMAN. Explain that to me. This is what I don't understand.

Secretary RICHARDSON. Let's say they have had bills in 1974 of $50,000.

Mr. BROTZMAN. All right.

Secretary RICHARDSON. The system has paid for those bills. That would mean then that in the beginning of 1975 they had no catastrophic coverage left, but it would build back up against at the rate of $2,000 a year so that to get back up to $50,000 again would take a long time.

Mr. BROTZMAN. That would be 25 years. The point is you would pay the $50,000 for the one catastropic illness, if I understand your correctly. When that is expended, then it would be zero as far as their ledger account is concerned. Then it would reconstitute at the rate of $2,000 a year, is that right?

Secretary RICHARDSON. Yes. I used the word "episode." It would be medical bills in the year whether associated with a single episode or not aggregating that amount.

Mr. BROTZMAN. On our 2 percent figure again, Mr. Secretary, did you say that only 2 percent would utilize the $50,000 whether you use the term "episode" or "catastrophic illness sequence"?

Secretary RICHARDSON. Yes. The 2 percent proposition is this: That less than 2 percent of the people covered would ever reach the $50,000 limit.

Mr. BROTZMAN. I see.

Secretary RICHARDSON. That is at the present time.

Mr. BROTZMAN. Thank you very much.

Mr. ULLMAN. Mr. Karth.

Mr. KARTH. Thank you very much, Mr. Chairman.

I will be very brief. I appreciate the time limitations under which your are operating.

Mr. Secretary, I want to thank you for providing us with this National Health Expenditures chart wherein you compare the cost of the Administration's plan in its various phases with the cost of the existing program, the fully federalized one, the tax approach, and the catastrophic plan, all of which are before this committee.

Now, as I view it, I understand it to say the following:

One, that the Administration's plan compared to all others and the existing situation is the least costly to the Federal Government.

Secretary RICHARDSON. That is correct.

Mr. KARTH. It is the least costly to the private health insurance companies. It is the second most costly to the voluntaries. It is the second most costly to individuals through direct payments, and it is the second most costly to State and local governments. Is that analysis correct?

Secretary RICHARDSON. Yes.

Mr. KARTH. Might it be worth both the attention of the administration and this committee to consider at least picking up that portion now ascribed to the local and State governments, since we are talking about general revenue sharing and the serious financial plight that the local and State governments are in.

Secretary RICHARDSON. Yes; I certainly think that that is something that the committee would want to consider, particularly as it applies to the adult categories under public assistance or welfare reform, at least with respect to those elements of coverage that are embraced by the family health insurance plan, leaving perhaps for the further participation by the State the problem of long-term care. I think a couple of things need to be emphasized as contributing to an explanation as to why the shares of each of these contributors to all of these proposals is what it is.

We set out from the beginning to design a proposal that was intended to meet identifiable deficiencies, and we felt that one of the most glaring of these was in the health insurance coverage of poor people, given the inequities as between one State and another in the medicaid program, and so on, and we wanted to deal with the problem of catastrophic costs along the lines which we have just been discussing with Mr. Brotzman. We wanted to deal with various identifiable deficiencies in the allocation of medical resources and manpower.

Mr. KARTH. I understand.

Secretary RICHARDSON. Beyond that, we didn't want to disrupt the existing structure more than we had to.

Mr. KARTH. I understand that, Mr. Secretary, but in spite of all of those areas that you suggest the administration plan is to cover, the increased Federal share is less than 2 percent of the total cost of the Federal share as compared to what it is today, right?

Secretary RICHARDSON. That is right. I was going to go on to identify some of the things that it seems to me that this committee would want to look at, assuming that it is otherwise convinced that the general approach we have taken is a valid approach.

One is the point you have just identified: namely, the relative split between the Federal Government and the State and local governments. Another is the scope of coverage of the family health insurance plan. That is, do you propose to extend it or to limit it to the people who are covered, as we have proposed. There is also the question of the benefit packages. These could be adjusted up or down. Finally, there is another major variable, that of copayment, and this again is subject to adjustment.

I only state these things, Mr. Chairman and members of the committee, by way of saying that we think that the most important issue the committee has, is what approach it wishes to take in dealing with the problem of financing of health care. A tax credit or Internal Revenue approach as in some of the bills, a totally federalized approach as in the Griffths-Corman bill, or one which seeks specifically to overcome identifiable deficiencies in the system relying primarily on private insurance supplementing this with Federally subsidized health insurance for the poor.

Having made that decision, then the committee is in a position to make other decisions with respect to these subsidiary issues, as I said of the one you started, and these others that I have just enumerated.

Mr. KARTH. Thank you, Mr. Secretary.

I am sorry I don't have greater time to pursue this as the moment. Let me just ask you one other question, and then I will submit some further questions for the record.

I know that your bill would require that the basic health package would include preventive care, and I think we ought to consider that.

Immediately some simplistic arithmetic came to my mind with respect to including routine physical examinations. If we were to have every American receive one physical examination each year, that would mean about 200 million physician-hours per year, because my doctor friends tell me it takes about 1 hour to perform a meaningful physical examination.

If we assume that there are about 100,000 primary physicians who are able to conduct a meaningful physical examination, including internists, general practitioners, and pediatricians, for example, they each would be spending 40 hours a week, 50 weeks a year, giving physical examinations.

My concern is that if all of our physicians were spending 40 hours a week to give physicals, heaven forbid, if they found anything wrong because they wouldn't have time to do anything about it.

Secretary RICHARDSON. This is an interesting analysis. I hadn't seen it put that way. I think the answer has to be that a great deal of

reliance will have to be placed on other means of identifying remediable problems, immunization, and so on. Physical checks can be made to ascertain the existence of conditions that may justify the treatment of a physician by paramedical personnel, office nurses, and public health nurses, and so on. So the answer has to be that the 1-hour physical examination-type of approach just doesn't make sense, as applied to every child, as an example, every year, and so on.

Mr. KARTH. Well, it makes sense, Mr. Secretary, if we had more doctors, but I guess we are liimted by numbers, aren't we?

Secretary RICHARDSON. Yes. Dr. Duval, who is our head doctor, may want to comment.

Mr. KARTH. I understand, Mr. Secretary, and I know full well that doctors don't work 40 hours a week, but, if we are going to increase their workweek by 40 hours, of course, we are going to seriously reduce the number of doctors we have, because their life expectancy is probably going to fall another 10 years. Then we further complicate the problem because eventually we have less doctors than now.

Secretary RICHARDSON. It is a vicious circle.

Mr. KARTH. Thank you, Mr. Chairman. I know the hour is late. I defer asking any more questions.

Dr. DUVAL. One doesn't amplify on a statement as exhaustive as the Secretary has just expressed for you. I would add one additional note, because I am sure you know that the Department is exceedingly eager to put its efforts behind our total approach to an integrated health system for distributing health care, one of which is the health maintenance organization wherein there is a fiscal incentive as well as to keep persons well, and this probably will include physical examinations.

Mr. ULLMAN. Mr. Byrnes.

Mr. BYRNES. I have just one thing, Mr. Chairman. I think the colloquy among Mr. Ullman, Secretary Richardson, and Mr. Veneman earlier in the day, points up to a fundamental question that has to be resolved as we move into this almost overwhelming problem of health care.

I think that question is: Are we, as a committee, going to assume jurisdiction here, and in one piece of legislation, cover and cope with all aspects of health care: Resources, delivery, utilization, availability, access, distribution, cost, and financing? My personal view would be that if we try to take care of all of those aspects and in one piece of legislation, it is going to be an awfully long time before we can have the committee finish its work. I think it is more appropriate that we recognize a certain area of concern that we must have, and I think it is the concern that the President has shown in the development of various pieces of legislation, one of which has come to this committee. I think it would be appropriate, Mr. Chairman, so that we at least get the perspective as proposed by the administration in our consideration of this legislation, that we have as part of this hearing and as part of the record, the President's overall message in health, which, if I remember correctly, was presented to the Congress on February 18. I would ask unanimous consent, Mr. Chairman, that that message be included in the record at this point.

Mr. ULLMAN. Without objection, it will be done.

(The President's message referred to follows:)

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HEALTH

MESSAGE

FROM

THE PRESIDENT OF THE UNITED STATES

RELATIVE TO BUILDING A NATIONAL HEALTH STRATEGY

FEBRUARY 18, 1971.—Referred to the Committee of the Whole House on the State of the Union and ordered to be printed

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MESSAGE

FROM

THE PRESIDENT OF THE UNITED STATES

RELATIVE TO BUILDING A NATIONAL HEALTH STRATEGY

FEBRUARY 18, 1971.—Referred to the Committee of the Whole House on the State of the Union and ordered to be printed

To the Congress of the United States:

In the last twelve months alone, America's medical bill went up eleven percent, from $63 to $70 billion. In the last *ten* years, it has climbed 170 percent, from the $26 billion level in 1960. Then we were spending 5.3 percent of our Gross National Product on health; today we devote almost 7% of our GNP to health expenditures.

This growing investment in health has been led by the Federal Government. In 1960, Washington spent $3.5 billion on medical needs—13 percent of the total. This year it will spend $21 billion—or about 30 percent of the nation's spending in this area.

But what are we getting for all this money?

For most Americans, the result of our expanded investment has been more medical care and care of higher quality. A profusion of impressive new techniques, powerful new drugs, and splendid new facilities has developed over the past decade. During that same time, there has been a six percent drop in the number of days each year that Americans are disabled. Clearly there is much that is *right* with American medicine.

But there is also much that is wrong.

One of the biggest problems is that fully 60 percent of the growth in medical expenditures in the last ten years has gone not for additional services but merely to meet price inflation. Since 1960, medical costs have gone up twice as fast as the cost of living. Hospital costs have risen five times as fast as other prices. For growing numbers of

Americans, the cost of care is becoming prohibitive. And even those who can afford most care may find themselves impoverished by a catastrophic medical expenditure.

The shortcomings of our health care system are manifested in other ways as well. For some Americans—especially those who live in remote rural areas or in the inner city—care is simply not available. The quality of medicine varies widely with geography and income. Primary care physicians and outpatient facilities are in short supply in many areas, and most of our people have trouble obtaining medical attention on short notice. Because we pay so little attention to preventing disease and treating it early, too many people get sick and need intensive treatment.

Our record, then, is not as good as it should be. Costs have skyrocketed but values have not kept pace. We are investing more of our nation's resources in the health of our people but we are *not* getting a full return on our investment.

Building a National Health Strategy

Things do not have to be this way. We can change these conditions—indeed, we must change them if we are to fulfill our promise as a nation. Good health care should be readily available to all of our citizens.

It will not be easy for our nation to achieve this goal. It will be impossible to achieve it without a new sense of purpose and a new spirit of discipline. That is why I am calling today not only for new programs and not merely for more money but for something more—for a *new approach* which is equal to the complexity of our challenges. I am calling today for a new National Health Strategy that will marshall a variety of forces in a coordinated assault on a variety of problems.

This new strategy should be built on four basic principles.

1. Assuring Equal Access. Although the Federal Government should be viewed as only one of several partners in this reforming effort, it does bear a special responsibility to help all citizens achieve equal access to our health care system. Just as our National Government has moved to provide equal opportunity in areas such as education, employment and voting, so we must now work to expand the opportunity for all citizens to obtain a decent standard of medical care. We must do all we can to remove any racial, economic, social or geographic barriers which now prevent any of our citizens from obtaining adequate health protection. For without good health, no man can fully utilize his other opportunities.

2. Balancing Supply and Demand. It does little good, however, to increase the demand for care unless we also increase the supply. Helping more people pay for more care does little good unless more care is available. This axiom was ignored when Medicaid and Medicare were created—and the nation paid a high price for that error. The expectations of many beneficiaries were not met and a severe inflation in medical costs was compounded.

Rising demand should not be a source of anxiety in our country. It is, after all, a sign of our success in achieving equal opportunity, a measure of our effectiveness in reducing the barriers to care. But since the Federal Government is helping to remove those barriers, it also has a responsibility for what happens after they are reduced. We must see to it that our approach to health problems is a balanced approach. We must be sure that our health care system is ready and able to welcome its new clients.

3. Organizing for Efficiency. As we move toward these goals, we must recognize that we *cannot* simply *buy* our way to better medicine. We have already been trying that too long. We have been persuaded, too often, that the plan that *costs* the most will *help* the most—and too often we have been disappointed.

We cannot be accused of having underfinanced our medical system—not by a long shot. We have, however, spent this money poorly—reenforcing inequities and rewarding inefficiencies and placing the burden of greater new demands on the same old system which could not meet the old ones.

The toughest question we face then is not *how much* we should spend but *how* we should spend it. It must be our goal not merely to finance a more expensive medical system but to organize a more efficient one.

There are two particularly useful ways of doing this:

A. Emphasizing Health Maintenance. In most cases our present medical system operates episodically—people come to it in moments of distress—when they require its most expensive services. Yet both the system and those it serves would be better off if less expensive services could be delivered on a more regular basis.

If more of our resources were invested in preventing sickness and accidents, fewer would have to be spent on costly cures. If we gave more attention to treating illness in its early stages, then we would be less troubled by acute disease. In short, we should build a true "health" system—and not a "sickness" system alone. We should work to maintain health and not merely to restore it.

B. Preserving Cost Consciousness. As we determine just who should bear the various costs of health care, we should remember that only as people are aware of those costs will they be motivated to reduce them. When consumers pay virtually nothing for services and when, at the same time, those who provide services know that all *their* costs will also be met, then neither the consumer nor the provider has an incentive to use the system efficiently. When that happens, unnecessary demand can multiply, scarce resources can be squandered and the shortage of services can become even more acute.

Those who are hurt the most by such developments are often those whose medical needs are most pressing. While costs should never be a barrier to providing needed care, it is important that we preserve some element of cost consciousness within our medical system.

4. Building on Strengths. We should also avoid holding the whole of our health care system responsible for failures in some of its parts. There is a natural temptation in dealing with any complex problem to say: "Let us wipe the slate clean and start from scratch." But to do this—to dismantle our entire health insurance system, for example—would be to ignore those important parts of the system which have provided useful service. While it would be wrong to ignore any weaknesses in our present system, it would be equally wrong to sacrifice its strengths.

One of those strengths is the diversity of our system—and the range of choice it therefore provides to doctors and patients alike. I believe the public will always be better served by a pluralistic system than by a monolithic one, by a system which creates many effective centers of responsibility—both public and private—rather than one that concentrates authority in a single governmental source.

This does not mean that we must allow each part of the system to go its own independent way, with no sense of common purpose. We must encourage greater cooperation and build better coordination—but not by fostering uniformity and eliminating choice. One effective way of influencing the system is by structuring *incentives* which reward people for helping to achieve national goals without forcing their decisions or dictating the way they are carried out. The American people have always shown a unique capacity to move toward common goals in varied ways. Our efforts to reform health care in America will be more effective if they build on this strength.

These, then, are certain cardinal principles on which our National Health Strategy should be built. To implement this strategy, I now propose for the consideration of the Congress the following six point program. It begins with measures designed to increase and improve the supply of medical care and concludes with a program which will help people pay for the care they require.

A. REORGANIZING THE DELIVERY OF SERVICE

In recent years, a new method for delivering health services has achieved growing respect. This new approach has two essential attributes. It brings together a comprehensive range of medical services in a single organization so that a patient is assured of convenient access to all of them. And it provides needed services for a fixed contract fee which is paid in advance by all subscribers.

Such an organization can have a variety of forms and names and sponsors. One of the strengths of this new concept, in fact, is its great flexibility. The general term which has been applied to all of these units is "HMO"—"Health Maintenance Organization."

The most important advantage of Health Maintenance Organizations is that they increase the value of the services a consumer receives for each health dollar. This happens, first, because such organizations provide a strong financial incentive for better preventive care and for greater efficiency.

Under traditional systems doctors and hospitals are paid, in effect, on a piece work basis. The more illnesses they treat—and

the more service they render—the more their income rises. This does not mean, of course, that they do any less than their very best to *make* people well. But it does mean that there is no economic incentive for them to concentrate on *keeping* people healthy.

A fixed-price contract for comprehensive care reverses this illogical incentive. Under this arrangement, income grows not with the number of days a person is sick but with the number of days he is well. HMO's therefore have a strong financial interest in preventing illness, or, failing that, in treating it in its early stages, promoting a thorough recovery, and preventing any reoccurrence. Like doctors in ancient China, they are paid to keep their clients healthy. For them economic interests work to re-enforce their professional interests.

At the same time, HMO's are motivated to function more efficiently. When providers are paid retroactively for each of their services, inefficiencies can often be subsidized. Sometimes, in fact, inefficiency is rewarded—as when a patient who does not need to be hospitalized is treated in a hospital so that he can collect on his insurance. On the other hand, if an HMO is wasteful of time or talent or facilities, it cannot pass those extra costs on to the consumer or to an insurance company. Its budget for the year is determined in advance by the number of its subscribers. From that point on it is penalized for going over its budget and rewarded for staying under it.

In an HMO, in other words, cost consciousness is fostered. Such an organization cannot afford to waste resources—that costs more money in the short run. But neither can it afford to economize in ways which hurt patients—for that increases long-run expenses.

The HMO also organizes medical resources in a way that is more convenient for patients and more responsive to their needs. There was a time when every housewife had to go to a variety of shops and markets and pushcarts to buy her family's groceries. Then along came the supermarket—making her shopping chores much easier and also giving her a wider range of choice and lower prices. The HMO provides similar advantages in the medical field. Rather than forcing the consumer to thread his way through a complex maze of separate services and specialists, it makes a full range of resources available through a single organization—often at a single stop—and makes it more likely that the right combination of resources will be utilized.

Because a team can often work more efficiently than isolated individuals, each doctor's energies go further in a Health Maintenance Organization—twice as far according to some studies. At the same time, each patient retains the freedom to choose his own personal doctor. In addition, services can more easily be made available at night and on weekends in an HMO. Because many doctors often use the same facilities and equipment and can share the expense of medical assistants and business personnel, overhead costs can be sharply curtailed. Physicians benefit from the stimulation that comes from working with fellow professionals who can share their problems, appreciate their accomplishments and readily offer their counsel and assistance. HMO's offer doctors other advantages as well, including a more regular work schedule, better opportunities for continuing education, lesser financial risks upon first entering practice, and generally lower rates for malpractice insurance.

Some seven million Americans are now enrolled in HMO's—and the number is growing. Studies show that they are receiving high quality care at a significantly lower cost—as much as one-fourth to one-third lower than traditional care in some areas. They go to hospitals less often and they spend less time there when they go. Days spent in the hospital each year for those who belong to HMO's are only three-fourths of the national average.

Patients and practitioners alike are enthusiastic about this organizational concept. So is this administration. That is why we proposed legislation last March to enable Medicare recipients to join such programs. That is why I am now making the following additional recommendations:

1. We should require public and private health insurance plans to allow beneficiaries to use their plan to purchase membership in a Health Maintenance Organization when one is available. When, for example, a union and an employer negotiate a contract which includes health insurance for all workers, each worker should have the right to apply the actuarial value of his coverage toward the purchase of a fixed-price, health maintenance program. Similarly, both Medicare and the new Family Health Insurance Plan for the poor which I will set out later in this message should provide an HMO option.

2. To help new HMO's get started—an expensive and complicated task—we should establish a new $23 million program of planning grants to aid potential sponsors—in both the private and public sector.

3. At the same time, we should provide additional support to help sponsors raise the necessary capital, construct needed facilities, and sustain initial operating deficits until they achieve an enrollment which allows them to pay their own way. For this purpose, I propose a program of Federal loan guarantees which will enable private sponsors to raise some $300 million in private loans during the first year of the program.

4. Other barriers to the development of HMO's include archaic laws in 22 States which prohibit or limit the group practice of medicine and laws in most States which prevent doctors from delegating certain responsibilities (like giving injections) to their assistants. To help remove such barriers, I am instructing the Secretary of Health, Education, and Welfare to develop a model statute which the States themselves can adopt to correct these anomalies. In addition, the Federal Government will facilitate the development of HMO's in all States by entering into contracts with them to provide service to Medicare recipients and other Federal beneficiaries who elect such programs. Under the supremacy clause of the Constitution, these contracts will operate to preempt any inconsistent State statutes.

Our program to promote the use of MHO's is only one of the efforts we will be making to encourage a more efficient organization of our health care system. We will take other steps in this direction, including stronger efforts to capitalize on new technological developments.

In recent years medical scientists, engineers, industrialists, and management experts have developed many new techniques for improving the efficiency and effectiveness of health care. These ad-

vances include automated devices for measuring and recording body functions such as blood flow and the electrical activity of the heart, for performing laboratory tests and making the results readily available to the doctor, and for reducing the time required to obtain a patient's medical history. Methods have also been devised for using computers in diagnosing diseases, for monitoring and diagnosing patients from remote locations, for keeping medical records and generally for restructuring the layout and administration of hospitals and other care centers. The results of early tests for such techniques have been most promising. If new developments can be widely implemented, they can help us deliver more effective, more efficient care at lower prices.

The hospital and outpatient clinic of tomorrow may well bear little resemblance to today's facility. We must make every effort to see that its full promise is realized. I am therefore directing the Secretary of Health, Education, and Welfare to focus research in the field of health care services on new techniques for improving the productivity of our medical system. The Department will establish pilot experiments and demonstration projects in this area, disseminate the results of this work, and encourage the health industry and the medical profession to bring such techniques into full and effective use in the health care centers of the nation.

B. MEETING THE SPECIAL NEEDS OF SCARCITY AREAS

Americans who live in remote rural areas or in urban poverty neighborhoods often have special difficulty obtaining adequate medical care. On the average, there is now one doctor for every 630 persons in America. But in over one-third of our counties the number of doctors per capita is less than one-third that high. In over 130 counties, comprising over eight percent of our land area, there are no private doctors at all—and the number of such counties is growing.

A similar problem exists in our center cities. In some areas of New York for example, there is one private doctor for every 200 persons but in other areas the ratio is one to 12,000. Chicago's inner city neighborhoods have some 1,700 fewer physicians today than they had ten years ago.

How can we attract more doctors—and better facilities—into these scarcity areas? I propose the following actions:

1. We should encourage Health Maintenance Organizations to locate in scarcity areas. To this end, I propose a $22 million program of direct Federal grants and loans to help offset the special risks and special costs which such projects would entail.

2. When necessary, the Federal Government should supplement these efforts by supporting out-patient clinics in areas which still are underserved. These units can build on the experience of the Neighborhood Health Centers experiment which has now been operating for several years. These facilities would serve as a base on which full HMO's—operating under other public or private direction—could later be established.

I have also asked the Administrator of Veterans Affairs and the Secretary of Health, Education, and Welfare to develop ways in which the Veterans Administration medical system can be used to supplement local medical resources in scarcity areas.

3. A series of new area Health Education Centers should also be established in places which are medically underserved—as the Carnegei Commission on Higher Education has recommended. These centers would be satellites of existing medical and other health science schools; typically, they could be built around a community hospital, a clinic or an HMO which is already in existence. Each would provide a valuable teaching center for new health professionals, a focal point for the continuing education of experienced personnel, and a base for providing sophisticated medical services which would not otherwise be available in these areas. I am requesting that up to $40 million be made available for this program in Fiscal Year 1972.

4. We should also find ways of compensating—and even rewarding—doctors and nurses who move to scarcity areas, despite disadvantages such as lower income and poorer facilities.

As one important step in this direction, I am proposing that our expanding loan programs for medical students include a new forgiveness provision for graduates who practice in a scarcity area, especially those who specialize in primary care skills that are in short supply.

In addition, I will request $10 million to implement the Emergency Health Personnel Act. Such funds will enable us to mobilize a new National Health Service Corps, made up largely of dedicated and public-spirited young health professionals who will serve in areas which are now plagued by critical manpower shortages.

C. MEETING THE PERSONNEL NEEDS OF OUR GROWING MEDICAL SYSTEM

Our proposals for encouraging HMO's and for serving scarcity areas will help us use medical manpower more effectively. But it is also important that we *produce* more health professionals and that we educate more of them to perform critically needed services. I am recommending a number of measures to accomplish these purposes.

1. First, we must use new methods for helping to finance medical education. In the past year, over half of the nation's medical schools have declared that they are in "financial distress" and have applied for special Federal assistance to meet operating deficits.

More money is needed—but it is also important that this money be spent in new ways. Rather than treating the symptoms of distress in a piecemeal and erratic fashion, we must rationalize our system of financial aid for medical education so that the schools can make intelligent plans for regaining a sound financial position.

I am recommending, therefore, that much of our present aid to schools of medicine, dentistry and osteopathy—along with $60 million in new money—be provided in the form of so-called "capitation grants," the size of which would be determined by the number of students the school graduates. I recommend that the capitation grant level be set at $6,000 per graduate.

A capitation grant system would mean that a school would know in advance how much Federal money it could count on. It would allow an institution to make its own long-range plans as to how it would use these monies. It would mean that we could eventually phase out our emergency assistance programs.

By rewarding *output*—rather than subsidizing *input*—this new aid system would encourage schools to educate more students and to educate them more efficiently. Unlike formulas which are geared to the annual number of enrollees, capitation grants would provide a strong incentive for schools to shorten their curriculum from four years to three—in line with another sound recommendation of the Carnegie Commission on Higher Education. For then, the same sized school would qualify for as much as one-third *more* money each year, since each of its graduating classes would be one-third larger.

This capitation grant program should be supplemented by a program of special project grants to help achieve special goals. These grants would support efforts such as improving planning and mangement, shortening curriculums, expanding enrollments, team training of physicians and allied health personnel, and starting HMO's for local populations.

In addition, I believe that Federal support dollars for the construction of medical education facilities can be used more effectively. I recommend that the five current programs in this area be consolidated into a single, more flexible grant authority and that a new program of guaranteed loans and other financial aids be made available to generate over $500 million in private construction loans in the coming Fiscal Year—five times the level of our current construction grant program.

Altogether, these efforts to encourage and facilitate the expansion of our medical schools should produce a 50 percent increase in medical school graduates by 1975. We must set that as our goal and we must see that it is accomplished.

2. The Federal Government should also establish special support programs to help low income students enter medical and dental schools. I propose that our scholarship grant program for these students be almost doubled—from $15 to $29 million. At the same time, this administration would modify its proposed student loans programs to meet better the needs of medical students. To help alleviate the concern of low income students that such a loan might become an impossible burden if they fail to graduate from medical school, we will request authority to forgive loans where such action is appropriate.

3. One of the most promising ways to expand the supply of medical care and to reduce its costs is through a greater use of allied health personnel, especially those who work as physicians' and dentists' assistants, nurse pediatric practitioners, and nurse midwives. Such persons are trained to perform tasks which must otherwise be performed by doctors themselves, even though they do not require the skills of a doctor. Such assistance frees a physician to focus his skills where they are most needed and often allows him to treat many additional patients.

I recommend that our allied health personnel training programs be expanded by 50% over 1971 levels, to $29 million, and that $15 million of this amount be devoted to training physicians' assistants. We will also encourage medical schools to train future doctors in the proper use of such assistants and we will take the steps I described earlier to eliminate barriers to their use in the laws of certain States.

In addition, this administration will expand nationwide the current MEDIHC program—an experimental effort to encourage servicemen and women with medical training to enter civilian medical professions when they leave military duty. Of the more than 30,000 such persons who leave military service each year, two-thirds express an interest in staying in the health field but only about one-third finally do so. Our goal is to increase the number who enter civilian health employment by 2,500 per year for the next five years. At the same time, the Veterans Administration will expand the number of health trainees in VA facilities from 49,000 in 1970 to over 53,000 in 1972.

D. A SPECIAL PROBLEM: MALPRACTICE SUITS AND MALPRACTICE INSURANCE

One reason consumers must pay more for health care and health insurance these days is the fact that most doctors are paying much more for the insurance *they* must buy to protect themselves against claims of malpractice. For the past five years, malpractice insurance rates have gone up an average of 10 percent a year—a fact which reflects both the growing number of malpractice claims and the growing size of settlements. Many doctors are having trouble obtaining *any* malpractice insurance.

The climate of fear which is created by the growing menace of malpractice suits also affects the quality of medical treatment. Often it forces doctors to practice inefficient, defensive medicine—ordering unnecessary tests and treatments solely for the sake of appearance. It discourages the use of physicians' assistants, inhibits that free discussion of cases which can contribute so much to better care, and makes it harder to establish a relationship of trust between doctors and patients.

The consequences of the malpractice problem are profound. It must be confronted soon and it must be confronted effectively—but that will be no simple matter. For one thing, we need to know far more than we presently do about this complex problem.

I am therefore directing—as a first step in dealing with this danger—that the Secretary of Health, Education, and Welfare promptly appoint and convene a Commission on Medical Malpractice to undertake an intensive program of research and analysis in this area. The Commission membership should represent the health professions and health institutions, the legal profession, the insurance industry, and the general public. Its report—which should include specific recom-

mendations for dealing with this problem—should be submitted by March 1, 1972.

E. NEW ACTIONS TO PREVENT ILLNESSES AND ACCIDENTS

We often invest our medical resources as if an ounce of cure were worth a pound of prevention. We spend vast sums to treat illnesses and accidents that could be avoided for a fraction of those expenditures. We focus our attention on *making* people well rather than *keeping* people well, and—as a result—both our health and our pocketbooks are poorer. A new National Health Strategy should assign a much higher priority to the work of prevention.

As we have already seen, Health Maintenance Organizations can do a great deal to help in this effort. In addition to encouraging their growth, I am also recommending a number of further measures through which we can take the offensive against the long-range causes of illnesses and accidents.

1. To begin with, we must reaffirm—and expand—the Federal commitment to biomedical research. Our approach to research support should be balanced—with strong efforts in a variety of fields. Two critical areas, however, deserve special attention.

The first of these is cancer. In the next year alone, 650,000 new cases of cancer will be diagnosed in this country and 340,000 of our people will die of this disease. Incredible as it may seem, one out of every four Americans who are now alive will someday develop cancer unless we can reduce the present rates of incidence.

In the last seven years we spent more than 30 billion dollars on space research and technology and about one-twenty-fifth of that amount to find a cure for cancer. The time has now come to put more of our resources into cancer research and—learning an important lesson from our space program—to organize those resources as effectively as possible.

When we began our space program we were fairly confident that our goals could be reached if only we made a great enough effort. The challenge was technological; it did not require new theoretical breakthroughs. Unfortunately, this is not the case in most biomedical research at the present time; scientific breakthroughs are still required and they often cannot be forced—no matter how much money and energy is expended.

We should not forget this caution. At the same time, we should recognize that of all our research endeavors, cancer research may now be in the best position to benefit from a great infusion of resources. For there are moments in biomedical research when problems begin to break open and results begin to pour in, opening many new lines of inquiry and many new opportunities for breakthrough.

We believe that cancer research has reached such a point. This administration is therefore requesting an additional $100 million for cancer research in its new budget. And—as I said in my State of the Union Message—"I will ask later for whatever additional funds can effectively be used" in this effort.

Because this project will require the coordination of scientists in many fields—drawing on many projects now in existence but cutting across established organizational lines—I am directing the Secretary of Health, Education, and Welfare to establish a new Cancer Conquest Program in the Office of the Director of the National Institutes of Health. This program will operate under its own Director who will be appointed by the Secretary and supported by a new management group. To advise that group in establishing priorities and allocating funds—and to advise other officials, including me, concerning this effort—I will also establish a new Advisory Committee on the Conquest of Cancer.

A second targeted disease for concentrated research should be sickle cell anemia—a most serious childhood disease which almost always occurs in the black population. It is estimated that one out of every 500 black babies actually develops sickle cell disease.

It is a sad and shameful fact that the causes of this disease have been largely neglected throughout our history. We cannot rewrite this record of neglect, but we can reverse it. To this end, this administration is increasing its budget for research and treatment of sickle cell disease fivefold, to a new total of $6 million.

2. A second major area of emphasis should be that of health education.

In the final analysis, each individual bears the major responsibility for his own health. Unfortunately, too many of us fail to meet that responsibility. Too many Americans eat too much, drink too much, work too hard, and exercise too little. Too many are careless drivers.

These are personal questions, to be sure, but they are also public questions. For the whole society has a stake in the health of the individual. Ultimately, everyone shares in the cost of his illnesses or accidents. Through tax payments and through insurance premiums, the careful subsidize the careless, the nonsmokers subsidize those who smoke, the physically fit subsidize the rundown and the overweight, the knowledgeable subsidize the ignorant and vulnerable.

It is in the interest of our entire country, therefore, to educate and encourage each of our citizens to develop sensible health practices. Yet we have given remarkably little attention to the health education of our people. Most of our current efforts in this area are fragmented and haphazard—a public service advertisement one week, a newspaper article another, a short lecture now and then from the doctor. There is no national instrument, no central force to stimulate and coordinate a comprehensive health education program.

I have therefore been working to create such an instrument. It will be called the National Health Education Foundation. It will be a private, non-profit group which will receive no Federal money. Its membership will include representatives of business, labor, the medical profession, the insurance industry, health and welfare organizations, and various governmental units. Leaders from these fields have already agreed to proceed with such an organization and are well on the way toward reaching an initial goal of $1 million in pledges for its budget.

This independent project will be complemented by other Federal efforts to promote health education. For example, expenditures to provide family planning assistance have been increased, rising four-fold since 1969. And I am asking that the great potential of our nation's day care centers to provide health education be better utilized.

3. We should also expand Federal programs to help prevent accidents—the leading cause of death between the ages of one and 37 and the fourth leading cause of death for persons of all ages.

Our highway death toll—50,000 fatalities last year—is a tragedy and an outrage of unspeakable proportions. It is all the more shameful since half these deaths involved drivers or pedestrians under the influence of alcohol. We have therefore increased funding for the Department of Transportation's auto accident and alcohol program from $8 million in Fiscal Year 1971 to $35 million in Fiscal Year 1972. I am also requesting that the budget for alcoholism programs be doubled, from $7 million to $14 million. This will permit an expansion of our research efforts into better ways of treating this disease.

I am also requesting a supplemental appropriation of $5 million this year and an addition of $8 million over amounts already in the 1972 budget to implement aggressively the new Occupational Safety and Health Act I signed last December. We must begin immediately to cut down on the 14,000 deaths and more than two million disabling injuries which result each year from occupational illnesses and accidents.

The conditions which affect health are almost unlimited. A man's income, his daily diet, the place he lives, the quality of his air and water—all of these factors have a greater impact on his physical well being than does the family doctor. When we talk about our health program, therefore, we should not forget our efforts to protect the nation's food and drug supply, to control narcotics, to restore and renew the environment, to build better housing and transportation systems, to end hunger in America, and—above all—to place a floor under the income of every family with children. In a sense this special message on health is one of *many* health messages which this administration is sending to the Congress.

F. A NATIONAL HEALTH INSURANCE PARTNERSHIP

In my State of the Union Message, I pledged to present a program "to ensure that no American family will be prevented from obtaining basic medical care by inability to pay." I am announcing that program today. It is a comprehensive national health insurance program, one in which the public and the private sectors would join in a new partnership to provide adequate health insurance for the American people.

In the last twenty years, the segment of our population owning health insurance has grown from 50 percent to 87 percent and the portion of medical bills paid for by insurance has gone from 35 percent to 60 percent. But despite this impressive growth, there are still serious gaps in present health insurance coverage. Four such gaps deserve particular attention.

First—too many health insurance policies focus on hospital and surgical costs and leave critical outpatient services uncovered. While some 80 percent of our people have some hospitalization insurance, for example, only about half are covered for outpatient and laboratory services and less than half are insured for treatment in the physician's office or the home. Because demand goes where the dollars are, the result is an unnecessary—and expensive—overutilization of acute care facilities. The average hospital stay today is a full day longer than it was eight years ago. Studies show that over one-fourth of hospital beds in some areas are occupied by patients who do not really need them and could have received equivalent or better care outside the hospital.

A second problem is the failure of most private insurance policies to protect against the catastrophic costs of major illnesses and accidents. Only 40 percent of our people have catastrophic cost insurance of any sort and most of that insurance has upper limits of $10,000 or $15,000. This means that insurance often runs out while expenses are still mounting. For many of our families, the anguish of a serious illness is thus compounded by acute financial anxiety. Even the joy of recovery can often be clouded by the burden of debt—and even by the threat of bankruptcy.

A third problem with much of our insurance at the present time is that it cannot be applied to membership in a Health Maintenance Organization—and thus effectively precludes such membership. No employee will pay to join such a plan, no matter how attractive it might seem to him, when deductions from his paycheck—along with contributions from his employer—are being used to purchase another health insurance policy.

The fourth deficiency we must correct in present insurance coverage is its failure to help the poor gain sufficient access to our medical system. Just one index of this failure is the fact that fifty percent of poor children are not even immunized against common childhood

diseases. The disability rate for families below the poverty line is at least 50 percent higher than for families with incomes above $10,000.

Those who need care most often get care least. And even when the poor do get service, it is often second rate. A vicious cycle is thus reinforced—poverty breeds illness and illness breeds greater poverty. This situation will be corrected only when the poor have sufficient purchasing power to enter the medical marketplace on equal terms with those who are more affluent.

Our National Health Insurance Partnership is designed to correct these inadequacies—not by *destroying* our present insurance system but by *improving* it. Rather than giving up on a system which has been developing impressively, we should work to bring about further growth which will fill in the gaps we have identified. To this end, I am recommending the following combination of public and private efforts.

1. I am proposing that a National Health Insurance Standards Act be adopted which will require employers to provide basic health insurance coverage for their employees.

In the past, we have taken similar actions to assure workers a minimum wage, to provide them with disability and retirement benefits, and to set occupational health and safety standards. Now we should go one step further and guarantee that all workers will receive adequate health insurance protection.

The minimum program we would require under this law would pay for hospital services, for physicians' services—both in the hospital and outside of it, for full maternity care, well-baby care (including immunizations), laboratory services and certain other medical expenses. To protect against catastrophic costs, benefits would have to include not less than $50,000 in coverage for each family member during the life of the policy contract. The minimum package would include certain deductible and coinsurance features. As an alternative to paying separate fees for separate services, workers could use this program to purchase membership in a Health Maintenance Organization.

The Federal Government would pay nothing for this program; the costs would be shared by employers and employees, much as they are today under most collective bargaining agreements. A ceiling on how much employees could be asked to contribute would be set at 35 percent during the first two and one-half years of operation and 25 percent thereafter. To give each employer time to plan for this additional cost of doing business—a cost which would be shared, of course, by all of his competitors—this program would not go into effect until July 1, 1973. This schedule would also allow time for expanding and reorganizing our health system to handle the new requirements.

As the number of enrollees rises under this plan, the costs per enrollee can be expected to fall. The fact that employees and unions will have an even higher stake in the system will add additional pressures

to keep quality up and costs down. And since the range within which benefits can vary will be somewhat narrower than it has been, competition between insurance companies will be more likely to focus on the overall price at which the contract is offered. This means that insurance companies will themselves have a greater motivation to keep medical costs from soaring.

I am still considering what further legislative steps may be desirable for regulating private health insurance, including the introduction of sufficient disincentive measures to reinforce the objective of creating cost consciousness on the part of consumers and providers. I will make such recommendations to the Congress at a later time.

2. I am also proposing that a new Family Health Insurance Plan be established to meet the special needs of poor families who would not be covered by the proposed National Health Insurance Standards Act—those that are headed by unemployed, intermittently employed or self-employed persons.

The Medicaid program was designed to help these people, but—for many reasons—it has not accomplished its goals. Because it is not a truly national program, its benefits vary widely from State to State. Sixteen States now get 80 percent of all Medicaid money and two States, California and New York, get 30 percent of Federal funds though they have only 20 percent of the poverty population. Two States have no Medicaid program at all.

In addition, Medicaid suffers from other defects that now plague our failing welfare system. It largely excludes the working poor—which means that all benefits can suddenly be cut off when family income rises ever so slightly—from just under the eligibility barrier to just over it. Coverage is provided when husbands desert their families, but is often eliminated when they come back home and work. The program thus provides an incentive for poor families to stay on the welfare rolls.

Some of these problems would be corrected by my proposal to require employers to offer adequate insurance coverage to their employees. No longer, for example, would a workingman receive poorer insurance coverage than a welfare client—a condition which exists today in many States. But we also need an additional program for much of the welfare population.

Accordingly, I propose that the part of Medicaid which covers most welfare families be eliminated. The new Family Health Insurance Plan that takes its place would be fully financed and administered by the Federal Government. It would provide health insurance to all poor families with children headed by self-employed or unemployed persons whose income is below a certain level. For a family of four persons, the eligibility ceiling would be $5,000.

For the poorest of eligible families, this program would make no charges and would pay for basic medical costs. As family income increased beyond a certain level ($3,000 in the case of a four-person

family) the family itself would begin to assume a greater share of the costs—through a graduated schedule of premium charges, deductibles, and coinsurance payments. This provision would induce some cost consciousness as income rises. But unlike Medicaid—with its abrupt cutoff of benefits when family income reaches a certain point—this arrangement would provide an incentive for families to improve their economic position.

The Family Health Insurance Plan would also go into effect on July 1, 1973. In its first full year of operation, it would cost approximately $1.2 billion in additional Federal funds—assuming that all eligible families participate. Since States would no longer bear any share of this cost, they would be relieved of a considerable burden. In order to encourage States to use part of these savings to supplement Federal benefits, the Federal Government would agree to bear the costs of administering a consolidated Federal-State benefit package. The Federal Government would also contract with local committees—to review local practices and to ensure that adequate care is being provided in exchange for Federal payments. Private insurers, unions and employees would be invited to use these same committees to review the utilization of their benefits if they wished to do so.

This, then, is how the National Health Insurance Partnership would work: The Family Health Insurance Plan would meet the needs of most welfare families—though Medicaid would continue for the aged poor, the blind and the disabled. The National Health Insurance Standards Act would help the working population. Members of the Armed Forces and civilian Federal employees would continue to have their own insurance programs and our older citizens would continue to have Medicare.

Our program would also require the establishment in each State of special insurance pools which would offer insurance at reasonable group rates to people who did not qualify for other programs: the self-employed, for example, and poor risk individuals who often cannot get insurance.

I also urge the Congress to take further steps to improve Medicare. For one thing, beneficiaries should be allowed to use the program to join Health Maintenance Organizations. In addition, we should consolidate the financing of Part A of Medicare—which pays for hospital care—and Part B—which pays for outpatient services, provided the elderly person himself pays a monthly fee to qualify for this protection. I propose that this charge—which is scheduled to rise to $5.60 per month in July of this year—be paid for instead by increasing the Social Security wage base. Removing this admission cost will save our older citizens some $1.3 billion annually and will give them greater access to preventive and ambulatory services.

Why Is a National Health Insurance Partnership Better Than Nationalized Health Insurance?

I believe that our government and our people, business and labor, the insurance industry and the health profession can work together in a *national partnership* to achieve our health objectives. I do *not* believe that the achievement of these objectives requires the *nationalization* of our health insurance industry.

To begin with, there simply is no *need* to eliminate an entire segment of our private economy and at the same time add a multi-billion dollar responsibility to the Federal budget. Such a step should not be taken unless all other steps have failed.

More than that, such action would be dangerous. It would deny people the right to choose how they will pay for their health care. It would remove competition from the insurance system—and with it an incentive to experiment and innovate.

Under a nationalized system, only the Federal Government would lose when inefficiency crept in or when prices escalated; neither the consumer himself, nor his employer, nor his union, nor his insurance company would have any further stake in controlling prices. The only way that utilization could be effectively regulated and costs effectively restrained, therefore, would be if the Federal Government made a forceful, tenacious effort to do so. This would mean—as proponents of a nationalized insurance program have admitted—that Federal personnel would inevitably be approving the budgets of local hospitals, setting fee schedules for local doctors, and taking other steps which could easily lead to the complete Federal domination of all of American medicine. That is an enormous risk—and there is no need for us to take it. There is a better way—a more practical, more effective, less expensive, and less dangerous way—to reform and renew our nation's health system.

Confronting a Deepening Crisis

"It is health which is real wealth," said Gandhi, "and not pieces of gold and silver." That statement applies not only to the lives of men but also to the life of nations. And nations, like men, are judged in the end by the things they hold most valuable.

Not only is health more important than economic wealth, it is also its foundation, it has been estimated, for example, that ten percent of our country's economic growth in the past half century has come because a declining death rate has produced an expanded labor force.

Our entire society, then, has a direct stake in the health of every member. In carrying out its responsibilities in this field, a nation serves its own best interests, even as it demonstrates the breadth of its spirit and the depth of its compassion.

Yet we cannot truly carry out these responsibilities unless the ultimate focus of our concern is the personal health of the individual human being. We dare not get so caught up in our systems and our strategies that we lost sight of *his* needs or compromise *his* interests.

We can build an effective National Health Strategy only if we remember the central truth that the only way to serve our people well is to better serve each person.

Nineteen months ago I said that America's medical system faced a "massive crisis." Since that statement was made, that crisis has deepened. All of us must now join together in a common effort to meet this crisis—each doing his own part to mobilize more effectively the enormous potential of our health care system.

RICHARD NIXON.

THE WHITE HOUSE, *February 18, 1971.*

Mr. ULLMAN. Mr. Secretary, may I express our appreciation for your appearance here, your patience in responding to our questions, and that of all of those associated with you. We look forward to spending a great deal of time with you when we get back into executive session.

Secretary RICHARDSON. Thank you very much, Mr. Chairman and members of the committee. Speaking for myself and my colleagues, we greatly appreciate this opportunity to present our recommendations and our views to the committee.

Mr. ULLMAN. Thank you again.

The committee is adjourned until 10 o'clock on Tuesday, October 26, 1971.

(Whereupon, at 12:45 p.m. the committee was adjourned, to reconvene at 10 a.m., Tuesday, October 26, 1971.)