NATIONAL HEALTH INSURANCE

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-SECOND CONGRESS

FIRST SESSION

ON

S. 3, S. 191, S. 836, S. 987, S. 1376, S. 1490, S. 1598, and S. 1623

VARIOUS BILLS PROPOSING NATIONAL HEALTH INSURANCE

APRIL 26, 27, AND 28, 1971

Printed for the use of the Committee on Finance

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CONTENTS

Departmental Witnesses

Public Witnesses

Additional Information

NATIONAL HEALTH INSURANCE

MONDAY, APRIL 26, 1971

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to call of the Chair, at 10:05 a.m., in room 2221, New Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present: Senators Long, Anderson, Ribicoff, Byrd, Jr., of Virginia, Bennett, Curtis, Jordan of Idaho, Hansen, and Griffin.

The CHAIRMAN. The hearing will be in order.

In fiscal 1970, the national health bill amounted to more than $67 billion. This was 7 percent of the gross national product. Only 10 years earlier, the cost of health care was $27 billion, representing 5.4 percent of the gross national product. One reason for the sharp rise in health care expenditures is that modern medicine and newly developed medical techniques have enabled Americans to survive illnesses and injuries which once had been fatal. In many of these cases, however, life is preserved only at tremendous costs.

Medical and social advances over the past decade have also resulted in an increased use of the hospital—and an increase in the costs of hospital care.

Hospital admissions rose from about 25 million in 1960 to about 31 million in 1969, an increase of 23 percent. Total hospital expenses rose 162 percent over this same period of time—from $8.4 billion to $22 billion—reflecting both this increased utilization and the increasing cost of providing hospital care. Unfortunately, development of ways to finance the better health care we get today has not kept pace with medical advances.

To help all Americans receive the care they need is the common goal of each of the national health care bills pending before the Committee on Finance. At present, there are eight such bills, ranging from my own modest bill to pay the costs of catastrophic illness to proposals which would put the Government in the business of paying for all the health care provided to all the people of America.

For the record, these bills are:

S. 3, the Health Security Act, sponsored by Senator Edward M. Kennedy;

S. 191, the National Catastrophic Illness Protection Act, sponsored by Senator J. Caleb Boggs;

S. 836, the National Health Insurance and Health Improvements Act, sponsored by Senator Jacob K. Javits;

S. 987, the Health Care Insurance Assistance Act, sponsored by Senator Clifford P. Hansen;

S. 1376, the catastrophic health insurance program, sponsored by myself;

S. 1490, the National Health Care Act, sponsored by Senator Thomas J. McIntyre;

S. 1598, the Health Rights Act, sponsored by Senator Hugh Scott; and

S. 1623, the National Health Insurance Partnership Act of 1971, sponsored by Senator Wallace F. Bennett on behalf of the administration. This is President Nixon's health plan.

In exploring the national health issue, there are many questions which must be developed, and I hope that in this—and the hearings that must follow—we can inquire into them all. For instance:

1. To what extent does private health insurance and Government health programs, such as medicare and medicaid, now cover the population?

2. Where public and private health insurance is available, is it adequate; or are there so many deductibles and copayment features and other limitations that in the event of serious need the protection is insufficient or nonexistent?

3. What would be the impact of a program of national health insurance on providers of health care in terms of their own operations, as well as in terms of their ability to meet increased demand?

4. Do we have sufficient facilities and providers of health care services such as doctors and nurses to provide quality care to all the people of America?

5. To what extent would a sharp increase in demand affect the quality of care?

6. To what extent can we build upon existing health care mechanisms, rather than starting from the ground up?

In large measure, many of these issues pose the rhetorical questions of whether the health care system can deliver what the politician promises with the various bills. Can paper solutions be translated into actual and workable answers?

There is no question but that the implications of national health insurance are great. The cost, too, is great. Estimates of costs of the various health plans before the Finance Committee range from $2½ billion a year for my catastrophic illness plan, S. 1376, to $66 billion a year for Senator Javits' bill S. 836, and $77 billion a year for Senator Kennedy's bill, S. 3.

In studying the question of national health, cost will be a factor we cannot ignore. Our experience with medicare and its own continuing financial crisis attest to the virtual impossibility of estimating costs and utilization when Federal dollars replace private dollars in paying for health care. Today, by official estimates, the medicare deficit over the next 25 years is $242 billion. The American Hospital Association's estimate of increases in hospital costs result in a 25-year deficit projected at $37 billion; their estimates in the past, I regret to say, have been more accurate than the Government's.

Our experience with the enormous cost overruns and administrative difficulties with medicare and medicaid justifies caution—to say the least. To put cost estimates in perspective, it is not reassuring to know that in the entire history of medicare we have never experienced costs

below or even near estimated levels. For example, when medicare was originally enacted in 1965, projected costs for the year 1975 will be exceeded by $7.4 billion, almost 200 percent.

For the year 1990, the estimated projected cost when medicare was enacted was $8.8 billion. Those costs are now projected at $33.3 billion! Quadrupled!

We are now turning to the consideration of proposals—some far larger than medicare in terms of benefits, population covered, and costs. Logic and experience indicate that the potential margin of error in cost estimates for those proposals is far greater also.

In large measure, these uncontrolled, rapid rises in health care costs have generated much of the impetus for national health insurance by pricing many people out of the private insurance market and substantially increasing their out-of-pocket costs not covered by insurance.

Substantial success in moderating the costs of health care might very well relieve pressure to the point where a partial, selective health insurance program might be more desirable to the American people than the total approach of a national program.

As a matter of fact, national health insurance itself poses a political paradox. Americans want the best health care money can buy. On the other hand, Americans are predictably sensitive when it comes to paying taxes required to finance the program. No one knows the maximum tax load the American people will tolerate. Tolerate is probably a good word choice—to my knowledge, no Government on earth has ever imposed a tax relished by those against whom it was assessed.

Assuming the need for a national plan is established, the problem then becomes one of fixing priorities. Today, this Nation faces crises in the cities, in housing, in education, and in other vital areas, in addition to health. Each of these crises, and their solutions, may make equally justifiable and competing claims on the Nation's available resources.

I am hopeful that this hearing, and those which the committee will hold subsequently, will provide the committee—and the Congress—with an insight and a perspective into the need for national health programs and the best way of filling that need. Unfortunately, we cannot say, let there be light, and then bask in perpetual sunshine. Answers to serious questions rarely come easily, and much long, hard work lies ahead of us if Congress is to meet its responsibility properly.

We will include at this point in the record, a copy of our committee's press release announcing these hearings and a document prepared by the committee staff outlining the various health bills now before the committee.

(The material referred to follows. Oral testimony continues at page 25.)

PRESS RELEASE

FOR RELEASE SUNDAY A.M.
April 25, 1971

COMMITTEE ON FINANCE
UNITED STATES SENATE
2227 New Senate Office Bldg.

FINANCE COMMITTEE BEGINS PUBLIC HEARINGS ON NATIONAL HEALTH INSURANCE PROPOSALS

Honorable Russell B. Long(D., La.), Chairman of the Committee on Finance, today released the text of a prepared statement on the matter of National Health Insurance. Senator Long will deliver the statement on Monday, April 26, as the Committee on Finance begins open hearings on eight separate bills proposing various solutions to the health care crisis in America. The statement follows:

"In fiscal 1970, the national health bill amounted to more than $67 billion. This was 7 percent of the Gross National Product. Only ten years earlier, the cost of health care was $27 billion, representing 5.4 percent of the Gross National Product. One reason for the sharp rise in health care expenditures is that modern medicine and newly developed medical techniques have grown increasingly complex and expensive. Further, these techniques have enabled Americans to survive illnesses and injuries which once would have been fatal. In many of these cases, however, life is preserved only at tremendous costs.

"Medical and social advances over the past decade have also resulted in an increased use of the hospital -- and an increase in the costs of hospital care.

"Hospital admissions rose from about 25 million in 1960 to about 31 million in 1969, an increase of 23 percent. Total hospital expenses rose 162 percent over this same period of time -- from $8.4 billion to $22 billion -- reflecting both this increased utilization and the increasing cost of providing hospital care. Unfortunately, development of ways to finance the better health care we get today has not kept pace with medical advances.

"To help all Americans receive the care they need is the common goal of each of the national health care bills pending before the Committee on Finance. At present, there are eight such bills, ranging from my own modest bill to pay the costs of catastrophic illness to proposals which would put the Government in the business of paying for all the health care provided to all the people of America. The combined cost of these bills total more than $300 billion.

" For the record, these bills are:

S. 3, the "Health Security Act," sponsored by Senator Edward M. Kennedy;

S. 191, the "National Catastrophic Illness Protection Act," sponsored by Senator J. Caleb Boggs;

S. 836, the "National Health Insurance and Health Improvements Act," sponsored by Senator Jacob K. Javits;

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"In large measure, many of these issues pose the rhetorical question of whether the health care system can deliver what the politician promises with his bill. Can paper solutions be translated into actual and workable answers?

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"In studying the question of national health, cost will be a factor we cannot ignore. Our experience with Medicare and its own continuing financial crisis attests to the virtual impossibility of estimating costs and utilization when Federal dollars replace private dollars in paying for health care. Today, by official estimates, the Medicare deficit over the next twenty-five years is $242 billion. The American Hospital Association's estimates of increases in hospital costs result in a twenty-five year deficit projected at $370 billion; their estimates in the past have been more accurate than the Government's.

"Our experience with the enormous cost overruns and administrative difficulties with Medicare and Medicaid justifies caution -- to say the least. To put cost estimates in perspective, it is not reassuring to know that in the entire history of Medicare we have never experienced costs below or even near estimated levels. For example, when Medicare was originally enacted in 1965, projected costs for the year 1975 were $4.3 billion. The 1975 costs are now estimated at $11.7 billion. Thus, the original estimates for 1975 will be exceeded by $7.4 billion.

"For the year 1990, the estimated projected cost when Medicare was enacted was $8.8 billion. Those costs are now projected at $33.3 billion! Quadrupled!

"We are now turning to the consideration of proposals -- some far larger than Medicare in terms of benefits, population covered, and costs. Logic and experience indicate that the potential margin of error in cost estimates for those proposals is far greater also.

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"Substantial success in moderating the costs of health care might very well relieve pressure to the point where a partial, selective health insurance program might be more desirable to the American people than the total approach of a national program.

"As a matter of fact, national health insurance itself poses a political paradox. Americans want the best health care money can buy. On the other hand, Americans are predictably sensitive when it comes to paying taxes required to finance the program. No one knows the maximum tax load the American people will tolerate. "Tolerate" is probably a good word choice -- to my knowledge, no Government on earth has ever imposed a tax relished by those against whom it was assessed.

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NATIONAL HEALTH INSURANCE

BRIEF OUTLINE OF PENDING BILLS

Prepared by the Staff of the Committee on Finance

CONTENTS

NATIONAL HEALTH INSURANCE

Brief Outline of Pending Bills

Health Security Act—S. 3

(SENATOR EDWARD M. KENNEDY)

A. General Approach

A national health insurance plan, administered by the Federal Government, covering all U.S. residents, comprehensive in benefits, and financed by a combination of payroll taxes and general revenues. Includes provisions intended to improve quality and efficiency of health care delivery system; medicare would be repealed, but medicaid would continue as a supplemental program.

B. People Covered

All U.S. citizens and aliens admitted for permanent residence would be covered. Allows for reciprocal and "buy-in" agreements to cover certain nonresident aliens and in some cases U.S. residents traveling abroad.

C. Scope of Benefits

Comprehensive health benefits, including physician services, inpatient and outpatient hospital care, home health services, supporting services such as optometry, podiatry, devices and appliances, subject to the following exclusions:

(1) Dental care initially limited to children under 15; covered age group is to be extended in each of succeeding 5 years until all under age 25 are covered. Once eligible, an individual is subsequently covered regardless of age.

(2) Drug benefit limited to inpatient drugs, specified drugs necessary for chronic conditions, drugs provided through group practice systems.

(3) Skilled nursing home care initially limited to 120 days with provision for expansion when feasible.

(4) Mental hospital care is limited to 45 days per year active treatment; limit of 20 consultations per year for outpatient psychiatric care if provided by solo practitioner.

Benefits are covered in full with no deductibles, coinsurance, waiting periods, maximums, or cutoffs other than the limitations described above.

Effective date for benefits is July 1 of second calendar year following enactment.

D. Payment to Providers

A total area budget would be established for all services. Hospitals, skilled nursing homes, home health agencies would be paid on basis of negotiated budget designed to pay reasonable costs. Such payments would constitute virtually the total income of a hospital. Comprehensive health service organizations or professional foundations will be

paid by capitation or approved budget. Independent physicians and dentists may be paid on fee-for-service basis or by capitation. Payments to practitioners would come from earmarked portion of total area budget. Supplemental stipends may be paid to practitioners locating in remote or deprived areas. System may also reimburse practitioners for costs of continuing professional education. The Health Security Board would establish schedules of allowances for fee-for-service reimbursement.

E. Administration

Direct Federal administration by a 5-member Health Security Board within Department of HEW. National Health Security Advisory Council, representing consumers, providers of care, health organizations, etc., would advise Board on program operation. Regional authorities would be given strong discretionary powers. The program would substantially supplant private health insurance.

F. Financing

Financed by a 3.5% tax on employer's payrolls (36% of costs); 1.0% tax on employees (12% of costs); 2.5% tax on self-employed (2% of costs); and the balance (50%) from general tax revenues. Annual taxable wage base for employed persons would be $15,000 initially, rising subsequently. Employers would pay on total payroll without maximum. Certain unearned income of individuals would also be subject to 2.5% tax.

G. Cost Estimates

Committee for National Health Insurance estimate: program would cost $57 billion in fiscal year 1974. HEW estimate: $77 billion for fiscal year 1974.

H. Other Major Provisions

Authorizes a total of $600 million for a Health Resources Development Fund to be used in two years preceding program operation for development of health manpower, education, training, group practice, etc. After the program is in effect, 5% of the Health Security Trust Fund would be set aside for these purposes. Establishes national standards for providers and incentives to encourage preventive health care and formation of group practice arrangements.

National Catastrophic Illness Protection Act—S. 191

(SENATOR J. CALEB BOGGS)

A. General Approach

A Federal health reinsurance program, designed to encourage the development by the private insurance industry of policies which would provide extended coverage against the costs of catastrophic illness. The Government would reinsure against losses in instances where private insurance companies paid out more in benefits than they received in premiums. Involves creation of state-wide plans for extended health insurance coverage which insurers or state-wide pools of insurers would be required to offer all eligible individuals at a reasonable cost in order to qualify for Federal reinsurance program.

B. People Covered

Individual State resident (and his dependents) who makes appropriate application for such extended insurance coverage.

C. Scope of Benefits

A catastrophic health insurance plan offered by private insurers would be designed to cover costs of any and all medical care rather than specified benefits. Before payments would be made under the plan, a sliding deductible based upon adjusted income of an individual or family would have to be satisfied. The deductible would be equal to ½ of the amount by which the individual or family's adjusted income exceeds $1,000 but does not exceed $2,000, plus all of the amount by which such adjusted income exceeds $2,000. (A person with an adjusted income of $10,000 would have a deductible of $8,500; an individual with adjusted income of $5,000 would have a $3,500 deductible.) The deductible would be reduced by the amount of any out-of-pocket payments or any public or private third-party payments made on behalf of an insured person.

D. Payment to Providers

Present methods under private insurance.

E. Administration

Federal Government role mainly limited to contracting with private insurers for reinsurance coverage. An insurance company would pay the Government certain premiums or fees for reinsurance. HEW would also set premium rates to be used by private insurers in charging individuals for catastrophic health insurance plans. State insurance authorities would develop state-wide plan for extended coverage and would provide for pooling of risks among private insurers within a State. Where a state-wide plan cannot be established, private insurers would deal directly with the Federal Government.

F. Financing

Catastrophic insurance would be financed by means of payments of premiums to private insurers. The Government's reinsurance program would be financed through premiums paid by private insurers into a National Catastrophic Illness Insurance Fund.

G. Cost Estimates

No estimate available.

National Health Insurance and Health Improvements Act—S. 836
(SENATOR JACOB K. JAVITS)

A. General Approach

A national health insurance plan established through a gradual expansion of the medicare program to cover the general population. Benefits would be broadened to include certain services not presently covered under medicare. The medicare Part B premium would be eliminated. Medicaid would be continued.

B. People Covered

Medicare would be extended to all those over 65, the disabled, widows over 60, and widowers over 62 effective July 1972. Effective July 1974, the program would be extended to all citizens and aliens admitted for permanent residence.

C. Scope of Benefits

Same benefits as under medicare at the beginning:

(1) 90 days of hospital care with $60 deductible and coinsurance of $15 per day after 60th day.

(2) 100 days post-hospital extended care with coinsurance of $7.50 per day after 20th day.

(3) Physician and related services including outpatient diagnostic services, home health services, and physical therapy.

Additional benefits would be phased in, as follows:

(1) Maintenance drugs for chronic conditions, effective July 1973.

(2) Annual physical examinations, effective July 1975.

(3) Dental care for children under 8, effective July 1975.

D. Payment to Providers

Until July 1, 1974, reasonable cost for hospitals and institutions and reasonable charges for physicians (as under medicare). Thereafter, new methods, developed in interim, may be employed.

E. Administration

Essentially the same as medicare. Federal administration using private carriers, intermediaries, and State health agencies for appropriate roles. New public insurance corporations could be set up to administer the program if private carriers and intermediaries could not do so properly.

F. Financing

Financed by taxes on employers, employees, and self-employed (3.3% each in 1976 and thereafter) with Federal general revenue contributions equal to ½ of the amount collected through payroll taxes. Annual taxable wages for workers would be $15,000; for employers, no taxable wage base would apply.

G. Cost Estimates

Estimate by Social Security Administration: $66.4 billion in fiscal 1975.

H. Other Major Provisions

Individuals can "elect out" of program by securing coverage from private insurers offering comparable or better protection and thereby exempt themselves from payroll taxation for Federal health insurance. Employer plans may qualify in lieu of Federal program if they pay 75% of the cost and the protection is better than the Government plan. Provides incentives for growth of comprehensive health service systems which would benefit from cost-savings for efficient operation.

Health Care Insurance Assistance Act—S. 987
(SENATOR CLIFFORD P. HANSEN)

A. General Approach

A voluntary health insurance program called "medicredit," under which the Federal Government would pay health insurance premiums for the poor, and allow income tax credits for all others toward the purchase of private health insurance plans. The amount of tax credit would include 1) 100% of premium charges for catastrophic insurance plans and 2) an income-related percentage of premium charges for other health insurance providing certain basic benefits approved by the Government. Medicare would continue as at present.

B. People Covered

The total population under age 65 would be eligible. Those with no Federal income tax liability would receive full payment of their health insurance premium costs. For all others, the Federal share of health insurance premiums gradually decreases from 100% until those with a tax liability of $891 or more would get a tax credit of 10% of premium cost.

C. Scope of Benefits

A health care policy, in order to qualify under this program for purposes of a tax credit, would have to provide, at a minimum, the following benefits:

(1) 60 days hospitalization (with extended care days counting as ½ hospital day or 2 days of extended care for each hospital day, including nursing services, drugs, blood, appliances, maternity and psychiatric care, physical therapy—subject to a $50 deductible.

(2) Emergency or outpatient services including diagnostic services, x-rays, lab tests, etc.—subject to 20% coinsurance on 1st $500 of expense.

(3) Medical care by physician, in hospital or office, including diagnosis and treatment, psychiatric care, immunizations, physical exams, lab services, radiation therapy, maternal and well-baby care—subject to 20% coinsurance.

(4) Dental or oral surgery, ambulance service—subject to 20% coinsurance.

(5) Catastrophic illness provisions beyond basic coverage, including hospital services, extended care services (limited to 30 additional days), outpatient blood, prosthetic aids—subject to graduated corridor of deductible expense based on a family's or individual's taxable income, on the following scale: 10% on 1st $4,000, 15% on next $3,000, 20% thereafter.

D. Payment to Providers

Usual and customary charges for all services, including hospital and extended care.

E. Administration

Establishes Health Insurance "Advisory" Board to write policy and regulations. Private insurance companies would each administer their own approved policies.

F. Financing

Costs of health insurance for the poor would be met by Federal general revenue expenditures and by reductions in Federal income tax collections for those receiving tax credits.

G. Cost Estimates

American Medical Association estimate: $14.5 billion.

Catastrophic Health Insurance Program—S. 1376
(SENATOR RUSSELL B. LONG)

A. General Approach

A national program of catastrophic health insurance for people under 65, covered under Social Security Program would be administered by Social Security and would supplement existing private health insurance. Medicare would continue for those age 65 or over. Medicaid would continue as is, except that the benefits provided to eligible individuals under the new program would no longer need to be paid for through the medicaid program.

B. People Covered

All persons under 65 fully or currently insured under Social Security, plus their spouses and dependents. "Buy-in" agreements for State and local governmental employees not covered by Social Security.

C. Scope of Benefits

Same as currently provided under medicare parts A and B, without limitations on the number of hospital days, extended care facility days, or home health visits, and benefits would be subject to following deductibles and coinsurance:

(1) Hospital deductible of 60 days hospitalization per year per individual, plus $15 a day coinsurance after 60th day. Post hospital extended care services provided after the 60-day hospital deductible was met would be covered subject to $7.50 a day coinsurance.

(2) Supplemental medical deductible initially established at $2,000 per year per family, with coinsurance of 20% of medical expenses exceeding the deductible.

Benefits would become effective January 1, 1972.

D. Payment to Providers

Payments made to patients, providers, and practitioners under this program would be subject to the same reimbursement controls as under medicare. Quality, health and safety standards and utilization controls used in the medicare program would apply also.

E. Administration

Same as medicare.

F. Financing

Financed through payroll contributions from employees, employers, and self-employed (0.3% in 1972–74, 0.35% in 1975–79, 0.4% in 1980 and thereafter). Wage base would be $9,000 initially, rising subsequently. Trust fund for Federal Catastrophic Health Insurance would be completely separate from other trust funds operating under Social Security programs.

G. Cost Estimates

H.E.W. estimate: $2.5 billion on an incurred basis and $2.2 billion on a cash basis for 1st year of operation.

National Health Care Act—S. 1490
(SENATOR THOMAS J. McINTYRE)

A. General Approach

A program which would provide financial assistance for State health care insurance plans for the poor and uninsurable and set a Federal Minimum Standard Health-care Benefits Program as a condition of eligibility for increased Federal income tax deductions for the costs of private health insurance coverage. Individuals who itemize deductions would be allowed an unlimited tax deduction from income equal to all premiums paid under health plans meeting the minimum standards. An employer would be eligible for a tax deduction equal to 100% of his costs in providing a qualified health plan to his employees. Only 50% of the cost of a nonqualified policy could be deducted. It would supplement medicare and medicaid.

B. People Covered

Persons on public assistance would be covered through qualified State health-care plans at no expense to themselves. Uninsurable individuals and those with low-incomes could enroll at a modest cost in the State plan. All other individuals participating in a qualified health care plan who itemize deductions would be entitled to receive increased tax deductions for insurance premium expenses.

C. Scope of Benefits

Different levels of minimum benefits would be required for private group and individual plans and for State pool plans for the poor, near poor, and previously uninsurable, with the State pool plans initially being more comprehensive. Effective January 1, 1973, the private group and individual plans would include the following subject to (a) in qualified employer plans, deductibles of up to $100 per family and coinsurance payments of up to $1,000 per family; (b) in qualified individual plans, unlimited deductible amounts and coinsurance ranging up to 20% of covered expenses and; (c) a ceiling on copayments for participants in the State pools:

(1) 30 days hospitalization—subject to $10 deductible for 1st day, $5 for each additional covered day.

(2) 60 days extended care services—subject to $2.50 per day deductible.

(3) 90 days home health services—subject to $2.50 per day deductible.

(4) All diagnostic, x-ray, and lab exams on an ambulatory basis—no limit and no deductible.

(5) 3 visits per year to physician in office or ambulatory center—$2 deductible per visit.

(6) Unlimited visits for outpatient surgery and radiation therapy—$2 deductible per visit.

(7) 6 exams for well-baby care—no deductible.

(8) Unlimited inpatient physician services—$3 deductible per day, for 1st 30 days, $5 per day thereafter.

Effective July 1, 1972, State pool plans would be identical to the above but also include the following benefits:

(1) Physician visits—6 per year
(2) Hospitalization—120 days
(3) Extended care facility—120 days
(4) Well-baby care—12 visits during 1st two years
(5) Home health services—180 days
(6) Additional benefits—dental care for children under 19 (20% coinsurance), prescription drugs ($1 per prescription), physical therapy (20% coinsurance), family planning services, prosthetic aids (20% coinsurance), maternity care (20% coinsurance).

By January 1, 1976, private group coverage would be expanded to cover the initial State pool plan level of coverage. Subsequent benefit improvements are provided for in future years.

D. Payment to Providers

Payments would be limited to the 75th percentile of prevailing charges for professional services and for institutions, to rates approved by a State Health Care Institutions Cost Commission.

E. Administration

Private insurers would each administer their own policy for qualified group and individual plans. For the qualified State health-care plans, each State would set up a health insurance pool, a portion of the risks of which private insurers would be required to underwrite. One or more private companies would be designated to administer the State plan. Premium rates for the State plans would be determined within each State, subject to review by HEW.

F. Financing

Costs of protection for all people not insured through a State pool would be borne by employers, employees and the self-employed through premium payments to private insurance companies, and indirectly by the Federal Government through tax deductions for these premium expenses.

A State pool would be financed with premium payments from the uninsurable, partial premium payments from the near-poor, and Federal-State contributions to subsidize, in part, costs of protection for the near-poor, and in full, the costs of protection for welfare recipients. Contributions of the near-poor vary with income.

The Federal matching payments would vary with a State's per capita income and range from 70% to 90%. Federal matching payments would come from general revenue funds.

G. Cost Estimates

The Health Insurance Association of America estimates cost of the program (using 1970 cost data) at $2.4 billion. The estimate is said to include Medicaid cost off-sets. The estimate does *not* include the amount of revenue loss to the Government from the tax deductions granted to cover the purchase price of qualified health care plans by employers and individuals.

H. Other Major Provisions

Includes provisions intended to 1) increase and redistribute supply of health manpower 2) promote ambulatory care 3) strengthen health planning 4) improve cost and quality controls for health services.

13

Health Rights Act—S. 1598

(SENATOR HUGH SCOTT)

A. General Approach

Establishes two separate health insurance programs to supplement existing private health insurance protection—1) a Federally-administered inpatient plan designed to cover costs of catastrophic illness 2) an optional outpatient health maintenance plan administered by private insurers under contract to the Government. Inpatient plan would pay for covered benefits when a family's or individual's medical expenses exceeded a "health cost ceiling." Outpatient plan would pay for covered services above a specified deductible. Would replace medicare and Retired Federal Employees Health Benefits program; medicaid would pay only for services not covered under inpatient plan.

B. People Covered

All U.S. residents and aliens admitted for permanent residence would be entitled to benefits. Reciprocal agreements could be arranged to cover aliens temporarily residing in U.S. and employed by foreign countries.

C. Scope of Benefits

Inpatient plan would pay 1) all costs for covered services (listed below), once a family's or individual's medical expenses exceeded a "health cost ceiling," based on family income and size, and 2) 50% of costs of covered services when such expenses exceeded ½ of the health cost ceiling. (For example, a family of 4 with income of $10,000 would have a health cost ceiling of $545. Once medical expenses reached $272.50, the inpatient plan would pay 50% of additional medical expenses up to $545, then 100% of costs beyond that.)

Inpatient plan would cover following services:

(1) inpatient hospital and dental care
(2) inpatient psychiatric services up to 180-day lifetime maximum
(3) skilled nursing home services
(4) home health services

Outpatient plan would pay for all covered services above an individual deductible of $50 per year, with lower deductibles for the poor. An additional $25 deductible would be applied to covered dental services.

Outpatient plan would cover the following:

(1) physicians' services, including diagnostic exams, limited physical exams, 3 pre-natal exams per pregnancy, 2 well-child care exams per year for children under 5
(2) outpatient physical therapy
(3) 100 home health visits
(4) outpatient psychiatric visits up to lifetime maximum of 104 visits
(5) dental services for children under 12
(6) long-term maintenance drugs.

Benefits would become effective January 1, 1973.

D. Payment to Providers

Provides that payment to providers of services under inpatient plan will be in accordance with regulations of the Secretary of HEW. For outpatient plan, insurance carriers who have contracted with the Government to administer the plan within a particular region will reimburse providers of services.

E. Administration

An Office of Health Care would be established in Department of HEW to administer, through its regional offices, the Government's inpatient plan. Private carriers under contract to HEW would be assigned responsibility for administering the outpatient plan within a particular region or subregion. A Health Services Review Committee, representing providers and consumers of health services, would be set up within each region to evaluate effectiveness of the program. A National Review Board would review overall administration, develop minimum national standards for participating health personnel, compile a generic list of drugs for use by participating institutions and health maintenance organizations. Providers would be required to have a utilization review program. HEW could contract with health maintenance organizations to provide all services covered under both inpatient and outpatient plans.

F. Financing

Inpatient plan would be financed in part through the present health insurance portion of Social Security payroll taxes and in part through general revenues. Supplementary outpatient plan would be financed through individual premium payments which would be supplemented in whole or in part with Federal payments for poor families. Employers could agree to pay part or all of their employees' premiums for the supplementary plan.

G. Cost Estimates

None available.

H. Other Major Provisions

Authorizes Federal grants and loans for planning, development, and construction of health maintenance organizations, with special grant provision for HMOs in physician short areas. Revises provisions of medical and nursing student loan program to extend the loan repayment periods and increase amount of loan. Establishes program of yearly capitation grants to medical schools to encourage increases in enrollment and shorter curricula.

National Health Insurance Act—S. 1623
(SENATOR WALLACE F. BENNETT)

A. General Approach

A program which would require health insurance coverage for all employed persons and their dependents through Federally-mandated employer-employee private insurance packages meeting National Health Insurance Standards established by the bill. Additionally, the program would provide medical care benefits to low-income families with children through establishment of a Federal family health insurance program (FHIP).

B. People Covered

All employees would be covered; employers would be mandated to provide private insurance coverage meeting minimal standards.

Low-income families (for example, a family of four with income up to $5,000) would be eligible for coverage under the Family Health Insurance Plan. Families with lower incomes (family of four with income below $3,000) would pay no premiums. Families with incomes between $3,000 and $5,000 would contribute toward premium costs.

C. Scope of Benefits

A. National Health Insurance minimum standards would be established for employer-employee policies: Such policies must include (up to a maximum of $50,000 in benefits and subject to deductibles and co-payment requirements described below):

(1) In-patient hospital service without limit;

(2) Physicians' services (including Christian Science practitioners or nurses) without limitation; and

(3) Laboratory and x-ray services without limitation.

B. The Family Health Insurance plan would provide:

(1) 30 days of in-patient hospital care (extended care day would count as (⅓) hospital day);

(2) In-patient physicians' services and 8 out-patient physicians' visits per year; and

(3) Varying number of visits for "well-child" care dependent upon age of child.

D. Deductibles and Co-insurance

A. The employer-employee package would have a two-day hospital deductible and a $100 deductible for other services. There would be a 25% co-insurance for all services (including hospital charges). Co-insurance and deductibles would be waived after an individual receives $5,000 of covered services in a year.

B. In the Family Health Insurance Program, deductibles and co-insurance amounts vary in accordance with the income of eligible families. A family of four with an income of $3,000 would pay no deductibles or co-insurance. Families with incomes above $3,000 but less than $5,000 would pay deductibles of one or two days of hospital

care depending upon income and those with income of more than $3,500 would also be required to pay varying co-insurance and/or dollar amounts.

E. Payments to Providers and Practitioners

Payments for care would be subject to Medicare limits on reasonable costs for institutions and reasonable charges for providers.

F. Administration

Employer-employee health insurance policies would be administered and underwritten by private insurance companies.

Family Health Insurance Program would be administered by the Federal government on a basis comparable to Medicare utilizing carriers and intermediaries.

G. Financing

Employer-employee health insurance plans would be financed by payments from both employer and employee. Employee contributions could be no higher than 35% of premium cost initially, and 25% after two and one-half years.

Family Health Insurance Plan would be financed through Federal general revenues and payments from the near-poor.

H. Estimates

The Administration estimates the cost of the employer-employee coverage for 1974 at $7 billion above estimated employer-employee health insurance expense for present benefit coverage.

The Federal general revenues contribution to the Family Health Insurance Program would be $3 billion in 1974. This would be offset in part, by an estimated savings of $1.8 billion in Medicaid.

The CHAIRMAN. We are pleased to have with us this morning as the first witness the senior Senator from Massachusetts, the Honorable Edward M. Kennedy, to testify on behalf of his proposal, S. 3.

STATEMENT OF HON. EDWARD M. KENNEDY, U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

Senator KENNEDY. Thank you very much, Mr. Chairman and members of the committee.

The CHAIRMAN. May I interrupt for a moment to say that I would prefer that we hear the Senator's statement in its entirety before we have any questions. I would hope that in order to accord all witnesses the opportunity to be heard during the morning session that we can confine the Senators to 5 minutes in their first round of interrogation, and thereafter they can ask such additional questions as they desire.

Senator KENNEDY. Thank you very much, Mr. Chairman and members of the committee.

I am pleased to have the opportunity to share with this committee my deep concern over the crisis in health care in America, and to describe how I believe the Health Security Act will alleviate the crisis.

The extensive and continuing efforts of this committee in the areas of catastrophic illness, mental illness, peer review, cost control, and above all, the health needs of the elderly, prove your long-standing concern with health care in the Nation.

The quality of health care in the Nation is rapidly becoming the overriding domestic issue of our day, and I look forward to working with the members of this committee as we in Congress seek to deal with the issue in the months ahead.

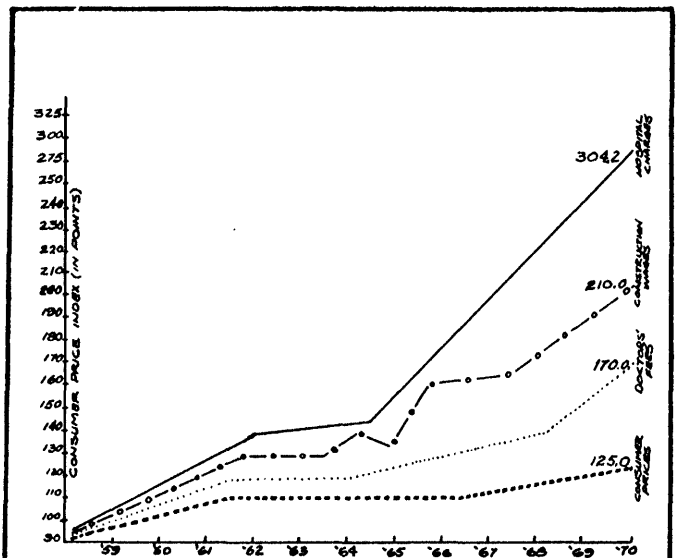
Eight weeks ago, our Subcommittee on Health began its own hearings on health care in America, as background for the wide variety of legislation currently referred to our subcommittee. During that period, we heard primarily from the experts—representatives of medical schools, hospitals, physicians, organized medicine, the insurance industry, and virtually all of the other major institutions of American health care.

Now we have begun to take the issue to the people. Already we have held field hearings in New York, West Virginia, and Tennessee, and hearings in a number of other States will take place in the coming weeks. We plan to hear testimony directly from the people who need, use, and pay for health care in every part of the country, as well as from the doctors, nurses, and others who are on the firing line, actually providing health care to the people.

Let me share with you what we have now learned of the health crisis in America.

The Finance Committee is, of course, preeminently aware of the soaring cost of health care. The chart I have brought with me—chart 1—illustrates how hospital charges have tripled in the last dec-

CHART 1



INFLATION IN HEALTH COSTS

ade, while physician fees have risen by 150 percent. Insurance premiums have soared to keep pace with these costs. The chart also shows that the inflation in hospital costs outstrips even the inflation in construction wages, which has concerned the Nation so much in recent months. Surely, in light of recent developments, it is fair to ask, if we need a stabilization review board for construction costs, why don't we need one for hospital costs?

From the purely economic standpoint alone, serious inflation in an industry as large as health care indicates a system that is out of control. But there are other signs of the loss of control as well. There is gross waste and inefficiency in the way health services are provided. We have heard testimony that hospitals are used unnecessarily because insurance covers hospitalization but not outpatient care. We have heard that costly hospital facilities, such as open heart surgery units, are built for prestige reasons, and then paid for by insurance companies, even when the facilities are not needed in the community and stand idle much of the time.

I have walked through emergency rooms packed with patients waiting long hours for routine health care. In the same city, I have also walked through empty emergency rooms. I have walked through crowded hospital wards, and I have also walked through hospitals with empty padlocked wings and half-filled wards.

We have heard from areas of the country with too many surgeons and too much surgery, and we have heard from areas where there are no doctors at all.

In short, behind the soaring costs of health care, we see a health system riddled with inefficiencies—a system that attracts physicians where they are needed least, treats patients where it costs the most, and overloads one facility only to leave neighboring facilities empty.

Worst of all, the health system seems unable to respond to these problems. It shows few signs of creativity, or of being able to take even the most rudimentary steps to eliminate the crisis. America is a prisoner of a health care system designed for a bygone era. Doctors, hospitals, and patients alike are trapped in a system they cannot change alone.

One further point needs to be made about the health crisis.

We can talk all we want about costs, and quality, and manpower shortages. But you do not really see the health crisis until you leave the hearing rooms of Congress and travel into America to listen to the people. We have a health crisis in this country, and it is a crisis in very human terms. Day in and day out across America, real tragedies are happening to real people, and they are happening because in the richest nation in the world, health is a forgotten right.

In the past few weeks, our Health Subcommittee has seen first hand the many different faces of the health crisis:

It is a union brewer from Queens, whose kidney dialysis machine is about to be unplugged unless he can pay $10,000 a year for its cost.

It is a ghetto mother in Harlem, whose oldest son is severely retarded for life because of lead paint poisoning, but whose younger children have not yet even been tested for symptoms of the disease.

It is a Cornell engineering student, paralyzed for life by a tragic football injury last fall, whose upper middle class family has been ruined by the devastating financial consequences of the accident—$50,000 in 5 months, and no end in sight. The family thought they were protected, because the father was an insurance salesman who carried the best health policy his company offered.

It is the elderly widow in West Virginia, whose husband died of black lung disease, and who now lives on a benefit of $84 a month. She pays $5 a month for insurance to cover the medicare deductible and coinsurance. Her doctor refuses to fill out any of the insurance forms so she has to do it all herself.

It is a paint sprayer for a bridge company in Nashville, who lost his health insurance when his company went out of business. He had to file for bankruptcy because he couldn't pay a $600 hospital bill when his son was born.

It is a disabled World War II veteran living on a pension of $200 a month, and paying $5 a month on what he still owes from a 1968 hospital bill.

It is countless citizens harassed by bill collectors, hired by hospitals that are better at chasing patients than at treating them.

It is a college linguistics professor dead of brain cancer at 46, after tens of thousands of dollars in expenses. Now, the lives of his wife and children are mortgaged for years into the future. The cruelest irony of all is that the wife is from Israel, where all of her expenses would be covered.

We have learned that a $500 expense for a working man can be just as catastrophic as a $50,000 expense for a businessman. We have learned that even the cost of health insurance premiums and medicare deductibles can be catastrophic expenses for millions of senior citizens.

When I think of the health crisis I also think of physicians working 12 to 14 hours a day, and still turning away patients in distress. We have heard hospital administrators boast of collecting over 95 percent of their bills—they do it by turning away the poor.

We have heard the same administrators say they don't know why their emergency rooms are empty, when a sign over the entrance demands $15 for the privilege of walking through the door. In New York City, we could not find private hospitals with emergency rooms in many counties. They take patients only by referral from private physicians. Despite the terrible need, only the public hospitals open their doors to the people at large.

We have a health crisis in America, and it cuts across all political, social, economic, and geographic lines. It affects old and young, black and white, rich and poor, urban and rural, business and labor, North and South, Republican and Democrat alike. Rarely, if ever, in our history has any issue so united so many different elements of our people.

The reason for this situation is clear. At every turn, it is financing that causes or contributes to the crisis.

Because hospital charges are covered by insurance, more people are hospitalized than necessary.

Because specialists are reimbursed at higher rates and enjoy shorter working hours, doctors enter specialties and abandon general practice.

Because suburban America can better pay for specialists, doctors flock to the suburbs, and leave rural and urban America to the brutality of hospital emergency rooms.

Because hospitals cannot afford to treat those who have no health insurance, private hospitals restrict their services to the affluent, and public facilities are swamped under an avalanche of people who are poor risks for payment.

Because insurance is marketed primarily for good health risks, fragmented public programs must be set up by Federal, State, and local governments for the unemployed and the chronically ill, and to respond to special problems like black lung disease, kidney disease, and other critical areas.

I am convinced that the way we finance health care has trapped Americans in this inefficient and enormously expensive system. My bill, the Health Security Act aims at breaking open this trap by changing the way we finance health care.

There are those who say it is un-American for the Government to intervene in the way we do business in the health care industry. This is utter nonsense.

If anything, the health care industry is itself un-American in the way it does business. In America we rely on competition and the informed choice of individual citizens to guarantee that products are available at reasonable prices in the marketplace. But where do we see doctors or hospitals actually competing in the American health care industry? Where do we find consumers able to judge quality well enough to compare the health services they receive?

Things simply don't operate this way in the medical marketplace. Doctors reach tacit agreements about prices among themselves, with the active support and blessing of the insurance industry. They refer their patients to hospitals, which charge what they please and then coerce the insurance industry into paying whatever price they think the public will bear.

Surely, we cannot rely on competition and consumer choice to keep the health care industry innovative and responsive to the country's needs.

Some will object that there is competition—competition among health insurance companies. There is indeed competition, but it is competition for profits, not for health services. The competition is in fact so fierce that it has forced even nonprofit companies like Blue Cross and Blue Shield into practices that skim the cream off the insurance market, and leave many Americans with exorbitant premiums, or without any health insurance at all.

But this sort of competition is worthless. It has failed to assure efficient, effective, and reasonably priced health care. In our subcommittee hearings, we have heard strong evidence that the insurance industry has neither the ability nor the will to control costs or promote efficiency in the health system.

They take the path of least resistance. They simply raise their premiums to cover the inefficiency and inflation. And then they add their profits on the top. Competition in the insurance industry is costing us billions of dollars in waste and inadequate health care. It is doing nothing to control costs, to stimulate new resources, or to improve the quality of service.

(CLERK'S NOTE: Senator Bennett subsequently requested that the following information appear at this point in the printed record. See page 72.)

FINANCIAL EXPERIENCE OF PRIVATE HEALTH INSURANCE ORGANIZATIONS, 1969

[Amounts in millions]

Type of plan	Total income	Subscription or premium income	Claims expense		Operating expense		Net underwriting gain		Net income	
			Amount	Percent of premium income	Amount	Percent of premium income	Amount	Percent of premium income	Amount	Percent of Premium income
Total	(1)	$14,657.7	$13,068.5	89.2	$2,133.7	14.6	−$544.5	−3.7	(1)	
Blue Cross-Blue Shield	$6,265.8	6,155.6	5,903.1	95.9	457.7	7.4	−205.2	−3.3	−$95.0	−1.5
Blue Cross	4,434.1	4,365.2	4,271.4	97.9	252.3	5.8	−158.5	−3.6	−89.6	−2.0
Blue Shield	1,831.7	1,790.4	1,631.7	91.1	205.3	11.5	−46.6	−2.6	−5.3	−.3
Insurance companies	(1)	7,569.0	6,306.0	83.3	1,609.5	21.3	−346.5	−4.6	(1)	
Group policies	(1)	5,685.0	5,349.0	94.1	750.4	13.2	−414.4	−7.3	(1)	
Individual policies	(1)	1,884.0	957.0	50.8	859.1	45.6	67.9	3.6	(1)	
Other plans	933.1	933.1	859.4	92.1	66.5	7.1	7.2	.8	7.2	.8
Community	375.0	375.0	349.0	93.1	27.0	7.2	−1.0	−.3	−1.0	.3
Employer-employee-union	490.0	490.0	450.0	91.8	35.0	7.2	5.0	1.0	5.0	1.0
Private group clinic	16.3	16.3	14.2	87.1	1.1	6.8	1.0	6.1	1.0	6.1
Dental service corporation	51.8	51.8	46.2	89.2	3.4	6.6	2.2	4.2	2.2	4.2

[1] Data not available.

Source: Social Security Bulletin, February 1971.

RETENTIONS[1] OF PRIVATE HEALTH INSURANCE ORGANIZATIONS AS A PERCENT OF SUBSCRIPTION OR PREMIUM INCOME, 1948-69[2]

Year	Total	Blue Cross-Blue Shield plans			Insurance companies			Other plans[3]				
		Total	Blue Cross	Blue Shield	Total	Group policies	Individual policies	Total	Community	Employer-employee-union	Private group clinic	Dental service corporations
1948	29.7	15.6	14.6	22.0	45.8	30.2	61.7	7.9	(3)	(3)	(3)	(3)
1950	23.2	14.5	12.3	21.6	33.9	22.8	47.4	10.0	(3)	(3)	(3)	(3)
1955	19.5	11.3	8.6	17.6	27.5	16.1	46.9	8.8	(3)	(3)	(3)	(3)
1960	14.5	7.9	7.2	9.6	21.1	9.6	47.1	3.5	(3)	(3)	(3)	(3)
1961	14.7	7.8	6.8	10.3	21.0	10.1	47.1	8.4	(3)	(3)	(3)	(3)
1962	14.4	7.2	5.7	11.0	20.9	9.4	49.3	9.2	(3)	(3)	(3)	(3)
1963	13.3	6.5	5.0	10.3	19.4	8.3	46.0	9.7	(3)	(3)	(3)	(3)
1964	12.8	5.6	3.9	9.7	19.1	8.3	45.5	9.5	(3)	(3)	(3)	(3)
1965	12.7	6.1	4.7	9.9	18.4	6.9	45.3	9.4	8.2	10.2	10.7	6.9
1966	13.5	8.1	6.6	12.0	18.1	6.9	45.6	9.3	8.0	10.2	11.8	6.5
1967	14.0	10.4	8.3	15.5	17.4	6.4	47.2	9.7	8.4	10.8	13.3	6.2
1968	10.4	6.7	3.7	13.8	16.5	6.2	46.4	8.6	6.2	9.7	5.8	17.2
1969	10.8	4.1	2.2	8.9	16.7	5.9	49.2	7.9	6.9	8.2	12.9	10.8

[1] Amounts retained by the organizations for operating expenses, addition to reserves, and profits.
[2] Derived from table 17.
[3] Data by type of plan before 1965 not available.

Source. Social Security Bulletin, February 1971.

Senator KENNEDY. The hospitals and doctors are not the villains. They, like us, are caught in a system that contains the wrong incentives and rewards the worst inefficiencies. If we are to succeed in our goal of achieving health reform, we must break the trap that binds us and free the hospitals and the doctors to create a health care system worthy of our Nation.

I believe the Health Security Act will do the job. Only the health insurance industry stands to lose if the bill is passed—and I believe we have already witnessed the failure of that industry to serve the people.

Frankly, Mr. Chairman, it is incredible to me that the administration proposes to place even greater responsibility in the hands of the insurance industry—and further abdicate public responsibility in this area. As the accompanying chart—chart 2—makes clear, the amount of health funds handled by the insurance industry will increase substantially under the administration's proposal—a windfall worth billions of dollars a year for the private carriers.

But let me turn specifically now to S. 3, the Health Security Act—its costs and benefits. I would like to submit for the record a detailed description of S. 3, and make summary remarks at this time.

At the outset, I believe that a nation as affluent as ours cannot afford not to offer comprehensive health care to all of our people, whatever the cost. But this is not the issue. I am convinced that the Health Security Act can be put into operation for the same amount of money we are now spending on the current system, and give us better care in the bargain.

You have heard enormous figures quoted as the "cost" of the Health Security Act, but the figures are meaningless unless we compare them with the cost of other programs.

As you can see by chart 2, the amount of money that will be spent under the existing system in 1974 is $100 billion, the same amount of money that would be spent if the Health Security Act is passed. Of that $100 billion, $68 billion will go for benefits covered by the Health Security Act, but none of that spending is new money.

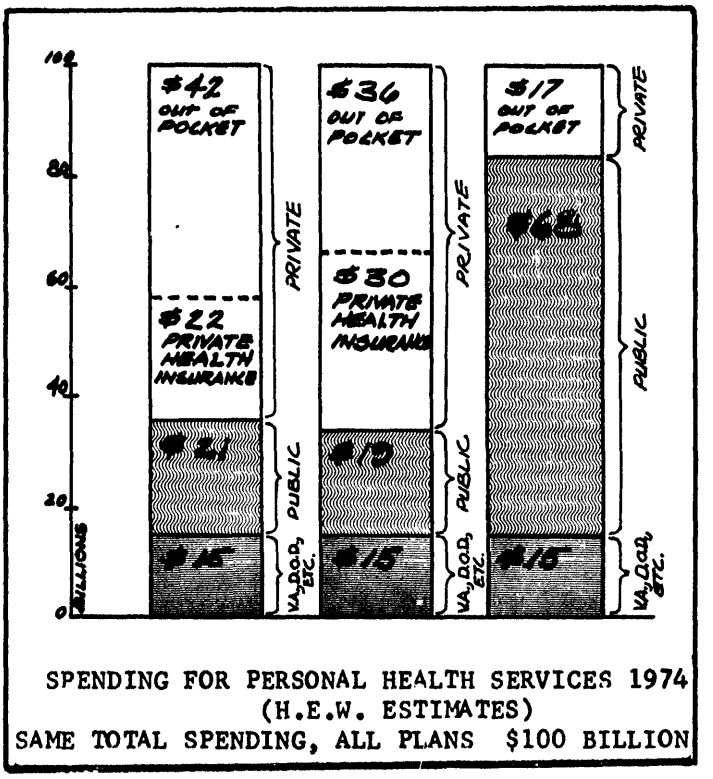
The crucial point is that under the Health Security Act, the major part of the funds will flow through the Federal Government, instead of through the private health insurance industry. The cost to the Nation, however, remains the same—$100 billion. The higher Federal payment is offset by a reduction of equal amount in spending for private insurance and out-of-pocket payments.

In addition, as chart 3 indicates, the Health Security Act will achieve substantial savings in future years, once it goes into effect. We estimate that, under the Health Security Act, by 1980, we will be saving $50 billion over what we would be spending then if things go on as they are today.

The key question in this and all national health insurance proposals, Mr. Chairman, is who should have the responsibility for administering the enormous funds being spent on health care in America. I believe that the Federal Government should have this responsibility—and I would make the Federal Government the health insurance carrier for all Americans.

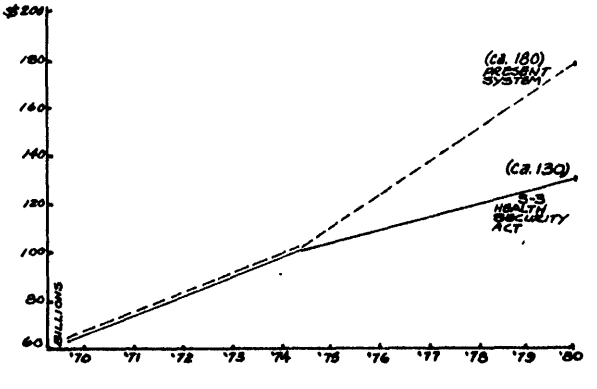
Under the Health Security Act, the doctors, the nurses, and the hospitals would not be owned by the Government, any more than they are currently owned by the private insurance industry. They remain

CHART 2



SPENDING FOR PERSONAL HEALTH SERVICES 1974
(H.E.W. ESTIMATES)
SAME TOTAL SPENDING, ALL PLANS $100 BILLION

CHART 3



HEALTH SPENDING IN THE 70's

free to organize themselves and charge for their services in a variety of ways. In fact, they would be freer than they are now, because more options would be open to them.

An insurance agent for the Nation, the Federal Government would effect controls on costs, as well as incentives for efficiency and quality of care. It would also undertake to increase the resources available to supply care.

Of all the bills before Congress, only the Health Security Act places positive and firm controls on costs. I want to stress that point, and I am sure we will have an opportunity to elaborate later. It does this by prospectively budgeting the amount of money available to cover all health care services for the population. The budget would be based on the previous year's expenditures for health care, plus a reasonable increase to cover inflation and new demand.

The budget would be broken down for various regions and areas of the country. Within a particular service area, the budget would be allocated among hospitals and other facilities, as well as among HMO's, medical foundations, and other organizations of physicians. A pool would be left for physicians in private practice who choose to offer care on a fee-for-service basis.

These budgets would be essentially absolute, and hospitals and physicians would have to live within the ceiling. In effect, the budgeting will place a lid on how much money can be spent to cover health services in the Nation.

The Health Security Act would also offer strong incentives for efficiency. The bill encourages the development of HMO's, medical foundations, and other more efficient patterns of health care.

The Health Security Act also promotes the efficient use of hospital and other facilities by an annual review of their budget proposals. During these reviews, costly duplicative, or grossly underutilized facilities would be phased out, and new construction would be based on areawide planning for health services.

There is another aspect of the health care crisis that has been little studied and is seldom discussed. It is the area of the quality of care Americans receive. Our subcommittee has heard extensive testimony that raises grave questions in this area. The Health Security Act would offer major assurances in this regard.

It would establish national licensing requirements for physicians and facilities, and require continuing education for health professionals. Controls would be set on the use of drugs, and referral arrangements would be required for both physicians and organizations, to insure against abuse of expensive specialist and inpatient services.

But the most important aspect of the Health Security Act is that it frees the people of this country to build a better health system. Some opponents have labeled the bill monolithic, and have raised the specter of oppressive Federal control of health services. In fact, the only thing monolithic about the bill is its proposal to create one national health insurance policy for all Americans. It replaces the many fragmented public and private insurance arrangements we have today with one public insurance system.

It is my conviction that this basic change will simplify the financing arrangements for health care, and break open the trap that keeps the

health professions from responding creatively to the country's problems.

Once the trap is broken, the Health Security Act allows for virtually unlimited pluralism in the patterns of practice, organization of services, and the manner of payment to physicians.

But the bill goes even further. Physicians are given a wide range of choice in how they offer care, and they are also offered financial backing and support for attempting innovative patterns of care.

The resources development fund, from which this support will come under the Health Security Act, is also available for training paraprofessionals, improving facilities and equipment, and otherwise expanding our capacity to offer health services.

Only the Health Security Act provides such a fund. It will be established prior to the act's effective date for benefits, in order to lay the groundwork for the bill and help to build the system we need. Once the act goes into operation, the Fund will provide several billions of dollars a year to keep the system running and responsive.

Mr. Chairman, let me conclude by offering my subcommittee's full cooperation and support in your investigations. As you know, the Health Subcommittee has many pieces of legislation under active consideration which affect the health care system, and which are closely related to bills under your review. I urge the Finance Committee to assess the health care crisis in all its aspects, and to report out a bill which is equal to the need. To me, the challenge is enormous, and I believe that only the Health Security Act is equal to the task.

The CHAIRMAN. Thank you for your statement, Senator, and let me assure you that this committee will undertake to thoroughly familiarize itself with the testimony that was developed in the hearings before your subcommittee.

When we went into the medicare program I had predicted for some time that the costs were going to greatly exceed any estimate ever made, and I submit that the record would prove me right on that. It is a good program, and I am happy that I participated in passing it. At the same time, I think that I was predicting some things that should have been taken into account at the time we passed that bill. Part of the reason I made that prediction was because in the elaborate charity hospital system we had in Louisiana prior to medicare. It was our experience that the average patient stayed 50 percent longer in a State-supported hospital than he was staying in a private hospital. We were providing good care in that State-supported hospital, but it was not superior to the private hospitals in small communities. Now, mainly that had to do with an element of psychology. It was costing a person at that time $35 a day, and now it would cost $100 a day for hospital care. If he is paying for himself, he wants to move himself from the hospital as soon as possible. On the other hand, if the Government is paying for it, he is inclined to stay a while longer. The pressures on the doctor vary; "can I go home today?" in the one instance, and in the other instance, "well, doctor, there is nobody at home to give me the kind of attention I might need, the wife is busy looking after the children, and is it all right if I stay on another day or so?" And we found that that latter type of philosophy came into effect when we had medicare.

Now, as I pointed out in the opening statement, in 1975 the medicare costs are going to exceed the estimate by almost 2 for 1, and looking a few more years down the road they are going to exceed the estimate by about 4 to 1. Even in that program there are some deductibles that a person has to pay. For example, under part A he pays the first $60 and under part B he would pay the first $50, and then he would pay 20 percent of the cost above that. Now, have you taken increased utilization into account in arriving at your estimate of what you think the plan you are recommending to us would cost?

Senator KENNEDY. Yes, I have Mr. Chairman, and I think you have stated accurately what has been the trend in the costs of medicare and medicaid, and in health costs generally. I think it is best illustrated by the enormous increase, as shown in chart 1, in hospital costs, and also in doctors services.

In the medicare and medicaid program, we increased demand without increasing supply. And we provided for the financing in inefficient ways. For example, as you pointed out, a person may stay in the hospital too long, but his treatment still gets paid. It is more expensive, for example, to operate on someone than to give them other kinds of treatment, yet we have excessive surgery. Take medicaid, for example, in California. Why is it that the children of Medi-Cal recipients in California have four times as much surgery as other children in Califorina? The experts will try to pass it off, but I would suggest that the system rewards those who operate the most, so long as Medi-Cal is there to pay the bill.

Why is it that under prepaid group practice, for example, Federal employees have only half as many tonsillectomies as those under Blue Cross? Obviously, you get more surgery when there is an open faucet to pay the bill. Now, what the Health Security Act is attempting to do is take the concept of prepayment and write it into a national program. What we are attempting to do is say we have only so much money to be spent in the health area in 1 year. We have only got so much money, and we are going to have to live within that budget.

There is not a businessman who would not do that if he were running the health system as a business. And what we are doing under the present system and under the administration's program, and what we would be doing under every other program that has been suggested to the Congress is to provide an open-ended system, where unlimited funds will be paid out by the consumers of this country. We have tried to control these costs by a front-end budgeting program for health generally, and also by an attempt to encourage the kinds of services which can provide comprehensive programs and do it more efficiently.

Another feature of our program under S. 3 is to build competition between health delivery systems. We do not have any of that now. The sicker people get, the more they are treated in hospitals. The more operations they have, the wealthier the doctor gets. These problems are built into the system now and what we are going to try to do with front-end budgeting is to bring this inflation under control. I think we can.

The CHAIRMAN. Well, I would like to ask more questions about this matter, Senator, but I want to adhere to my own rule that I imposed on the committee, so now I yield to Senator Anderson.

Senator ANDERSON. Mr. Chairman, I recall that we discussed medicare at great length, and debated it thoroughly and as a result it is a good program. But medicaid was passed more rapidly and has had more problems. I am glad that we are starting early with a full debate on national health insurance. This full debate will result, I am sure, in sound legislation.

The CHAIRMAN. Thank you. Senator Bennett.

Senator BENNETT. Well, Mr. Chairman, this is the beginning of a series of hearings in which we are going to at least have presented to us one after another of the eight proposals to which you referred. I do not think there is too much to be gained by attempting to question the Senator closely about this proposal. I think we would do better to wait until we get them all in, and then begin to compare the various features.

I would like to remind our audience that we consider ourselves to be a responsible committee, and whenever we approach a proposal, the best example is in medicare and social security, we provide the revenue to pay for it. That is our ultimate responsibility to see that there is revenue to meet the costs of government.

Now, the Senator says his proposal will cost $68 billion, roughly $50 billion more than the money that is now being spent in the public sector. Last year we collected in income tax from private individuals $88 billion. So, in order to cover this, assuming that it would have to, the cost would have to come in terms of additional individual income tax, and we would be, assuming that $50 billion, looking at an increase of about 70 percent in the individual income tax. Now, it is easy to say, well, this is going to be linked by a reduction in the burden that the individual will have to pay for himself. I am not sure that the American people are prepared to face an individual income tax increase of something like 70 percent. This is the kind of problem that we have to face.

I have just one question to ask the Senator as a matter of information. I have been told that you recently updated your estimate of cost from $57 to $68 billion. How long ago was that change made in your estimate?

Senator KENNEDY. When we introduced the bill last January, our estimate was that it would cost $57 billion in 1971, the year it goes into effect. That wasn't new money, of course, since the American people would be paying $57 billion for health services covered by the Health Security Act, whether the bill is passed or not. The $57 billion figure was reached by extrapolation from 1970 to 1971 at the current rate of inflation. Since January, however, as the chairman has suggested, HEW has increased its estimate of the rate of inflation, so we revised our figure to $68 billion. The rate is now 12 percent a year.

Senator BENNETT. But your estimates of cost are in 1974?

Senator KENNEDY. Yes, and the longer we wait before we begin to control costs, the longer the inflation will continue.

Senator BENNETT. Well, in other words, to me you are validating the statement of the chairman that when you get to 1974 actually you will find the costs will have risen above your current estimate, and that you have already indicated that by the mere passage of time, 2 years that you have been forced to increase your estimate of the cost about——

Senator KENNEDY. Twelve percent.

Senator BENNETT. From 57 to 68. Well, I will not do the arithmetic.

Senator KENNEDY. We have done the arithmetic.

Senator BENNETT. So, we are still facing this idea that it is probably grossly under the cost. The costs are grossly underestimated, but I return to my point that somebody has got to raise the extra money, and it has got to come from some tax fare. If you take it all from the individual taxpayer it is an increase of about 70 percent, and I am not sure the American people are prepared for an increase in their individual taxes of that rate; that is all.

Senator KENNEDY. The increase won't be anywhere near that step on individuals. In S. 3 as we introduced it, the resources will be raised, half by general revenues, and half by a payroll tax on employers and employees. Of course, we are quite flexible in terms how particular ratio would be set if the committee were to accept the principle. Basically, we feel that half should be raised by general revenues, and half by a payroll tax.

I think it is important to realize that we are going to be expending this money in any event. We have to start with that. Opponents of the Health Security Act have been using scare tactics to suggest we are going to bankrupt the taxpayer. The taxpayer has to realize that he is going to be spending his money on health in this country, whether we have a Health Security Act or not. The administration is deluding the American taxpayer, by not raising his taxes and by making him pay by other means, such as by increasing the cost of his private insurance premiums, or by increasing his deductibles, increasing his coinsurance, and increasing what he will be paying to doctors. All of these private costs would be eliminated by the Health Security Act. He is going to be paying an increase in terms of taxes, but he is not going to be getting a doctor's bill every month, and he is not going to be paying separately for medicare, and he is not going to be paying deductibles and coinsurance when he goes to the hospital or sees a doctor.

The important fact is, this country is going to be spending many billions of dollars on health care in 1974, and we have to make a decision whether we are going to be spending it efficiently and effectively and usefully, or whether we are going to continue to spend it in a system, as stated by the Chairman so eloquently and dramatically, that is open-ended, absolutely open-ended in terms of increased costs.

We have tried to provide a realistic kind of ceiling on costs, and if better ceilings can be built in by this committee, I would welcome them.

I believe we have the only bill that provides these kinds of ceilings. You will hear testimony later by the administration, talking about the development of health maintenance organizations and how they are going to control costs that way. I think that approach is unrealistic because it cannot do the job. The Health Security Act provides a businesslike, sound, prudent, and prebudget method of controlling expenditures, and I think that we have got a handle on the costs which we have never had before.

And finally, I would say, it is fair to ask how much the taxpayer will tolerate. I think it is also fair to ask how long we are going to tolerate one of the most inefficient and wasteful health systems in the world.

Senator BENNETT. Well, I just have one comment to make. On page 4, the Senator talks about the budgets that are going to be set up in advance, and in the fourth paragraph in the bottom of his statement, he says, "these budgets will be absolute, and hospitals and physicians would have to live within the ceiling and, the budgeting would place a lid on how much money can be spent." But, I can see a situation in which a hospital because of an epidemic, or for some reason or another runs out of its budget in September and then you are faced with the question of do we break the budget, or do we turn people away from the emergency room, as the Senator has so dramatically indicated? So, I think his plan is, in effect, open-ended. You cannot put an absolute predetermined budget and enforce it against the vagaries of accidents or the pattern of disease and hospital needs.

Senator KENNEDY. If there is an urgent need as you have described, I think, obviously, the Congress would want any Secretary of Health, Education, and Welfare to respond. Other than that, we have to build in sound businesslike practices like prebudgeting. The health industry must live within a budget.

We also have to ask whether the insurance companies can do the job, as the administration wants them to. I don't think they can. The Finance Committee's staff report last year makes the point very clearly:

> Carrier performance under Medicare has in a majority of instances been erratic, inefficient, costly, and inconsistent with congressional interest. Unquestionably, many millions of dollars of public funds have gone to subsidize carrier inefficiencies.

That is what this committee's staff has stated about the insurance carriers that the administration wants to use. That is their record. I think the Committee on Finance has performed an enormous public service with this report.

Senator BENNETT. Can you guarantee that a Federal bureaucracy set up to operate under this system would not be subjected to those same criticisms?

Senator KENNEDY. I think we can rely on the record of social security. The performance of social security has been efficient and effective. It has the confidence of the American people. We will model our national health insurance system after social security.

Senator BENNETT. I have more than used my share of the time, Mr. Chairman.

The CHAIRMAN. Senator Curtis.

Senator CURTIS. Senator, it was reported that the social security bill now being considered by the Ways and Means Committee will provide for a tax of 7.1 percent on employer and employee each, now, your plan would add 3½ percent to the employer payroll, would it not?

Senator KENNEDY. That is correct, yes.

Senator CURTIS. And 1 percent to the employee?

Senator KENNEDY. That is correct.

Senator CURTIS. That would make a combined payroll tax of 18.7 percent?

Senator KENNEDY. I think your addition is correct.

Senator CURTIS. Do you think that that is satisfactory? Do you think that is too high a social security tax of 18.7 percent?

Senator KENNEDY. As I mentioned earlier, that is the proposal which is included in S. 3. If this committee wants to vary the formula with respect to the 3.5 and 1 percent, we are flexible in that particular feature of the bill. This was the best recommendation that we were able to make. I think the rate is high.

Senator CURTIS. Is that in itself inflationary? If social security tax is going to be a fifth of payroll, almost a fifth, would not increased wages have to follow?

Senator KENNEDY. The increased wages might be inflationary, but the effect would be offset by the increased taxes. In any event, the inflationary feature which does not begin to equal what will happen if we let the current inflation in health costs continue.

Senator CURTIS. Did your subcommittee take any testimony in reference to the hospital medical plan provided for Government employees and retired Government employees?

Senator KENNEDY. No, no we did not.

Senator CURTIS. Have you heard any complaint about it?

Senator KENNEDY. In what respect?

Senator CURTIS. Generally.

Senator KENNEDY. Yes, in terms of the coverage, the deductibles, coinsurance, waiting time, paper work.

Senator CURTIS. You have heard complaints about it?

Senator KENNEDY. Yes, we have, in general terms. But we have not had much specific testimony about the program.

Senator CURTIS. I think you will find that that program has been freer from criticism than any health program for any comparable number of people. It offers three options. The employee can decide what he wants, and that is handled entirely by the private sector, is it not?

Senator KENNEDY. Yes.

Senator CURTIS. The Government does not operate that at all. It is contracted for by the private insurers.

Senator KENNEDY. How have the premiums gone up in the last few years?

Senator CURTIS. I do not know whether they have exceeded the other costs in that connection. What cushion of the hospital——

Senator KENNEDY. Have their deductibles gone up?

Senator CURTIS. Not to my knowledge.

Senator KENNEDY. As I say, we have not had testimony on the particular features.

Senator CURTIS. It is a pretty good plan.

Senator KENNEDY. Unfortunately, as I understand it, the program covers only about 50 percent of their total health expenses. The other 50 percent is paid out of pocket by the employee.

Senator BENNETT. May I comment?

Senator CURTIS. I will not take the time, but I wish you would elaborate and establish that.

Senator BENNETT. I would like to correct that.

Senator CURTIS. I think most of the employees in this building and the departments find that it substantially takes care of the greater portion of their medical expenses. This is one of the best working systems we have.

Senator KENNEDY. I do not question that it is one of the best. I do not dispute that. I think what I question is whether the private insurance companies can do the job. As Senator Bennett stated in his floor statement last week introducing the administration's health program:

> On the one hand we hear that our people have a right to health care, but the evidence is overwhelming that with a crisis in availability in delivery of essential health services the cost of health care simply overwhelms the vast majority of our people and if we are to avoid the collapse of our health care system we must take drastic action.

But I do not think the administration's program is drastic action, and I rest on what Senator Bennett said.

Senator CURTIS. At the top of page 3 I notice, or the top of page 5 I notice that you call for a national licensing of physicians.

Senator KENNEDY. That is right.

Senator CURTIS. If the Federal Government had power to license physicians they would have power to take their licenses away from them, would they not?

Senator KENNEDY. That would probably be correct. Yes.

Senator CURTIS. Do you think that any insurer, whether it be the Government or anybody else, should have such authority?

Senator KENNEDY. Yes, I do. The problems are enormous, and we find that many of the medical societies have been absolutely unresponsive in terms of disciplining even clear-cut malpractice situations.

Senator CURTIS. This provision is put in there in order to exercise the necessary control?

Senator KENNEDY. Yes. But in addition it was put in there to provide greater flexibility for our mobile population. Too often, reciprocity is denied in a number of States.

What we hope to do is to provide a greater sense of mobility in terms of distribution of doctors, in enabling them to move around the country to practice in different areas.

Senator CURTIS. Yes. So that the same level of government that had power to license and remove licenses would be running the Government health program?

Senator KENNEDY. If what you are suggesting is that we are going to have a strong standard of quality and quality control, the answer is affirmative. We feel that there are two ways of building that in. There are some direct ways, which I have outlined, and there are some indirect ways, such as through group practice.

Senator CURTIS. I notice in your chart there is a very great increase in hospital costs. Now, the facts before this committee indicates that about 65 or 70 percent of hospital costs represent wages. It is attributable to labor costs. In your statement you state you are going to budget this in advance and put a lid on it. Would this lid include a provision that wages could not be raised?

Senator KENNEDY. I would like to ask this committee if there have been any hospitals that have turned over their records to the committee to examine, to determine what the labor costs are?

I question that figure. We have had wage increases, the increases have been generally a catching up for hospital employees. They have been unquestionably the poorest paid group in our society with the possible exception of migrant workers, such as the grape workers in

California. They have been poorly paid, and the increases have certainly been added to hospital costs.

Senator CURTIS. Well, I am not arguing about that. I think that these people were underpaid. My point is you say that there will be budget and a lid placed on it.

Senator KENNEDY. That is right.

Senator CURTIS. Will that lid prohibit wage increases?

Senator KENNEDY. It will provide for a bargaining system within that framework. The hospitals will have to bargain within that framework, but wage increases certainly will be possible.

Senator CURTIS. My time is up.

The CHAIRMAN. Senator, you asked a question. So far as I know, we have not had experience with the problem. It is not so much the committee as the auditors of the Department of Health, Education, and Welfare who have the primary burden to go out and find out what these costs are and why. Working with them, we have not found it a problem to find out how much they are paying and where the money is going. What we challenge is whether knowing that most of the hospital cost is labor, whether they are making the most efficient use of that labor in these hospitals.

Senator Jordan.

Senator JORDAN. Thank you, Mr. Chairman.

Senator, to what extent are present facilities underutilized? Does your committee have any information on that?

Senator KENNEDY. I think HEW would be able to provide better data here.

Senator JORDAN. Do you have any estimates as to the number of additional facilities that would be required to implement your plan and the number of doctors and technicians that would be required to implement your plan?

Senator KENNEDY. We already have a general shortage of health manpower, and a major part of the problem is the maldistribution of personnel, both in terms of geographic distribution and the number of physicians in the various specialities. What we are attempting to do in the Health Security Act is to encourage a much more efficient utilization of the existing doctors.

We probably have to many surgeons and not enough general practitioners. We have not been able to train or utilize paramedical personnel effectively. The Health Security Act would establish more realistic licensing procedures, instead of placing excessive reliance on individual States.

We have the capability within S. 3 of a faster expansion of health personnel than any of the other proposals. In addition, other legislation will give direct assistance to medical schools and health maintenance organizations, to create what I consider to be more innovative delivery systems.

I think we can make a significant impact in terms of future increases in health personnel, but I want to say quite clearly that we are not going to see a dramatic, enormous increase in the outputs of the medical schools. What we are going to have to do is to use what we already have, and to use them more efficiently. I think there can be a much better utilization of health personnel, and we intend to encourage it with this bill.

Senator JORDAN. Another matter, Senator, you are rather severe in your indictment of hospitals and doctors generally. You say hospitals turn away the people that cannot pay, that they brag about being able to collect 95 percent of their bills and so on, and you have said doctors reach tacit agreements about prices among themselves, and so on, and you go on to say, and I think this appears to be a contradiction, that the hospitals and the doctors are not the villains. Who are the villains?

Senator KENNEDY. It is the system that is the villain, it is the system itself. It is not the doctors. I cannot imagine, in a fee-for-service operation, that the doctors would not take full advantage of it, and act in their own financial interest. The doctor knows, for example, that if you spend the night in the hospital, Blue Cross will cover it, but that if you use the outpatient department, you have to pay the cost yourself. So the doctor takes the path of least resistance. He's trapped in a system that contains the wrong incentives.

Everybody is a part of the system except the consumer. The insurance companies are part of the system, but they are in it for profit. Every time someone has a claim against an insurance company, it is a threat to their profit.

I can understand that. They are in business, so they have to go out and make a buck. Everyone is caught up in it. Everyone is frustrated by it. And the one person who is left out is, of course, the consumer, and he is the one who is suffering from it.

What we hope to do is to enact a program capable of comprehensive health reform. A patchwork response will not work. We can't just add another feature, another special program for the indigent, another program for the working man. If that is all we do, we will simply be compounding what is already a festering sore in this country.

Senator JORDAN. Thank you. I yield, Mr. Chairman.

The CHAIRMAN. Senator Ribicoff.

Senator RIBICOFF. Thanks, Mr. Chairman.

Senator Kennedy, I have followed your work in this field with great interest, and I want to commend you for your most provocative set of hearings and your commitment to this cause. I have not cosponsored your bill or any other, but I would expect the complications are so vast that there will have to be a lot of new thoughts and ideas before we get through.

Now, the legislation that you propose would generate a fantastic expansion of demand, which is an indication that so many people are not getting the medical care they need.

Now, how do you believe that you are going to be able to increase the facilities and manpower and the delivery system quickly enough to take care of the increased demand?

Senator KENNEDY. First of all, Senator, I do not believe we are going to have the extraordinary kind of increased demand that many people have predicted.

One of the most important observations that we have been able to make so far is the fact that even with health resources available, workingmen and lower-income people are extremely reluctant to use them. In the neighborhood health centers, for example, which in many cases are bringing health care into communities for the first time, they have to reach out to get the people to come in and utilize the facilities. They have actually established outreach programs to do this. I have

the greatest reservations about any deductibles and coinsurance for health care. People do not go to the doctor or the hospital just for the fun of it.

Senator RIBICOFF. That is true, and the examples you used in your testimony represent, I believe, what is happening all across the country, namely that many people who need medical care, are not seeking it because they do not have the money to pay for it.

Once the funds are made available, I believe a great many people who want very much good health care for themselves and their families, will begin to seek that medical help.

Now, what I am driving at is this: What you are talking about is a basic national need. We do have a system that is broken down, that is not delivering health care to great segments of the American people.

Now, once your system, or a system similar goes into effect there will be a large demand, and we do not have the system throughout the country, uniformly, to take care of the need among the poor, among the rural areas, as you point out.

You have plenty of health care areas in the suburban areas where people with large incomes live. Now, under those circumstances, would it not be, would we not all be better off if we gradually phase in a system such as you propose, with Congress setting an ultimate goal, whether it is your line or the administration line, whether it be 5 or 10 years, and working up to the maximum goal of what you would like to see a health system include?

Then we could have interim goals until we have the facilities and manpower to take care of the demand. I think we have run into this with medicare, and then we handle the problem. Once we find we are overwhelmed we start altering and changing, and asking for larger contributions and fewer days, and so would you contemplate working your program out in such a way that we would try to dovetail the facilities and manpower with the demand that would be generated?

Senator KENNEDY. I don't think we can afford to phase a comprehensive national health care program. We know now that we can produce a much more efficient utilization of existing facilities. I think, obviously, that over a period of time there will have to be an increase in the number of health facilities in the community. But I have seen myself, for example, that there are many hospitals with wards that are virtually empty. In the same community, I have visited hospitals with wards that are vastly overcrowded.

Now, you can speculate that people will abuse the right, and that suddenly under national health insurance everybody is going to want cosmetic surgery. But I don't think that will happen.

In addition, the Health Security Act provides a 2-year tooling up period, before the benefits begin, in order to help prepare the system for the program. We have a resources development fund that will enable us to spend about $600 million in having the groundwork in those 2 years.

Of course, there will be a transitional period, and I am sure there are going to be many different ideas as to how to get through the transitional period. But I do not want to leave the committee with the impression that S. 3 does not take into consideration the need to prepare the system for increased demand. I think we can do the job, and provide better health care in the bargain.

There are many existing programs that offer comprehensive care, and you do not find overdemand in these situations.

Senator RIBICOFF. It is not the overdemand.

Senator KENNEDY. There is no overutilization.

Senator RIBICOFF. Take your State, or mine, where you would not have a shortage of physicians, but then you look around here at the Senator from Wyoming, or Idaho, or Nebraska, or Utah, and I would wager if you went into their State that you would find county after county and district after district that did not even have one doctor, and a shortage of facilities which are endemic throughout this country.

The problem of the migrant workers that you are so interested in, the problem of the poor and the black, area after area where they are deficient in health care facilities and availability, and your own testimony indicates it.

Now, I think the basic goal that all of these bills seek are worthwhile goals, but there could be no greater tragedy than to give the people of this country the idea that once you pass a piece of legislation that all of their ills would be cured, and then find the great frustrations that we did not have the system to deliver.

The system has broken down. Now, then, do we not, with a sense of responsibility, have to phase this in where there is a balance between our programs and your facilities, and our manpower?

Many of your suggestions are absolutely essential, and they are needed, but it is going to take a little time to dovetail it. I do not think you could pass the bill and expect everything to happen at one time, without clogging the entire delivery system.

Senator KENNEDY. Your examples of the doctor shortage is like my own. We have hundreds of counties in America that have no doctor.

How are we going to get the doctor out to rural America? The best answer that we have been able to come up with is that you have to provide a variety of incentives.

You have to provide the kind of facilities in which they can practice modern medicine. You cannot isolate them medically. You cannot isolate them socially. You have to create a financing mechanism that will not disadvantage them financially from their peers who work in the suburbs.

Now, to create that kind of system for rural America is going to take time, and I agree with you in terms of the length of time it will take.

Senator RIBICOFF. Now, in your opinion, is the health industry as principally constituted, able to do the job of delivering this type of program to the American people?

Senator KENNEDY. No, not as it is structured at the present time. After 40 years of effort, the health insurance industry has been a massive failure—the commercial carriers and the nonprofit carriers alike.

Senator RIBICOFF. Do you think that the health industry could be so regulated to make them responsive to the proper delivery and supervision of a health system?

Senator KENNEDY. We would have to turn the health insurance industry into a regulated industry, like the FCC, and I think the industry would be even more reluctant to accept that than to accept national health insurance.

Senator RIBICOFF. But basically your program is to have it all done by social security?

Senator KENNEDY. Not everything. Just the financing. We do not say that a doctor cannot have a private patient, or practice on a fee-for-service basis. What we do say is that we must have Federal financing. That doesn't mean there will be Federal control of the health delivery system.

Senator RIBICOFF. I understand that, but do you think the health insurance industry itself could do it with, the insurance industry itself could do it with proper rules and regulations?

Senator KENNEDY. I do not see why we ought to go that route. The failure of the industry in that field has lasted for 40 years. Today, they pay only approximately one-third of the total health bills in the Nation. Why should we build the feature of profit into the health system. We do not have this feature of private profit built into the educational system. Why should we have it built into the health system?

I do not think that private business ought to be making a profit on something as basic as the right to health.

Senator RIBICOFF. That is all, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Hansen.

Senator HANSEN. Thank you, Mr. Chairman.

Senator Kennedy, I, too, want to compliment you for your decisive work in the field of health care and the presentation of the bill that we have before us now.

I suspect that I would say that you would agree with me that as we look at all of the bills that have been introduced, that no one likely is to pass and receive the stamp of approval of the Congress without some modification.

It is with that thought in mind that I would like to ask you a few questions.

I think you testified that S. 3 would cost, according to the most recent estimates you have made, some $68 billion, and you stated that the budget would be absolute, that the hospitals and physicians would have to live within that ceiling. A year ago, as I recall, when we were faced with the situation of another budget, that of the Post Office Department, it proved to be inaccurate because of the demands of employees within that Department. As matter af fact, I know you will recall the strike that occurred. Do you recall how you voted on the bill to authorize additional funds for postal employees following that strike?

Senator KENNEDY. I believe I supported it.

Senator HANSEN. Would you think that the Government was right in agreeing to a percentage increase? I have forgotten what it was. I think it was around—well, I have forgotten what the figure was, but there was an increase given to the post office employees. Were you generally in sympathy with that rise?

Senator KENNEDY. Yes; I recall the New York strike and the issues surrounding the reorganization of the Post Office Department and I believe that I voted for the increase.

Senator HANSEN. I think you have already touched this point once, and perhaps there is no further reason to question but just to be sure

that I understand, I think you did observe that in your opinion there were too many specialists, surgeons and others, and not enough general practitioners in the country. I think you said in response to the question by Senator Ribicoff that it was not your intention, not the intent of this bill to tell a person what he had to do, but rather to provide incentives so as to result in a better delivery of health care services; was that right?

Senator KENNEDY. That is right. We have some incentives in the Health Security Act, but we also attack the problem in other pending legislation, including the major health manpower bills now before our Health Subcommittee.

The question is, How much control the Federal Government should impose? The medical schools are supported in part by the taxpayers, and the taxpayer himself has an interest in seeing that the money is spent wisely, and does not just add to the problem.

I think we are going to have to think about this hard and long. I have talked to the medical schools and to medical student organizations, and they are very concerned about the problem.

Senator HANSEN. Well, if we talk about providing increased incentives for people to practice and to offer the type of service that we think is in short supply now, would not this imply that the costs would rise? How, otherwise, would we deliver incentives to physicians?

Senator KENNEDY. We would use the incentives to encourage group practice, medical foundations, and other more efficient forms of health care. We have to encourage alternatives to fee-for-service, which is contributing very greatly to the inflation in the cost of health care. We have to encourage less surgery and more family practice.

Senator HANSEN. Then what we are saying is certain services, certain kinds of services at present being provided will be denied some people, or that we are going to have to tell a doctor that he can only do a certain amount of that or this, and you must do a certain amount of something else, and the incentive would be how other than to tell him what he has got to do other than through the profit incentive?

How do you change him, encourage him to change his practice?

Senator KENNEDY. Increasing his remuneration for increased services he provides within the system.

Senator HANSEN. This would cost more instead of less.

Senator KENNEDY. I do not see why it would, because we are going to be working within a fixed budget. We know the incentives that exist in the case of prepaid group practices. That's the sort of thing we want to encourage, and the savings will be enormous.

Take the San Joaquin Medical Foundation in California, for example. The foundation offered to take over the medicaid program in the area. Governor Reagan told the foundation that the State would be paying a certain amount of money for the program, and he agreed to let the foundation try to carry out the program more cheaply and efficiently. And that's exactly what they did.

The foundation returned $280,000 to the State. Now, the doctors were delighted with this result. They were providing increased services, and with greater efficiency.

Senator HANSEN. One final question, Mr. Chairman. It has been estimated that there are some 350,000 persons employed by the vari-

ous health insurance organizations around the country, exclusive of Blue Cross and Blue Shield. With the adoption of your plan what role, what further employment might this have?

Senator KENNEDY. There would be many possibilities. The insurance companies could serve as agents for doctors, hospitals, and medical organizations. They could underwrite insurance in areas not covered by the Health Security Act. Many of them could also work for the health security program.

Senator HANSEN. Would they work for the Government? Is that what you say?

Senator KENNEDY. Yes, that might be one possibility.

I would just say, however, that I do not think that we ought to continue running one of the most inefficient health systems in the world, solely for the purposes of maintaining high employment in the private health insurance industry.

I do feel that there may be a difficult problem, just as with SST and other issues, but we have to try to come to grips with it.

Senator HANSEN. Thank you, Senator Kennedy.

The CHAIRMAN. Thank you very much, Senator.

I will address any further questions I have by way of staff, and I am sure there is a great deal of information that you can provide based upon your study of this matter and also your hearings.

Do other Senators have further questions they care to ask?

Senator CURTIS. I will try to be brief because you have been very helpful to the committee in outlining your bill here today.

Coming back to these tax rates, there are tax rates in there.

Senator KENNEDY. I am familiar with them.

Senator CURTIS. Three and a half percent added on to the employer.

Senator KENNEDY. And 1-percent employee, and 2.5 percent on the self-employed.

Senator CURTIS. That is based on a $15,000 wage base?

Senator KENNEDY. That is right.

Senator CURTIS. Now, if the House and Senate should decide on a lower wage base, I understand the Ways and Means Committee are talking about $10,600 wage base, if the wage base were lower, these rates would have to be higher, would they not?

Senator KENNEDY. Yes, if we wish to keep the same 50–50 formula with respect to the portions from general Treasury revenues and payroll taxes. As I mentioned earlier, I think the formula in the act is the most equitable and most progressive way of paying for the program but obviously we are very flexible on the formula. If the wage base is lowered, of course the tax rates would have to go up.

Senator CURTIS. Now, as I understand your proposal it would, by means of raising the social security taxes, would take care of half of the costs?

Senator KENNEDY. That is right.

Senator CURTIS. And 50 percent would be out of general revenues?

Senator KENNEDY. That is right.

Senator CURTIS. Where would you—what would you tax to raise those general revenues?

Senator KENNEDY. It would come from the general Treasury revenues, and there many different ways we could do it. The State of West

Virginia, for example, has done it by taxing liquor and cigarettes to support their medical schools. I am open to any innovative idea that could be developed by this committee.

We are going to have to raise the money. I am prepared to recognize that.

Senator CURTIS. Would you recommend a raise in the corporate tax?

Senator KENNEDY. As I say, Senator, I am not prepared to commit myself to any particular tax increase. Possibly, we may not need a tax increase at all, if we make reductions in other areas like defense spending, and if the economy gains substantial benefits from the so-called "Vietnam" and "fiscal" dividends.

Senator CURTIS. I think that is all.

The CHAIRMAN. Thank you very much.

Senator KENNEDY. Thank you very much.

(A section-by-section analysis of S. 3, submitted by Senator Kennedy, follows. Hearing continues on page 66.)

SECTION-BY-SECTION ANALYSIS OF THE HEALTH SECURITY ACT

TITLE I

Part A—Eligibility for benefits

(Sections 11–12.) Every resident of the U.S. (and every non-resident citizen when in the U.S.) will be eligible for covered services. Reciprocal and "buy-in" agreements will permit the coverage of groups of non-resident aliens, and in some cases benefits to U.S. residents when visiting in other countries.

Part B—Nature and scope of benefits: Covered services

(Section 21.) Every eligible person is entitled to have payments made by the Board for covered services provided within the United States by a participating provider.

(Section 22.) All necessary professional services of physicians, wherever furnished, are covered, including preventive care, with two important restrictions:

(1) Major surgery, and other specialist services designated in regulations, are covered only when performed by a qualified specialist—except in emergency situations—and generally only on referral from a primary physician. This is intended to protect the public from inadequately trained practitioners and to restore the primary or family practitioner to the role of the manager of health services.

(2) Psychiatric services to an ambulatory patient are covered only for active preventive, diagnostic, therapeutic or rehabilitative service with respect to mental illness. If the patient seeks care in the organized setting of a comprehensive health service organization, or a hospital out-patient clinic, or other comprehensive mental health clinic, there is no limit on the number of consultations. In these kinds of organized settings, peer review and budgetary controls can be expected to curtail unnecessary utilization. If the patient is consulting a solo practitioner, there is a limit of 20 consultations per benefit period. In communities where psychiatric services are in especially short supply the Board may prescribe referral or other non-financial conditions to give persons most in need of services a priority of access to solo practitioners.

(Section 23.) Comprehensive dental services (exclusive of most orthodontia) are covered for children under age 15, with the covered age group increasing by two years each year until all those under age 25 are covered. This benefit is limited initially because, even with full use of dental auxiliaries, there is insufficient manpower to provide dental benefits for the entire population. Persons once covered for dental services remain covered throughout their lives, and it is the declared intention to extend dental benefits to persons initially excluded, as rapidly as this becomes feasible.

(Section 24.) Inpatient and outpatient hospital services and services of a home health agency are covered without arbitrary limitation. Pathology and radiology services are specifically included as parts of institutional services, thus reversing the practice of Medicare. Domiciliary or custodial care is specifically excluded in any institution, thus necessitating the two important restrictions on payments for institutional care:

(1) Payments for skilled nursing home care is limited to 120 days per benefit period except that this limit may be increased when the nursing home is owned or managed by a hospital and payment for care is made through the hospital's budget. It is not practical to assume that the majority of nursing homes and extended care facilities in the country will be able to implement effective utilization review and control plans in the first years of Health Security. The demand for essentially domiciliary or custodial care in nursing homes is so overwhelming that an initial arbitrary limit on days of coverage is necessary. Extension of the benefit is authorized when this becomes feasible.

(2) Many state hospitals do not provide optimal active treatment to their psychiatric patients but rather maintain them in a maintenance or custodial setting. If Health Security provided unlimited coverage for patients in these hospitals, it might tend to freeze the level of care instead of stimulating these institutions to upgrade their medical-care performance. Therefore the psychiatric hospital benefit is limited to 45 consecutive days of *active treatment* during a benefit period.

(Section 25.) The bill provides coverage for two categories of drug use: prescribed medicines administered to inpatients or outpatients within participating hospitals, or to enrollees of comprehensive health service organizations, and drugs necessary for the treatment of specified chronic illnesses or conditions requiring long or expensive drug therapy. This will provide coverage of most drug costs for individuals who require costly drug therapy.

The bill requires the Board and the Secretary of HEW to establish two lists of approved drugs, taking into account the safety, efficacy and cost of each drug. There will be a broad list of approved medicines available for use in institutions and by comprehensive health service organizations and a more restricted list which is available for use outside such organized settings. The restricted list shall stipulate which drugs on it shall be available for treatment of each of the specified chronic diseases. No such restrictions shall be placed upon drug therapy within an institutional setting.

Use of the restricted list will meet the most costly needs for drug therapy while restraining unnecessary utilization. The benefit is more liberal where adequate control mechanisms exist.

(Section 26.) The appliances benefit is similar in concept and operation to the drug benefit, subject to a limitation on aggregate cost. The Board shall prepare lists of approved devices, appliances or equipment which it finds are important for the maintenance or restoration of health, employability or self-management (taking into consideration the reliability and cost of each item). The Board will also specify the circumstances or the frequency with which the item may be prescribed at the cost of the Health Security program.

(Section 27.) The professional services of optometrists and podiatrists are covered, subject to regulations, as are diagnostic or therapeutic services. The care of a psychiatric patient in a mental health day care service is covered for up to 60 days (day care benefits are unlimited if furnished by a comprehensive health service organization or by a community mental health center). Ambulance and other emergency transportation services are covered, as well as non-emergency services where (as in some sparsely settled areas) transportation is essential to overcome special difficulty of access to covered services.

Supporting services such as psychological, physiotherapy, nutrition, social work and health education are covered if they are part of institutional services or are furnished by a comprehensive health service organization. This establishes the important principle that these and other supporting services should be provide as part of a coordinated program of health maintenance and care. Psychologists, physical therapists, social workers, etc. will not be permitted to establish independent practices and bill the program on a fee-for-service basis. This is intended to assure that whenever services of this nature are provided they are under appropriate medical supervision and are germane to the over-all care of the patient.

(Section 28.) Health services furnished or paid for under a workmen's compensation law are not covered. Reimbursement for loss of earnings is so closely interlocked with the health services aspects of workmen's compensation that absorption of the health services portion of workmen's compensation by Health Security could have the effect of delaying findings of eligibility for income payments.

School health services are covered only to the extent provided in regulations.

The Board may exclude from coverage medical or surgical procedures which are essentially experimental in nature. The Board may exclude coverage of specified non-emergency surgical procedures unless an appropriately qualified specialist has been consulted and has recommended surgery. Individuals who enroll in a comprehensive health service organization or enroll themselves with a primary practitioner accepting capitation payments are not entitled to seek covered services from other providers of services (except as specified in regulations). Surgery primarily for cosmetic purposes is excluded from coverage.

The services of a professional practitioner are not covered if they are furnished in a hospital which is not a participating provider. This is intended to discourage physicians from admitting patients to hospitals which cannot or will not meet standards for participation in the program.

Part C—Participating providers of services

(Section 41.) Participating providers are required by subsection (a) to meet standards established in this title or by the Board. In addition, they must agree to provide services without discrimination, to make no charge to the patient for any covered service, and to furnish data necessary for utilization review by professional peers, statistical studies by the Board, and verification of information for payments.

Under subsection (b) the Board may, for those surgical procedures for which advance consultation is required under section 28, require pathology reports on tissue removed and clinical abstracts or discharge reports of the cases.

(Section 42(a).) Professional practitioners licensed when the program begins are eligible to practice in the State where they are licensed. All newly licensed applicants for participation must meet national standards established by the Board in addition to those required by their State. While stopping short of creating a Federal licensure system for health professionals, this will guarantee minimum national standards. A state-licensed practitioner who meets national standards will be qualified to provide Health Security covered services in any other state. (See also Section 56(a)(1).)

(b) For purposes of this title a doctor of osteopathy is a physician, as is a dentist when performing procedures which, in generally accepted medical practice, may be performed either by a physician or a dentist.

(c) Participating professional providers shall be required to meet continuing education requirements established by the Board (in consultation with appropriate professional organizations).

(d) Major surgery and certain other specialty services shall be covered only when provided by a board certified or board eligible physician (except in emergency circumstances). Physicians who do not meet these standards but who are providing such services as a substantial part of their practice when the program begins may be found qualified if they meet standards established by the Board and, where appropriate, if recommended by a participating hospital.

(Section 43.) This section establishes conditions of participation for general hospitals similar to those required by Medicare. Two requirements not found in the Medicare program are: (1) that the hospital must not discriminate in granting staff privileges on any grounds unrelated to professional qualifications; (2) that the hospital establish a pharmacy and drug therapeutics committee for supervision of hospital drug therapy. Medicare allows any hospital accredited by the Joint Commission on the Accreditation of Hospitals (if it provides utilization review) to participate in the program, thus in effect delegating to the Commission the determination whether the standards are met. This title requires all participating hospitals to meet standards established by the Board.

(Section 44.) Psychiatric hospitals will be eligible to participate only if the Board finds that the hospital (or a distinct part of the hospital) is engaged in furnishing *active* diagnostic, therapeutic and rehabilitative services to mentally ill patients. Psychiatric hospitals are required to meet the same standards as those prescribed for general hospitals in Section 43, and such other conditions as the Board finds necessary to demonstrate that the institution is providing active treatment to its patients. These standards will exclude costs incurred by state mental institutions to the extent they serve domiciliary or custodial functions. In addition, psychiatric hospitals must be accredited by the Joint Commission on the Accreditation of Hospitals. (As in Medicare, accreditation

is an *additional* requirement in the case of psychiatric hospitals, as further assurance that they meet the requirements of an active treatment program.)

(Sections 45 and 46.) Section 45 establishes conditions of participation for skilled nursing homes similar to those established for extended care facilities under Medicare. Important differences, however, are the requirement for affiliation with a participating hospital or comprehensive health service organization (see Section 52(b), and changes in the requirements for utilization review (see Section 51). Under section 46 participation by home health agencies will be limited to public agencies and non-profit private organizations—proprietary home health agencies are specifically excluded.

(Section 47.) Subsection (a) describes a comprehensive health service organization which undertakes to provide an enrolled population either with complete health care or, at the least, with complete Health Security services (other than institutional services, mental health or dental services) for the maintenance of health and the care of ambulatory patients. The bill, in its aim to improve the methods of delivery of health services, places much emphasis on the development of new organizations of this kind and the enlargement of old ones.

The section is designed to accommodate forms of organization typical of existing prepaid group practice plans, but also to be flexible enough to permit experimentation with somewhat different forms. In some urban or rural areas, for example, it may be impracticable to bring all of the various services together in one place, and the section has been designed to encompass what has been described as "comprehensive group practice without walls"; the basic essential is the assumption of responsibility for a reasonably comprehensive range of services (including health maintenance) on a continuing and coordinated basis to a group of persons who have chosen to receive all or nearly all their health care from the organization.

Other requirements are spelled out in this section: The organization must furnish services through the prepaid group practice of medicine, or as near an approximation to prepaid group practice as is feasible. It must be a nonprofit organization, or if several providers share in the furnishing of services the prime contractor with the Board must be nonprofit. All persons living in or near a specified service area will be eligible to enroll, subject to the capacity of the organization to furnish care and subject to minimal underwriting protections. Services must be reasonably accessible to persons living within the specified service area. Periodic consultation with representatives of enrollees is required. Professional policies and their effectuation, including monitoring the quality of services and their utilization, are to be the responsibility of a committee or committees of physicians. Health education and the use of preventive services must be stressed, and lay persons are to be employed so far as is consistent with good medical practice. Charges for any services not covered by Health Security must be reasonable. Finally, the organization must agree to pay for services furnished by other providers in emergencies, either within the service area of the organization or elsewhere, but may meet this requirement to the extent feasible through reciprocal service arrangements with other organizations of like kind.

Subsection (b) makes clear that the organization, or professionals furnishing services for it, may also serve non-enrollees, with payment to be made to the organization, or, at its request, to such professionals.

(Section 48.) This section permits a foundation sponsored by a city, county, or State medical or dental society, by agreement with the Board, to participate as a provider of services. The foundation's general policies must be developed, and reviewed periodically, by the society or a committee selected by it, and it must establish a professional group to review the quality and utilization of services. Generally, the foundation must furnish all covered medical or dental services, and may furnish other covered or non-covered services if the Board approves; it must accept for enrollment any resident of the area it serves, subject to the same limitations as appear in section 47(a). It must permit any practitioner who meets its professional qualifications to participate in furnishing services, whether or not he is a member of the sponsoring society. The foundation must agree to pay for emergency services to its enrollees in or outside its area, and must make no more than reasonable charges for any services not covered by Health Security. Finally, it must meet requirements for continuing education and other requirements which the Board may specify.

(Section 49.) This section deals with several classes of health organizations that vary widely, even within a single class, in their structure and in the scope of the services which they offer. Because statutory specifications cannot well be tailored to so many variables, the section sets forth only a general statement of the kinds of organizations to which it relates and leaves participation of each organization to a case-by-case decision of the Board.

Subsection 49(a)(1) permits the participation of community health centers or the like which, though furnishing services as comprehensive as are required by section 47(a), do not serve an enrolled or otherwise predetermined population and may not meet some other requirements of section 47(a). Subsection (a)(2) authorizes the Board to deal separately with the primary care portion of a system of comprehensive care where it is necessary to rely on arrangements with other providers, rather than on a unified structure, to round out the other elements of the system, Where organizations meeting the extensive requirements of section 47(a) are not available, these two subsections will give the Board flexibility in furthering one of the bill's prime objectives, the development and broad availability of comprehensive services furnished on a coordinated basis.

Because of the extent to which mental health services are separated from other health care, subsection (a)(3) permits the Board to contract directly with public or other nonprofit mental health centers and mental health day care services.

If a State or local public health agency is providing preventive or diagnostic services, such as immunization or laboratory tests, the Board may under subsection (a)(4) contract with it for the continuance of these services. Subsection (a)(5) permits the Board to contract with nonprofit health prepayment or insurance organizations which provide substantially comprehensive services to ambulatory patients, on terms similar to those specified in section 48 for professional foundations.

In the field of private practice, physicians or dentists or other practitioners may group themselves in a clinic, nonprofit or proprietary, or in any number of other ways, and it may be more convenient both to them and to the Board to regard them as an entity than to deal with each practitioner separately. Subsection (a)(6) permits this. The Board will have wide discretion in contracting with such entities subject only to the limitation that, like other organizations described in section 49(a), the entity may not (under section 88(a)) be paid on a fee-for-service basis. Practitioners who elect that method of payment may of course pool their bills for submission to the Board, but there is no reason to contract with a unit for the payment of fees to it.

Subsection (d) sets forth the Board's authority to specify terms and conditions or agreements under this section. Subsection (c) makes clear that agreements with the Board under section 48 or 49 shall not (unless expressly so stipulated) preclude practitioners furnishing services under the agreements from furnishing other services as independent providers.

(Section 50.) This section specifies the broad and general conditions under which independent pathology laboratories, independent radiological services, providers of drugs, devices, appliances, equipment, or ambulance services may qualify as providers under Health Security. As under Medicare, a Christian Science Sanatorium qualifies if operated, or listed and certified, by the First Church of Christ, Scientist, Boston.

(Section 51.) The requirements of utilization review in hospitals and skilled nursing homes are in the main similar to those which Medicare has, since 1966, imposed with respect to services to aged patients. In Health Security the requirements will of course apply to the entire patient population. As in Medicare, the review is designed to serve a dual purpose: identification of certain specific misuses of the institutional services with a view of their termination, and a focusing of continuing attention and concern of the medical staff on the necessity for efficient utilization of institutional resources. Section 51(a) strengthens the educational aspect of the process by requiring specifically that records of reviews be maintained and statistical summaries of them be reported periodically to the institution and its medical staff (and, on request, to the Board). As under Medicare, the review committee will consist of two or more physicians, with or without other professional participation; and in the case of hospitals, will normally be drawn from the medical staff unless for some reason an outside group is required. For skilled nursing homes, on the other hand, section 51(c) departs from Medicare by permitting as an alternative that the Committee be established by the State or local public health agency under contract with the Board, or

failing that, by the Board. If the nursing home operates under a consolidated budget with a hospital, the review will be made by the hospital committee. Like Medicare, section 51(d) calls for review of specific long-stay cases as required by regulations, and section 51(e) for notice to the institution, the attending physician, and the patient when a decision adverse to further institutional services is made.

(Section 52.) Subsection (a) of Section 52 is also like Medicare in requiring a participating skilled nursing home to have in effect an agreement with at least one participating hospital for the transfer of patients and medical and other information as medically appropriate. Subsection (b) introduces a requirement, applicable two years after the effective date of health benefits to both skilled nursing homes and home health service agencies, of affiliation with a participating hospital or comprehensive health service organization. Unless the medical staff of the hospital or organization undertakes to furnish the professional services in the nursing home or the professional services of the home health service agency, that medical staff or a committee of it must assume responsibility for these services. Subsection (c) allows the Board to waive the application of either of these requirements to a skilled nursing home or a home health agency which the Board finds essential to the provision of adequate services, if (but only for as long as) lack of a suitable hospital or organization within a reasonable distance makes a transfer or an affiliation agreement impracticable.

(Section 53.) If the construction or substantial enlargement of a hospital or skilled nursing home has been undertaken after December 31, of the year of enactment, without prior approval by a planning agency designated by the governor of the state or the Board, section 53 precludes the institution from participating in the Health Security program. This should greatly strengthen state and local planning authorities.

(Section 54.) Subsection (a) requires the Board in fixing, for institutional and other providers, standards beyond those specified in the statute, to take into consideration criteria established or recommended by appropriate professional organizations. The Board is given authority under subsection (b) to require upgrading in staffing patterns and personnel standards of participating institutional providers that fall below standards recommended by such organizations.

(Section 55.) Institutions of the Department of Defense and the Veterans' Administration, and institutions of the Department of Health, Education, and Welfare serving merchant seamen or Indians or Alaskan natives, are excluded by section 55 from serving as participating providers, as is also any employee of these institutions when he is acting as an employee. The Board will, however, provide reimbursement for any services furnished (in emergencies, for example) by these institutions or agencies to eligible persons who are not a part of their normal clientele. It will also provide reimbursement for services furnished by the Public Health Service under the recently enacted Emergency Health Personnel Act of 1970.

(Section 56.) This section overrides, for purposes of the Health Security program, State laws of several kinds which inhibit the utilization or the mobility of health personnel, cloud the legality of so-called "corporate practice" of health professions, or restrict the creation of group practice organizations. The authority of Congress to do this, in conjunction with a program of Federal expenditure to provide for the general welfare, flows from the Supremacy Clause of the Constitution and seems now to be clearly established. (*Ivanhoe Irrigation District* v. *McCracken*, 357 U.S. 275 (1958); *King* v. *Smith*, 392 U.S. 309 (1968)).

The first three paragraphs of subsection (a), while stopping short of creating a system of Federal licensure for health personnel, will greatly facilitate both the interstate mobility of State licensees and the effective use of ancillary personnel in the furnishing of health care. The dispensations contained in these paragraphs will be available to persons who meet national standards established by the Board.

Paragraph (1) permits a physician, dentist, optometrist, or podiatrist, licensed in one State and meeting the national standards, to furnish Health Security benefits in any other state, the scope of his permissible practice being governed by the law of the State in which he is practicing. This paragraph obviates the difficulty and cost which a practitioner may encounter, especially where reciprocity of licensure is not available, in taking up practice in a State in which he has not been licensed.

Paragraph (2) grants a similar authority to other health professional and nonprofessional personnel. For occupations such as pharmacy and professional nurs-

ing, which are subject to licensure in all States, a person can avail himself of this paragraph only if he is licensed in one State and meets the national standards; in other cases, where licensure is not universally required, compliance with national standards is sufficient. Here again, impediments to mobility created by existing licensure laws will be removed.

The restrictions which many professional practice acts impose on the use of lay assistants, and the legal uncertainties which often deter such use, discourage practices that can increase greatly, without sacrifice of safety, the volume of services which professionals can render. Accordingly, paragraph (3) of subsection (a) enables the Board to permit physicians and dentists, participating in public or nonpublic hospitals and comprehensive health service organizations, to use ancillary health personnel, acting under professional supervision and responsibility, to assist in furnishing Health Security benefits. Such assistants may do only things which the Board has specified, and may be used only in the context of an organized medical staff or medical group. Persons employed as assistants must not only meet national standards for their respective occupations, but must also satisfy special qualifications that the Board may set for particular acts or procedures.

In the interest of encouraging salaried practice and the integration of professional practitioners into well-structured organizations for the delivery of health services, paragraph (4) of subsection (a) does away with the "corporate practice" rule insofar as concerns participating public or other nonprofit hospitals and comprehensive health service organizations. These institutions may employ physicians or make other arrangements for their services, unless in the unlikely event that lay interference with professional acts or judgments should be threatened. No conflict of interest results from such arrangements; in the nonprofit setting loyalty to employer and loyalty to patient run parallel.

Some state laws place restrictions of one kind or another on the incorporation of group practice organizations. When these restrictions prevent the State incorporation of an organization meeting the strict requirements of the Health Security Act, section 56(b) empowers the Secretary to incorporate it for purposes of the Act. Except for the special restrictions, State law will govern the corporation.

Part D—Trust fund; allocation of funds for services

(Section 61.) This section establishes the Health Security Trust Fund, to receive the net assets of existing (Medicare) funds taken over by the Health Security program, the yield of the Health Security taxes, and the Government's contribution from general revenues amounting to 100% of the yield from these taxes.

Accordingly, this section amends the Social Security Act to convert the present Hospital Insurance Trust Fund (Medicare, Title XVIII, Part A) into the Health Security Trust Fund, and to provide that the appropriations that would have gone into the former (increased by the new tax provisions) shall go into the latter. In addition, on the effective date of benefits the assets and liabilities of the Federal Supplementary Medical Insurance Trust Fund (Medicare, Title XVIII, Part B) will be transferred to the Health Security Trust Fund. Also, a Government contribution to the new Trust Fund is authorized to be appropriated, equal to 100% of the aggregate yield from the payroll taxes on employees and employers and the taxes on self-employment and unearned income, imposed for Health Security under Title II of this Act. The Fund will also receive recoveries of overpayments, and receipts from loans and other agreements. To implement the role of the Trust Fund, the Managing Trustee (the Secretary of the Treasury) will make payments from the Trust Fund provided for under Title I, as the Board certifies, and with respect to administrative expenses as authorized annually by the Congress.

(Section 62.) The Health Security program is intended to operate on a budget basis overall. Accordingly, subsection (a) requires the Board to determine for each fiscal year the maximum amount which may be available for obligation from the Trust Fund. The amount so determined in advance (by March 1 preceding each fiscal year) shall not exceed the smaller of two stated limitations. The first limit is fixed at 200% of the expected net receipts from all the Health Security taxes (i.e., the tax receipts augmented by 100% thereof, to be appropriated into the Fund from general revenues of the Government). The second limit, applicable to each fiscal year after the first year of benefit operation, (i.e., after a year's availability of covered services), is an amount equal to the estimated obligations of the current year (within which the estimate is being made), subject to cer-

tain adjustments. Such adjustments will reflect changes expected in: (A) the price of goods and services; (B) the number of eligible persons; (C) the number of participating professional providers, or the number of capacity of institutional or other participating providers so far as such changes are not readily adequately reflected; and (D) the expected cost of program administration.

In the interest of prudent fiscal management, subsection (b) requires the Board to restrict its estimate of the amount available for obligation in the next fiscal year (in accordance with subsection (a)) if the Board estimates that the amount in the Trust Fund at the beginning of the next fiscal year will be less than one-quarter of the total obligations to be incurred for the current year, and that such restriction will not impair the adequacy or quality of the services to be provided. Also, the Board is required to reduce its alternative estimate of the maximum amount to be available if it finds that the aggregate cost to be expected has been reduced (or an expected increase has been lessened) through improvement in organization and delivery of service or through utilization control.

Subsection (c) provides against various other contingencies which may result in increase or decrease in the estimate of the maximum amount to be available for obligation in the next fiscal year. The amount may be modified before or during the fiscal year: if the Secretary of the Treasury finds that the expected Health Security tax receipts will differ by 1 percent or more from the estimate used under subsection (a); or if the Board finds that either its factors of expected change or the cost of administration is expected to differ from the estimate by 5 percent or more; or if an epidemic, disaster or other occurrence compels higher expenditure than had been expected. If, as a result, the maximum estimate has to be increased (rather than being decreased), the Board (through the Secretary) shall promptly report its action to the Congress with its reasons.

(Section 63.) Subsection (a) provides that three separate accounts shall be established in the Health Security Trust Fund—a Health Services Account, a Health Resources Development Account, and an Administration Account, as well as a residual General Account. Subsection (b) provides that in each of the first two years of program operation, 2% of the Trust Fund shall be set aside for the Health Resources Development Fund; and the allocation shall increase by 1% at two-year intervals to 5% within the next 6 years. The money in this account will be used exclusively for the planning and system improvement purposes described in part F.

(c) (d) After deducting the amount appropriated by the Congress into the Administration Account, the remainder of the monies shall be allocated to the Health Services Account, and shall be used exclusively for making payment for services in accordance with part E.

(Section 64.) This section provides for allocation of the Health Services account among the regions of the country. (a) The allocation to each region shall be based on the aggregate sum expended during the most recent 12-month period for covered services (with appropriate modification for estimated changes in the price of goods and services, the expected number of eligible beneficiaries, and the number of participating providers). (b) In allocating funds to the regions the Board shall seek to reduce, and over the years gradually eliminate, existing differences among the regions in the average per capita amount expended upon covered health services (except when these reflect differences in the price of goods and services). To accomplish this, the Board will curtail increases in allocations to high expenditure regions and stimulate an increase in the availability and utilization of services in regions in which the per capita cost is lower than the national average. (c) A contingency reserve of up to 5% may be withheld from allocation. If the remaining funds available are inadequate, allocations will be reduced pro rata. (d) Allocations may be modified before or during a fiscal year if the Board finds this is necessary.

(Section 65.) The Board will divide the allocation to each region into funds available to pay for: institutional services; physician services; dental services; furnishing of drugs; furnishing of devices, appliances and equipment; and other professional and supporting services, including subfunds for optometrists, podiatrists, independent pathology laboratories, independent radiology services, and other items. The percent allocated to each category of service may vary from region to region. In determining the allocation to these funds, it will be guided by the previous year's expenditures for each category of service but also take into account trends in the utilization of services and the desirability of stimulating improved utilization of resources. It will encourage a shift from heavy reliance

on institutional care to better utilization of preventive and ambulatory services.

(Section 66.) These regional funds will be subdivided among the health service areas in each region, primarily upon the basis of the previous year's expenditure for each kind of service. Again, the Board will gradually attempt to achieve the equalization of services within each region by restraining the increase of expenditures in high cost areas and channeling funds into health service areas with a low level of expenditures.

(Section 67.) Before or during a fiscal year, the division of regional funds by classes of service or the allotments to health service areas may be modified if necessary or if indicated by newly acquired information.

Part E—Payment to providers of services

(Section 81.) Payments for covered services provided to eligible persons by participating providers will be made from the Health Services Account in the Trust Fund.

(Section 82.) This section delineates methods of paying professional practitioners. Every independent practitioner (physician, dentist, podiatrist, or optometrist) shall be entitled to be paid by the fee-for-service method (subsection (a)), the amounts paid being in accordance with relative value scales prescribed after consultation with the professions (subsection (g)). Each physician engaged in general or family practice of medicine in independent practice may elect to be paid by the capitation method if he agrees to furnish individuals enrolled on his list with all necessary and appropriate primary services, make arrangements for referral of patients to specialists or institutions when necessary, and maintain records required for medical audit; and independent dentist practitioners may elect the capitation method of payment similarly (subsection (b)).

These requirements in connection with capitation payments are intended to assure that the physician (or dentist) provides to his patients all professional services within the range of his undertaking and secures other needed services by referral. Through regular medical audits, the Board will monitor the level and quality of care provided.

When necessary to assure the availability of services in a given area, subsection (c) permits paying an independent practitioner a full-time or part-time stipend in lieu of or as a supplement to other methods of compensation. This method of payment will be used selectively by the Board, mainly to encourage the location of practitioners in remote or deprived areas. Practitioners may also be reimbursed for the special costs of continuing education required by the Board and for maintaining linkages with other providers—for example, communication costs. Incentives operative under this provision will encourage physicians to improve the quality and continuity of patient care, even if the physician does not participate in a group practice. The Board may pay for specialized medical services on a per session, or per case basis, or may use a combination of methods authorized by this section.

Subsection (d) defines the capitation method of payment.

Subsection (e) of this section describes the method to be used in applying, as between practitioners electing the various methods of payment the monies available in each health service area for payment to each category of professional providers. From the amount allocated to each service area, the Board will earmark funds sufficient to pay practitioners receiving stipends and for the professional services component of institutional budgets, such as hospitals. The remainder of the money will be divided to compute the amount available per capita in the eligible population of the area for each category of service (i.e. physicians, dentists, podiatrists, optometrists). This per capita amount in each category will fix the capitation payments to organizations that undertake to provide the full range of services in that category to enrolled individuals. Lesser amounts will be fixed for more limited services. For example, if the per capita amounts available for physician, dental and optometric services are $65, $25, and $5 respectively, primary physicians accepting capitation payments will receive the percentage of that $65 which is allocated for primary services, a medical society sponsored foundation would receive the entire $65 for physician services, a dental society foundation would receive the $25 allocated for dental services, and organizations which undertake to provide all physician, dental and optometric services to enrolled individuals will receive $95 for each enrolled individual.

The budgeted per capita amount for each type of covered service (physician, dental, etc.) will be divided between the categories of providers of service accord-

ing to the number of individuals who elect to receive care from those providers. For example, in a city of 100,000 people, 25,000 may enroll in a comprehensive health service organization. Using the figures cited in the example above, the Board will pay the comprehensive health service organization $1,625,000 ($65 x 25,000) for physician services. The other 75,000 individuals elect to receive their physician services from solo, fee-for-service practitioners. The Board will create a fund of $4,875,000 ($65 x 75,000) to pay all fee-for-service bills submitted by physicians in that community, in accordance with relative value scales and unit values fixed by the Board. The fund for fee payments will be augmented to the extent that some capitation payments have been lowered because they cover only primary services, and may be augmented further where a substantial volume of services is furnished, on a fee basis, to nonresidents of the area.

Subsection (h) authorizes the Board to experiment with other methods of reimbursement so long as the experimental method does not increase the cost of service or lead to overutilization or underutilization of services.

(Section 83.) Hospitals will be paid on the basis of a predetermined annual budget covering their approved costs. To facilitate review of these budgets, the Board will institute a national uniform accounting system. Subsection (b) stipulates that the costs recognized for purposes of the budget will be those incurred in furnishing the normal services of the institution except as changed by agreement, or by order of the Board under section 134. This will enable the Board, on the basis of State and local planning, to eliminate gradually any wasteful or duplicative services, and also to provide for an orderly expansion of hospital services where needed.

Physicians and other professional practitioners whose services are held out as available to patients generally (such as pathologists and radiologists) will be compensated through the institutional budget, whatever the method of compensation of such practitioners and whether or not they are employees of the hospital. This departs from the practice in Medicare which allowed independent billing by such physicians. The institution's budget may also be increased to reflect the cost of owning or operating an affiliated skilled nursing home, or home health service agency. Hospital budgets will be reviewed by the Board, locally or regionally, which may permit participation by representatives of the hospitals in each region. Budgets may be modified before, during, or after the fiscal year if changes occur which make modification necessary.

(Section 84.) If an entire psychiatric hospital is found by the Board to be providing active treatment to its patients, and the institution is therefore primarily engaged in providing covered services to eligible beneficiaries, it will be paid on the same basis as a general hospital (on the basis of an approved annual budget). Otherwise the Board will negotiate a patient-day rate to be paid for each day of covered service provided to an eligible beneficiary.

(Section 85.) This section provides that skilled nursing homes and home health agencies will be paid in the same manner as a general hospital (on an approved annual budget basis). The Board may specify use of nationally uniform systems of accounting and may prescribe by regulation the items to be used in determining approved costs and the services which will be recognized in budgets.

(Section 86.) Reimbursement for drugs will be made to the dispensing agent on the basis of an official "product price" for each drug on the approved list plus a dispensing fee. The official product price will be set at a level which will encourage the pharmacy to purchase substantial quantities of the drug (this should result in significant reductions in the unit cost of each drug). The official price may be modified regionally to reflect differences in costs of acquiring drugs. The Board will establish dispensing fee schedules for reimbursing independent pharmacies. These schedules will take into account regional differences in costs of operation, differences in volume, level of services provided and other factors.

(Section 87.) A comprehensive health service organization or professional foundation will be paid for other than hospital or skilled nursing home services, on the basis of a fixed capitation rate multiplied by the number of eligible enrollees. The amount of the capitation rate will be determined by the per capita amounts available for the several professional services in the area, and a rate fixed by the Board as the average reasonable and necessary cost per enrollee for such other covered services as the organization or foundation undertakes to provide (exclusive of hospital and skilled nursing home services) such as physical therapy, nutrition, etc.

A comprehensive health service organization or foundation which undertakes to provide for hospital or skilled nursing home services for its enrollees may be paid on an approved annual budget basis or on a capitation basis. An organization or foundation which arranges for such services through other providers may be reimbursed on the basis of patient days of service utilized by enrollees. The organization or foundation will also be entitled to share in up to 75% of any savings which are achieved by lesser utilization of such institutional services. Entitlement to such savings is conditional upon a finding by the Board that the services of the organization or foundation have been of high quality and adequate to the needs of its enrollees, and that the average utilization of hospital or skilled nursing services by enrollees of the comprehensive health service organization or foundation is less than use of such services by comparable population groups under comparable circumstances. This money may be used by the comprehensive health service organization or professional foundation for any of its purposes, including the provision of services which are not covered under the Health Security Program.

(Section 88.) Subsection (a) provides that organizations or agencies with which the Board has entered into an agreement under section 49 (such as a neighborhood health center, a nonprofit mental health center, a nonprofit prepayment insurance agency, or local health agency furnishing preventive or diagnostic services) may be paid by any method agreed upon other than fee-for-service.

Subsection (b) provides that independent pathology or radiology services may be paid on the basis of an approved budget or such other methods as may be specified in regulations.

Subsection (c) leaves the method of payment for other types of supporting services to be specified in regulations.

(Section 89.) All participating providers will be paid from the Health Services Account in the Trust Fund at such time or times as the Board finds appropriate (but not less often than monthly). The Board may make advance payment to supply providers with working funds when it deems advisable.

Part F—Planning; funds to improve services and to alleviate shortages of facilities and personnel

(Section 101.) This section sets forth the general purposes of Part F and authorizes appropriations, and subsequently expenditure from the Trust Fund, for these purposes. The part envisages a substantial strengthening of the health planning process throughout the country with an eye, first, to the special needs for personnel, facilities and organization which inauguration of the Health Security program will entail, and thereafter, to continuing improvement of the capabilities for effective delivery of health services. Beyond this, the part enables the Board, through selective financial assistance, to stimulate and assist in the development of comprehensive health services, the education and training of health personnel who are in especially short supply, and the betterment of the organization and efficiency of the health delivery system. For the two-year "tooling-up" period, appropriations of $200 and $400 million are authorized for financial assistance. Beginning with the effective date of health benefits, percentages of the Trust Fund expenditures will be earmarked for such assistance (section 63). From that date on, the leverage of these expanding funds will supplement and reinforce the incentives, which are built into the normal operation of the Health Security program, for improvement of the organization and methods of delivery of health services.

(Section 102). This section directs the Secretary, in collaboration with State comprehensive health planning agencies, regional medical programs, and other planning agencies, to institute a continuous process of health service planning. Prior to the effective date of health benefits, the planning process must give first consideration to the most acute shortages and needs for delivery of covered services under this Act. Thereafter, planning shall be focused on maximizing continuing capability for delivery of these services.

This section places primarily on the State agencies the responsibility for coordinating the work of the many health planning agencies within the States, and for coordination with interstate agencies and with agencies planning in other fields related to health, but charges the Secretary with this function in any State that fails to meet the responsibility. The section amends the Public Health Service Act to increase the authorized appropriations for State and for

local health planning to extend them to 1978, and to condition grants upon collaboration for these national purposes. Thus the section, strengthening State planning agencies, focuses in them a responsibility, visualized in the "partnership-for-health" legislation but in many States not yet an operating reality, for pulling together all health planning efforts within their territories. The task will not be easy, but it is one that is lent new urgency by the Health Security program. It belongs more properly to the States than to the national Government, but if any State proves unequal to the task it must and will be assumed by the Secretary.

(Section 103.) In administering part F, this section stipulates, the Board will give priority to improving comprehensive health services for ambulatory patients through the development or expansion of organizations furnishing such services, the recruitment and training of personnel, and the strengthening of coordination among providers of services. Financial assistance will be dispensed, so far as possible, in accordance with recommendations of the appropriate health planning agencies. Funds will not be used to replace other Federal financial assistance, and may supplement other assistance only to meet specific needs of the Health Security program. Other Federal assistance programs are to be administered when possible to further the objectives of part F, and the Board may provide loans or interest subsides to help the beneficiaries of other programs to meet the requirements for non-Federal funds.

(Section 104.) Help of several kinds will be available under this section for the creation or the enlargement of organizations and agencies providing comprehensive care to ambulatory patients—either organizations to serve an enrolled population on a capitation basis, or agencies such as neighborhood health centers which need not require enrollment in advance. Grants may be made to any public or other nonprofit organization (which need not be a health organization) to help meet the cost, other than construction cost, of establishing such a health service organization, and to existing health service organizations to help meet the cost of expansion; the maximum grants being, in the former case 90 percent of the cost, in the latter 80 percent. The Board may also provide technical assistance for these purposes. Loans may be made for the cost of necessary construction, subject to the same 90 and 80 percent limitations on amount. Finally, start-up costs of operation of these organizations may be underwritten, for five years in the case of organizations which must build up an enrollment to assure operating income, and in other cases until the Health Security program begins payment for services in the first year of entitlement to benefits. The effect of these several provisions is to reduce sharply, if not eliminate, the financial obstacles which have heretofore impeded the growth of comprehensive group practice organizations.

(Section 105.) This section contains a series of provisions to assist in the recruitment, education, and training of health perosnnel. The Board will establish priorities to meet the most urgent needs of the Health Security system, but the priorities will be flexible both as between different regions and from time to time. Professional practitioners will be recruited for service in shortage areas, both urban and rural, and in comprehensive health service organizations, and such practitioners may be given income guarantees. Other Federal assistance for health education and training will be availed of, but the Board may supplement the other assistance if the Board believes it inadequate to the needs, until Congress has had opportunity to review its adequacy. The training authorized includes the development of new kinds of health personnel to assist in furnishing comprehensive services, and the training of area residents to participate in personal health education and to serve liaison functions and serve as representatives of the community in dealing with health organizations. Grants may be made to test the utility of such personnel, and to assist in their employment before the effective date of health benefits. Education and training are to be carried out through contracts with appropriate institutions and agencies, and suitable stipends to students and trainees are authorized. Physicians will be recruited and trained to serve as hospital medical directors. Finally, special assistance may be given, both to institutions and to students, to meet the additional costs of training persons disadvantaged by poverty, membership in minority groups, or other cause.

(Section 106.) This section authorizes special improvement grants: first, to any public or other nonprofit health agency or institution to establish improved coordination and linkages with other providers of services; and, second, to orga-

nizations providing comprehensive ambulatory care, to improve their utilization review, budget, statistical, or records and information retrieval systems, to acquire equipment needed for those purposes, or to acquire equipment useful for mass screening or for other diagnostic or therapeutic purposes.

(Section 107.) This section provides that loans under Part F are to bear 3 percent interest and to be repayable in not more than 20 years. Other terms and conditions are discretionary with the Board, except for required compliance with the Davis-Bacon Act and related laws. Repayment of loans made from general appropriations will go to the general fund of the Treasury; repayment of later loans will revert to the Health Resources Development Account in the Trust Fund.

(Section 108.) This section specifies that payments under Part F shall be in addition to, and not in lieu of, payments to providers under Part F.

Part G—Administration

This part of the bill creates an administrative structure within the Department of Health, Education, and Welfare with exclusive responsibility for administration of the Health Security program. Program policy will be made by a five-member Board serving under the Secretary of HEW. The Board will be assisted by a National Health Security Advisory Council which will recommend policy and evaluate operation of the program, and an Executive Director who will serve as Secretary to the Board and chief administrative officer for the program. Administration of the program will be greatly decentralized among the HEW Regional Offices. Regional and local health services advisory councils will advise on all aspects of the program in their regions and local areas. The Board may also appoint such professional or technical committees as it may deem necessary.

(Section 405.) This section authorizes appropriations for the conduct of studies under this title and confers authority to employ consultants and to contract for services in making the studies.

(Section 121.) This section establishes a five-member full-time Health Security Board serving under the Secretary of Health, Education, and Welfare. Board members will be appointed by the President with the advice and consent of the Senate, for five-year overlapping terms. Not more than three of the five appointees may be members of the same political party. A member who has served two consecutive terms will not be eligible for reappointment until two years after the expiration of his second term. One member of the Board shall serve as chairman at the pleasure of the President.

(Section 122.) This section charges the Secretary of HEW and the Board with responsibility for performing the duties imposed by this title. The Board shall issue regulations with the approval of the Secretary. It is required to engage in the continuous study of operation of the Health Security program; and, with the approval of the Secretary, to make recommendations on legislation and matters of administrative policy, and to report to the Congress annually on administration and operations of the program. The report will include an evaluation of adequacy and quality of services, costs of services and the effectiveness of measures to restrain the costs. The Secretary of HEW is instructed to coordinate the administration of other health-related programs under his jurisdiction with the administration of Health Security, and to include in his annual report to the Congress a report on his discharge of this responsibility.

The Civil Service Commission is instructed to make every effort to facilitate recruitment and employment, to work in the Health Security Administration, of persons experienced in private health insurance administration and other pertinent fields.

(Section 123.) This section creates the position of an Executive Director, appointed by the Board with the approval of the Secretary. The Executive Director will serve as secretary to the Board and shall perform such duties in administration of the program as the Board assigns to him. The Board is authorized to delegate to the Executive Director or other employees of HEW any of its functions or duties except the issuance of regulations and the determinaiton of the availability of funds and their allocations to the regions.

(Section 124.) This section provides that the program will be administered through the regional offices of the Department of HEW. It also requires the establishment of local health service area offices and local offices.

The health service areas will in most instances be a State or a part of a State except where patterns in the organization of health services and the flow of

patients indicate that an interstate area would provide a more practical administrative unit. One of the responsibilities of local offices will be to investigate complaints about the administration of the program.

(Section 125.) Subsection (a) establishes a National Health Security Advisory Council, with the Chairman of the Board serving as the Council's Chairman and 20 additional members not in the employ of the Federal Government. A majority of the appointed members will be consumers who are not engaged in providing and have no financial interest in the provision of health services. Members of the Council representing providers of care will be persons who are outstanding in fields related to medical, hospital or other health activities or who are representatives of organizations or professional associations. Members will be appointed to four-year over-lapping terms by the Secretary upon recommendation by the Board.

Subsection (b) authorizes the Advisory Council to appoint professional or technical committees to assist in its functions. The Board will make available to the Council all necessary secretarial and clerical assistance. The Council will meet as frequently as the Board deems necessary, or whenever requested by seven or more members, but not less than four times each year.

Subsection (c) provides that the Advisory Council will advise the Board on matters of general policy in the administration of the program, the formulation of regulations and the allocation of funds for services. The Council is charged with responsibility for studying the operation of the program and utilization of services under it, with a view to recommending changes in administration or in statutory provisions. They are to report annually to the Board on the performance of their functions. The Board, through the Secretary, will transmit the Council's report to the Congress together with a report by the Board on any administrative recommendations of the Council which have not been followed, and a report by the Secretary of his views with respect to any legislative recommendations of the Council.

(Section 126). To further provide for participation of the community, the Board will appoint an advisory council for each region and local area. Each such Council would have a composition parallel to that of the National Council; and each will have the function of advising the regional or local representative of the Board on all matters directly relating to the administration of the program.

(Section 127.) The Board is authorized to appoint standing committees to advise on the professional and technical aspects of administration with respect to services, payments, evaluations, etc. These committees will consist of experts drawn from the health professions, medical schools or other health educational institutions, providers of services, etc. The Board is also authorized to appoint temporary committees to advise on special problems. The committees will report to the Board, and copies of their reports are to be made available to the National Advisory Council.

(Section 128.) Subsection (a) requires the Board to consult with appropriate State health and planning agencies to assure the coordination of the Health Security program with State and local activities in the fields of environmental health, licensure and inspection, health education, etc.

Subsection (b) requires the Board, whenever possible, to contract with States to survey and certify providers (other than professional practitioners) for participation in the program. This is similar to Medicare except that the Board is given authority to establish the qualifications required of persons making the inspections.

Subsection (c) authorizes the Board to contract with State agencies to undertake health education activities, supervision of utilization review programs, and programs to improve the quality and coordination of available services in that State.

Subsection (d) requires the Board to reimburse States for the reasonable cost of performing such contract activities and authorizes the Board to pay all or part of the cost of training State inspectors to meet the qualifications established by the Board.

(Section 129.) The Board is authorized to provide technical assistance either directly or through contract with a State to skilled nursing homes and home health agencies to supplement the skills of their permanent staff in regard to social services, dietetics, etc.

(Section 130.) Subsection (a) charges the Board with responsibility for informing the public and providers about the administration and operation of the Health Security program. This will include informing the public about entitle-

ment to eligibility, nature, scope, and availability of services. Providers would be informed of the conditions of participation, methods and amounts of compensation, and administrative policies. In support of the program's effort to improve drug therapy, the Board is authorized, with the approval of the Secretary, to furnish all professional practitioners with information concerning the safety and efficacy of drugs appearing on either of the approved lists (Section 25), indications for their use and contraindications. Information of this nature is not always available to practitioners.

Subsection (b) requires the Board to make a continuing study and evaluation of the program, including adequacy, quality and costs of services. Subsection (c) authorizes the Board directly or by contract to make detailed statistical and other studies on a national, regional, or local basis of any aspect of the title, to develop and test incentive systems for improving quality of care, methods of peer review of drug utilization and of other service performances, systems of information retrieval, budget programs, instrumentation for multiphasic screening or patient services, reimbursement systems for drugs, and other studies which it considers would improve the quality of services or administration of the program.

(Section 131.) This section authorizes the Board to enter into agreements with providers to experiment with alternative methods of reimbursement which offer promise of improving the coordination of services, their quality or accessibility.

(Section 132.) This section grants authority to the Board, in accordance with regulations, to make determinations of who are participating providers of service, determinations of eligibility, or whether services are covered, and the amount to be paid to providers. The Board is granted authority to termination participation of a provider who is not in compliance with qualifying requirements, agreements or regulations. But unless the safety of eligible individuals is endangered, the provider shall be entitled to a hearing before the termination becomes effective.

(Section 133.) This section establishes procedures for appeals similar to those under the Social Security Act.

(Section 134.) This section has one of the bill's most important provisions with respect to achieving improvement in coordination, availability, and quality of services. It greatly strengthens state and local planning agencies and gives the Board authority to curtail inefficient administration of participating institutional providers.

The Board is authorized to issue a direction to any participating provider (other than an individual professional practitioner) that, as a condition of participation, the provider add or discontinue one or more covered services. For example, if two community hospitals are operating maternity wards at low occupancy rates, the Board may require that one hospital cease to provide such service. A provider may be required to provide services in a new location, enter into arrangements for the transfer of patients and medical records, or establish such other coordination or linkages of covered services as the Board finds appropriate.

In addition, if the Board finds that services furnished by a provider are not necessary to the availability of adequate services, under this title, that their continuance is unreasonably costly, or that the services are furnished inefficiently (and that efforts to correct such inefficiency have proved unavailing) the Board may terminate participation of the provider.

No direction shall be issued under this section except upon the recommendation of, or after consultation with, the appropriate state health planning agency. And no direction shall be issued under this section unless the Board finds that it can be practicably carried out by the provider to whom it is addressed. The Board is required to give due notice and to establish and observe appropriate procedures for hearings and appeals, and judicial review is provided.

(Section 135.) Subsection (a) creates the positions of Deputy Secretary of Health, Education, and Welfare and Under Secretary for Health and Science in the Department of Health, Education, and Welfare.

Subsection (b) fixes the levels of compensation in the Executive pay rates scale for the Deputy Secretary (level II), the Under Secretary for Health and Science (level III), the Health Security Board chairman (level III), Board Members (level IV), and the Exec. Director (level V).

Part H—Miscellaneous provisions

(Section 141.) This section contains definitions of certain terms used in the title.

(Section 142.) This section stipulates that the effective date for entitlement for benefits will be July 1, of the second calendar year following enactment.

(Section 143.) Subsection (a) provides that an employer will not be relieved, by the enactment of the Health Security Act, of any existing contractural or other non-statutory obligation to provide or pay for health services to his present or former employees and their families. Subsection (b) expresses the sense of Congress that if, nevertheless, inauguration of the Health Security Program lessens the cost of an employer's aggregate obligations for health services to such persons, the savings should, at least for the period of any contract subsisting on the effective date of benefits, be applied to the payment of the employees' health security taxes, to wage increases, or to other employee benefits.

TITLE II

Part A—Payroll taxes

(Section 201.) Effective on January 1 of the second year after enactment, subsections (a) and (b) convert the existing Medicare hospital insurance payroll taxes into Health Security taxes, and raise the rates to 1 percent on employees and 3.5 percent on employers. Subsection (c) raises the wage base for the employee tax from the present $7,800 to $15,000 with subsequent further increase if wage levels rise, eliminates the wage ceiling from the employer tax, and broadens the definitions of covered employment to include foreign agricultural workers. employees of the U.S. and its instrumentalities (other than members of the armed forces, and the President, Vice-President, and Members of Congress), employees of charitable and similar organizations, railroad employees, and (for the employee tax only) employees of States and their political subdivisions and instrumentalities. This subsection also provides the mechanism for increasing the wage base, by $600 intervals, in proportion to future increases in average wage levels.

(Section 202.) Section 202 makes a number of conforming and technical amendments. Chief among these are provisions for refund of excess taxes collected from an employee, who has held two or more jobs, on wages aggregating in a year more than the amount of the new wage base; exclusion of Health Security contributions from agreements with State governments for the social security coverage of State and municipal employees (since these employees will contribute to Health Security through payroll taxes); and exclusion of Health Security contributions from agreements for the coverage of United States citizens employed by foreign subsidiaries of United States corporations (since these employees will not benefit directly from Health Security in its present form).

(Section 203.) This section excludes from the gross income of employees, for income tax purposes, payment by their employers of part or all of the Health Security taxes on the employees.

(Section 204.) This section spells out the precise effective dates of the new payroll tax provisions.

Part B—Taxes on self-employment income and unearned income

(Section 211.) Effective at the beginning of the second calendar year after enactment, this section converts the existing Medicare self-employment tax into a Health Security self-employment tax, raises the rate to 2.5 percent, and raises the maximum taxable self-employment income from $7,800 to $15,000 (with the same upward adjustment as in the employee tax for subsequent rises in average wage levels).

(Section 212.) Effective on the same date, this section adds a new 1 percent Health Security tax on unearned income (unless such income is less than $400 a year), subject to the same maximum on taxable income as is applicable to the employee and self-employment taxes. Taxable unearned income is adjusted gross income up to the stated maximum, minus wages and self-employment income already taxed for Health Security purposes (excluding certain items of income specifically excluded from the other taxes).

(Section 213.) This section makes appropriate changes in nomenclature and in the requirements of tax returns, including reports of estimated tax liability under the new tax on unearned income.

(Section 214.) This section details the specific effective dates of the taxes imposed by this part.

TITLE III

(Section 301.) Subsection (a) repeals Medicare on the date benefits become effective but stipulates that this shall not affect any right or obligation incurred prior to that date.

(Section 302.) This section requires that after the effective date of benefits, no State shall be required to furnish any service covered under Health Security as a part of its State plan for participation under Medicaid, and that the Federal government will have no responsibility to reimburse any State for the cost of providing a service which is covered under Health Security. After the effective date of benefits, the Secretary of HEW shall prescribe by regulation the new minimum scope of services required as a condition of State participation under Title XIX. To the extent the Secretary finds practicable, the new minimum benefits will be designed to supplement Health Security—especially with respect to skilled nursing home services, dental services and the furnishing of drugs.

(Section 303.) This section provides that funds available under the Vocational Rehabilitation Act or the Maternal and Child Health title of the Social Security Act shall not be used to pay for personal health services after the effective date of benefits, except (to the extent prescribed in regulations by the Secretary of HEW) to pay for services which are more extensive than those covered under Health Security.

TITLE IV

(Section 401.) This section authorizes the Secretary of Health, Education, and Welfare in consultation with the Secretary of State and the Secretary of the Treasury to study the coverage of health services for U.S. residents in other countries.

(Section 402.) Subsection (a) sets forth Congressional findings concerning the shortage of appropriate services and facilities for the long-term care of the aged or chronically sick. It notes that the shortage is in large measure due to the inadequacy and fragmentation of public programs, and that the shortage of appropriate services results in a severe hardship to the elderly and disabled and causes much improper use of hospitals and skilled nursing homes. Subsection (b) directs the Secretary to make a comprehensive study of the need for additional social, homemaker and other services for persons described in subsection (a) and the most equitable and appropriate means of financing such services. The Secretary is required to report his findings together with recommendations of legislation to the Congress within two years of the enactment of this title.

(Section 403.) Subsection (a) directs the Secretary of HEW to study the feasibility and desirability of coordinating the federal health benefit programs for merchant seamen, and Indians and Alaskan natives with the health security benefit program. The Secretary and the Administrator of Veterans Affairs shall conduct a similar joint study of the desirability and feasibility of coordinating veterans health care programs with the health security benefits program. Reports to the Congress and any legislative recommendations arising from the studies are required within three years after the enactment of this title.

Subsection (b) requires the Secretary and Administrator to consult with representatives of the affected beneficiary groups and include a summary of their views in the reports to Congress.

With respect to the joint study to determine the most effective method of coordinating the Veterans Administration Health Program with the Health Security Program established under this bill, it is important to understand that there is no intention to require either the integration of the VA program into the Health Security Program, or even the consideration of such integration. Rather, the section recognizes that any national health security or health insurance program would be so pervasive as to require other federal health programs such as those of the Veterans Administration to be effectively coordinated with them. Through such coordination, needless duplication and expenditures should be avoided.

(Section 404.) Subsection (a) sets forth Congressional findings concerning medical malpractice, and the methods of determining liability and assessing damages, are unsatisfactory. It notes that the cost of malpractice insurance is a significant element in the mounting cost of health care, and points to increasing evidence that the cost, together with the limited availability of insurance, may tend to discourage desirable medical procedures and have a detrimental effect on the use of health services. It concludes that better mechanisms must be found to determine and award fair compensation in appropriate cases to patients who have been injured in the course of the receipt of health services.

Subsection (b) directs the Secretary to make a comprehensive study of the problem, including the most appropriate criterion of compensable injury, means of adjudication, and means of financing the payment of compensation. The Sec-

retary is required to make to the Congress an interim report within one year, and a final report and recommendations for legislation within two years of enactment of this title.

The CHAIRMAN. The next witness will be the Honorable Clifford Hansen. Senator, we will ask you to take the witness seat for the purposes of explaining the bill to the committee and also to those here today in the audience.

STATEMENT OF HON. CLIFFORD P. HANSEN, A U.S. SENATOR FROM THE STATE OF WYOMING

Senator HANSEN. Mr. Chairman and members of the committee, I am a sponsor along with a number of cosponsors in the Senate of S. 987, the Health Care Insurance Act of 1971.

This program is also known as Medicredit. Briefly, it would give to every person in America, who is under the age of 65, equal access to high quality medical and other health care regardless of ability to pay. This program would not disturb the present medicare program. It would replace much of medicaid.

The bill would provide a private program of comprehensive medical and other health care protection covering both the ordinary and the catastrophic expenses of illness of accident.

The CHAIRMAN. Senator, could you suspend for just a moment? The staff is passing out copies of your statement to the press, so if you would just suspend for a moment until those are taken care of and everyone has copies of your prepared statement.

(Short pause)

The CHAIRMAN. All right, Senator, I think you can proceed.

Senator HANSEN. The protection could be by a health insurance policy, membership in a prepayment plan such as Blue Cross-Blue Shield, or membership in a prepaid group practice plan. The choice would be made by the family or individual to be covered.

The program is designed to provide full Federal Government payment for health cost protection for those with low incomes. As income increases, the Federal contribution would decrease. This health insurance protection will be available for all, with each family or individual contributing to the costs of this protection according to his ability to do so.

I should mention that the Health Care Insurance Act of 1971 is based on use of the private sector to the greatest extent possible. This not only allows for continued expansion and improvement of the strengths of the present system, it brings the ingenuity and responsiveness of the free enterprise system to bear on the problems of that system. It insures the free competition of ideas and approaches and the resulting improvements to health care delivery.

One further general note is that the total Federal cost of this bill is estimated to be $14.5 billion. The cost in new funds will be lower still due to offsets based on present expenditures no longer needed. This reduction would be particularly noticeable in the medicaid program.

I would now like to get into a somewhat more detailed description of what this bill would do and how the program would operate.

First, all coverage under the program would have to provide com-

prehensive benefits. These benefits would be divided into basic and catastrophic coverage.

Under the basic plan, 60 days of inpatient care in a hospital or extended care facility would be provided. Two days of care in an extended care facility would count as 1 hospital day. All services customarily provided by these institutions would be covered, including bed, board, and nursing services, drugs, blood, surgery or delivery rooms, intensive care or coronary care, care for pregnancy and psychiatric care in a hospital and bed, board and nursing services, physical, occupational and speech therapy, drugs, supplies, and equipment furnished by an extended care facility.

Also covered would be outpatient and emergency care and all medical care, including preventive, diagnostic, and therapeutic services. Covered medical care would include psychiatric care, well-baby care, infant and adult innoculations and immunizations and physical examinations.

The catastrophic coverage pays for expenses for services provided under the basic program in a hospital or extended care facility beyond the 60-day limit. Extended care facility coverage would be limited to 30 additional days.

The amount of individual or family contribution is based on ability to pay. We feel that the best indication of amount of money available for health protection is income tax liability. Accordingly, the bill would base the percentage of the Federal contribution on the individual's payment on that individual's tax liability. In the case where there is no Federal tax liability, the Federal Government would pay the extra cost of the basic and catastrophic protection as well.

In order to provide financial safeguards in the program, this bill has certain low deductibles and coinsurance features built into it. These cost-sharing features will help keep the total cost of the program lower. Also, they will help prevent abuse or overuse of the program.

Under the basic program, there would be a $50 deductible for each inpatient stay in a hospital. Also, there would be a coinsurance payment of 20 percent of the first $500 of expenses of outpatient or emergency care in a 12-month period, and 20 percent of the first $500 of medical expenses in each 11-month period.

There is also a corridor established under the catastrophic provisions. It should be noted that deductible and coinsurance payments made toward basic coverage would apply to satisfying this corridor. Also, it should be noted that the inpatient deductible applies to each individual while the coinsurance features and the catastrophic corridor apply to the family as a whole.

The size of the corridor is based on the financial condition of the family, using taxable income as the basis. The corridor is determined by adding 10 percent of the first $4,000 of taxable income, plus 15 percent of the next $3,000 plus 20 percent of any additional taxable income. From this total would be subtracted those deductible and coinsurance payments made under the basic plan.

To illustrate, let us use the example of a family of four with an income of $6,100. Taxable income for this family would be $2,000. The corridor would be 10 percent of this amount or $200, reduced by

any payments made for basic coverage. Once the corridor amount has been paid, the program would pay for all expenses and covered services.

This concludes my outline of the Health Care Insurance Act of 1971. Unlike some of the other proposals before this committee, my bill is concerned solely with the financing of health care. But, after all, that is what national health insurance is all about. This bill is designed to solve the problems of financial access to health care.

There are, of course, other problems in health care delivery. I recognize these problems and support programs to overcome them. However, I believe these programs should be proposed through separate pieces of legislation. There are many different problem areas but let us look at them individually and not lump them together in supposed cure-all omnibus legislation.

Mr. Chairman, the Health Care Insurance Act of 1971 offers an opportunity to met the health care needs of the American people in a manner which is both effective and at a cost which the people, the taxpayers, can afford to pay. I am extremely proud that 132 Members of the Congress have joined in sponsoring S. 987 and its companion measure, H.R. 4960.

I am confident that my distinguished colleague of this committee will give earnest consideration to the concepts embodied in the Health Care Insurance Act of 1971.

Mr. Chairman, I respectfully ask that the remarks which I made on the floor of the Senate on the introduction of S. 987, and the accompanying summary of the legislation be included in the hearing record at the close of my testimony.

Thank you.

The CHAIRMAN. Without objection.

(Senator Hansen's remarks on the Senate Floor and the summary referred to follows. Hearing continues on p. 71.)

[From the Congressional Record, Feb. 25, 1971]

Mr. HANSEN. Mr. President, I introduced today legislation to provide for a national health insurance program.

Along with a number of cosponsors, I am pleased to submit this national health insurance bill, called medicredit. It is designed to help people pay for their health and medical care and it is a measure that can means a great deal to the people in this country.

The bill's cosponsors include Senators Beall of Maryland; Dole of Kansas; Eastland of Mississippi; Fannin and Goldwater of Arizona; Gurney of Florida; Hruska of Nebraska; Tower of Texas; and Thurmond of South Carolina.

Mr. President, the bill will accomplish three important things:

First, it would pay the full cost of health insurance for those too poor to buy their own. Second, it would help those who can afford to pay a part—if not all of their health insurance premium. The less they can afford to pay, the more the Government would help out.

And third, this measure would see to it that no American would have to bankrupt himself because of a long-lasting, catastrophic illness.

In other words, the poor would pay nothing for their health insurance certificate; the well-to-do would pay just about all of it; and those in between would pay what they could afford, according to a sliding scale. Everyone—rich and poor—would be protected against the cost of a catastrophic illness.

We think this bill would help those who need help—and do it at a cost the taxpayers can live with.

I am seriously concerned about the devastating effect which a catastrophic illness can have on families unfortunate enough to be stricken by such illness.

Great progress has been made in this century through scientific achievement in the ability to sustain and prolong life. It is now possible for patients to survive catastropic illnesses and injuries which previously were fatal, and oftentimes rapidly fatal.

With the advent of these near miracle cures which often require long hospitalization and expensive initial surgery and sometimes continuing surgery and high-cost treatment—new problems have arisen in American life.

The net cost of a catastrophic illness or injury usually is staggering. Almost any family in America can be bankrupted in just a few months or even weeks by the cost. Many can never recover financially—even in more than a generation.

I believe the Government can be instrumental in helping to provide a safeguard against these destructive costs— through a catastrophic health insurance program. This would protect all Americans and their families from the tragedy of being wiped out financially through catastrophic illness cost.

Medicredit gives every American family the opportunity to protect itself against the cost of a catastrophic illness.

No family need face the prospect of losing its savings and even its home, because of medical bills.

The point at which a medical bill represents a catastrophe for a family certainly will vary.

It generally will relate to the family income. Thus, medicredit, provides that insurance policies covered under this program must protect against catastrophic illness and defines what constitutes a catastrophic illness for families in different economic situations.

The sponsors of medicredit agree that a medical bill of virtually any size would represent a catastrophe for a family whose income is under $3,000. On the other hand, a family with income of $8,000 could be expected to have resources which would enable it to afford a medical bill of $500, either from savings or through additional insurance protection. Similarly, a family with an income of $20,000 would be expected to afford medical bills of $2,750. Again, this amount could be paid from savings or the family could protect itself against this expenditure or a portion of it through health insurance.

The Senate Finance Committee last year voted 13 to 2—and I voted with the majority—in favor of a similar provision to protect all Americans against the cost of a catastrophic illness.

I am confident that the Congress will enact such legislation during this 92d Congress.

Mr. President, I ask unanimous consent to place in the Record at this point a brief summary of the Health Care Insurance Assistance Act of 1971—called medicredit—a proposal for Federal financing of health insurance.

There being no objection, the summary was ordered to be printed in the Record, as follows:

SUMMARY

Medicredit would: (1) pay the full cost of health insurance for those *too poor* to buy their own, (2) help those who can afford to *pay a part*—if not all—of their health insurance premium. The less they can afford to pay, the more the government would help out, (3) see to it that no American would have to bankrupt himself because of a long-lasting, catastrophic illness.

(This bill addresses itself only to *financing* health care; other legislation and programs involve medical manpower supply and distribution, the method of delivering care, and other problems such as environment, health education, and peer review.)

ANALYSIS

Federal contribution

The Government would pay 100% of the premium for low-income beneficiaries (an individual and his dependents whose combined income for a taxable year would not give rise to any income tax liability). For others, the Government would provide scaled participation ranging between 97.5% and 10%, favoring lower-income persons, in the payment of premiums for basic coverage, and would pay in full the premium for catastrophic expense coverage. A table of allowable percentages for related income tax liabilities is included in the bill.

The extent of participation would be determined with reference to federal income tax liability of an individual in a particular year (base year). A health

care insurance policy, qualified under this program, would run for a 12-month period beginning in the year following (benefit year).

Health insurance certificates; income tax credits

A beneficiary eligible for full payment of premium by the Federal Government would be entitled to a certificate acceptable by carriers for health care insurance for himself and his dependents. Eligible beneficiaries with whom the Government would be sharing the cost of premium could elect between a credit against income tax or a certificate. The carrier, as defined in the bill, would present certificates received in payment of premium to the Federal Government for redemption.

Qualification of participating carriers

To participate in the plan, a carrier would have to qualify under state law, provide certain basic coverage, make coverage available without pre-existing health conditions, and guarantee annual renewal. An assigned risk insurance pool among carriers would be utilized as appropriate.

Health insurance coverage

A qualified policy would offer comprehensive insurance against the ordinary and catastrophic expenses of illness. Basic benefits in a 12-month policy period would include 60 days of inpatient care in a hospital or extended care facility (but any two days in an extended care facility would count as one of the 60 days). Other basic benefits would provide emergency and outpatient services and all medical services provided by doctors of medicine or osteopathy. The catastrophic expense protection would pay incurred expenses for benefits in excess of the basic coverage, including hospital, extended care facility, inpatient drugs, blood, prosthetic applicances, etc.

Deductibles

A policy purchased under this program will contain:

(a) Under the basic coverage—a deductible of $50 per hospital stay, and 20% coinsurance of the first $500 of medical expense and on the first $500 of emergency or outpatient expenses; and

(b) Under the catastrophic illness provisions—a corridor, between the basic coverage and the catastrophic illness coverage, of expenses to be incurred by the beneficiaries before payments under the catastrophic illness provisions would begin. The amount of the corridor would be based on taxable income (that is, net income after all tax deductions and personal exemptions): 10% of the first $4,000, 15% on the next $3,000, and 20% thereafter.

A family of four, having an adjusted gross income of $6,100, would have a taxable income (after all tax deductions) of $2,900. Its corridor would be 10% of $2,900, or $290.

Health insurance advisory board

A health insurance advisory board of eleven members, a majority of whom shall be practicing physicians, and including the Secretary of HEW and the Commissioner of Internal Revenue and other persons qualified by virtue of education, training, or experience, would be appointed by the President with Senate consent. The Board would establish minimum qualifications for carriers, and in consultation with carriers, providers and consumers, would develop programs designed to maintain the quality of health care and the effective utilization of available financial resources, health manpower, and facilities. It would report annually to the President and Congress.

PARTICIPATION IN CATASTROPHIC COVERAGE

The point at which a medical bill represents a catastrophe for a family certainly will vary. It generally will relate to the family income. Thus Medicredit provides that insurance policies covered under this program must protect against catastrophic illnesses and defines what constitutes a catastrophic illness for families in different economic situations.

As an example of how the program would be applied, a medical bill of virtually any size would represent a catastrophe for a family whose income is under $3,000. Therefore, catastrophic coverage would begin without any payments by the individual. On the other hand, a family with income of $8,000 could be expected to have resources which would enable them to handle a medical bill of $500, either from savings or through additional insurance protection. Similarly a family with an income of $20,000 would be expected to afford medical bills of $2,750. Again this amount could be paid from savings or the family could protect itself against this expenditure or a portion of it through health insurance.

The following table illustrates the scale of payments to be made by a family of four in each of several economic situations:

Corridor table

(10% on 1st $4,000; 15% next $3,000; 20% thereafter)

Adjusted gross income:	*Corridor for family of 4*
$1,000	$0
$2,000	0
$3,000	0
$4,000	70
$5,000	190
$6,000	290
$7,000	380
$8,000	505
$9,000	640
$10,000	775
$20,000	2,750
$30,000	4,750

The CHAIRMAN. Senator Bennett?

Senator BENNETT. I have no questions.

The CHAIRMAN. Senator Curtis?

Senator CURTIS. Is this proposal based on the premise that the Government does have a responsibility?

Senator HANSEN. Yes, it is.

Senator CURTIS. To provide hospital and medical care for those citizens who financially cannot provide it for themselves?

Senator HANSEN. That is right.

Senator CURTIS. And those who can carry the load and pay for their own hospital and medical expenses would not be included.

Senator HANSEN. It ranges in the amount of support that would go to the people, depending whether an individual or family found itself unable to pay for any part of it, in which case the Federal Government would pick up 100 percent of the cost of the insurance premiums; and goes from that point down to 10 percent for those who are able to pay their bills.

Senator CURTIS. Now, those who are able to pay, do they get any benefit, taxwise or otherwise?

Senator HANSEN. They have two options. You are speaking of people who pay income taxes, who have incomes adequate to provide most of the kind of medical care they require. In this case, that taxpayer has either the choice of taking the insurance premium benefits that would be afforded him, depending upon the amount of his income tax payment, or he may take an income tax benefit directly if he wants to provide his own and not bother with any health insurance program.

Senator CURTIS. Part of which he can do now.

Senator HANSEN. Right.

Senator CURTIS. That is all.

The CHAIRMAN. Thank you very much, Senator.

Senator HANSEN. Thank you, Mr. Chairman.

The CHAIRMAN. I assure you that I and the other members of this committee, will give your proposal very careful study.

Senator HANSEN. Thank you, Mr. Chairman.

Senator BENNETT. Mr. Chairman, before the next witness, may I make a request?

The CHAIRMAN. Yes.

Senator BENNETT. Something was said when Senator Kennedy was on the stand implying that the insurance companies make substantial profits out of their health insurance. It is my impression that that particular part of the insurance industry has been generating substantial losses, and I am asking the staff to check these figures, and I would like to put them in the record following Senator Kennedy's statement when they become available.

The CHAIRMAN. The Senator will, of course, have that opportunity.*

Senator Scott is unable to be with us this morning, but he has provided a statement explaining his bill which we will include at this point in the record.

(The statement referred to follows:)

PREPARED STATEMENT OF SENATOR HUGH SCOTT

Mr. Chairman, members of the Committee, I appreciate having the opportunity to present a statement in support of the Health Rights Act which I introduced in the Senate on April 21.

I will outline briefly what I believe to be the major strengths of the Health Rights Act, and Senator Percy, who is the chief cosponsor of my proposal, will testify in greater detail later this week. Appended to my statement is a summary of the provisions of this Act.

The Health Rights Act proposes a new single program to improve and reorder our Nation's health care system. It replaces both Medicare and Medicaid. All citizens, regardless of age, family size, or income would be eligible to participate. However, while the program makes equal benefits available to all, it requires a personal contribution toward the cost of services based on ability to pay.

The first part of this program covers inpatient health care. It is designed to relieve all persons from the possibility of financial ruin due to the high costs of an illness. This plan differs from the traditional catastrophic concept in that it recognizes that each person has his own financial threshold. A catastrophic coverage of all costs above $2,000, for example, would be more than adequate for some families. On the other hand, it would be useless to the family which could not pay the first $2000 in health care costs.

Therefore, my proposal provides for catastrophic coverage on a sliding scale based on family size and income. Each family would have its own "health cost ceiling" based on its ability to cover its own health care costs.

The second part of this program defines a comprehensive insurance package to cover the costs of out-patient care. The new Federal Office of Health Care will contract on a regional basis with private insurers to make this package of benefits available to *all* persons and will pay a portion of the premium for those who are financially unable to do so

*See p. 29.

themselves. Provision is made for employers who provide insurance benefits for their employees to arrange group contracts with the regional carrier.

The Health Rights Act is designed to stabilize and reduce the costs of health care. Inpatient care is emphasized by requiring only a small individual payment for the first costs of outpatient treatment, and larger individual payments for the first costs of inpatient treatment. The accessibility of preventive health services will cut down on costly long-term illnesses. Strict utilization review and coordination is required of providers. Federal standards are substituted for state laws which restrict or impede the efficient delivery of health services. Nationwide standards will be developed under the Act for the creation of coordinated health maintenance organizations.

Following is a summary of the provisions of the Health Rights Act. I hope that it will prove a substantial contribution to the other proposals which have been submitted, as well as to the task of formulating a program to meet the health care needs of our Nation.

SUMMARY OF THE MAJOR PROVISIONS OF THE HEALTH RIGHTS ACT

A. Programs to Provide Adequate Health Care for all Americans

The Health Rights Act establishes two programs to assure all Americans of protection from unmeetable financial obligations due to the costs of health maintenance and recovery from illness. It replaces both the Medicare and Medicaid programs now in effect.

The first program provides Federally administered, inpatient, "major illness" protection for all individuals. It differs from traditional catastrophic plans by covering all costs above each *family's* "health cost ceiling."

The second program is an optional, outpatient, health maintenance insurance plan. The Federal Government will contract with private insurers to make available a standard health maintenance benefit package for all families.

Administration

Inpatient Plan—is administered by regional or subregional offices of the newly created Office of Health Care within the Department of Health, Education, and Welfare.

Outpatient Plan—is administered by private insurance carriers who have contracted with the Office of Health Care to make available insurance for health services covered under the outpatient plan.

Financing

Inpatient Plan—is financed in part through present health insurance portion of Social Security payroll taxes and in part through general revenues.

Outpatient Plan—is financed through individual premium payments which will be supplemented in whole or in part with Federal payments for low income families. Employers may arrange to finance all or part of their employees' premiums under this plan.

Benefits (see sample figures in chart)

Inpatient Plan—pays all covered costs above each family's "health cost ceiling". This health cost ceiling is determined on a family by

family basis, by use of a formula taking into account both family income and family size. The family must spend an amount equal to one-half of its cost ceiling on covered expenses before there is any Federal contribution. Covered expenses between one-half the cost ceiling and the cost ceiling will be matched on a 50%–50% coinsurance basis. Families may cover costs which fall under their health cost ceiling either with their own assets or through a personally purchased insurance policy. All covered expenses above the family's cost ceilings are covered by Federal payments. For low income families, this program completely supplements the outpatient program.

Outpatient Plan—pays all covered costs above an individual deductible of $50 per year, with lower individual deductibles for low income persons. There is an additional individual deductible of $25 for covered dental services, with lower individual deductibles for low income persons. The small initial payment for, and the breadth of, covered outpatient services will encourage illness prevention and discourage overutilization of inpatient services.

Covered Services

Inpatient Plan—covers hospital inpatient services, secondary care inpatient services (without a prior requirement of hospital care), and home health services following inpatient status in either a hospital or secondary care facility. Inpatient mental health services are also covered, with a lifetime limit of 180 inpatient days for each individual.

Outpatient Plan—covers outpatient physician services, including diagnostic services, limited "check-up" examinations, well-child care for children under the age of 5; dental care for children under the age of 12; and outpatient mental health services, with a lifetime limit of 104 visits for each individual.

Effect on Other Federal Health Programs

The Health Rights Act replaces both the Medicare and Medicaid programs.

Utilization Review and Coordination of Health Services

By Providers—inpatient and outpatient plans require each participating provider to have an approved utilization review program in effect, as is presently required under the Medicare program. Within each region or subregion, utilization review committees of each provider must meet periodically to review health care resources and services within the region, to institute programs for the coordination and sharing of facilities, and to make administrative and legislative recommendations to the regional Office of Health Care for improvements in these programs.

By Office of Health Care—each regional or subregional office of the Office of Health Care will have a health services review committee to review, on a sample basis, the administration and effectiveness of the program within its region or subregion and make any administrative and legislative recommendations which would improve the quality and delivery of health services in the region.

B. Program to Encourage the Development and Utilization of Health Maintenance Organizations

The Health Rights Act authorizes Federal grants and loans for the planning and development, including construction, of pre-paid health maintenance organizations. A new Health Delivery Committee, composed of representatives of the medical and allied health fields, is established for a two-year period within the Department of Health, Education, and Welfare. The first function of the Committee is to prepare preliminary specifications for the establishment of health maintenance organizations under this Act.

Grants for the planning and development of health maintenance organizations may cover 50% of the development costs. For health maintenance organizations which locate in and serve patients in physician shortage areas, grants may cover 70% of the development and initial operating costs.

As of January 1, 1974, the Secretary of Health, Education, and Welfare is authorized to enter into contracts with qualified health maintenance organizations to provide the services covered by the outpatient and inpatient plans described above.

C. Programs to Increase Health Manpower Resources

To provide an immediate incentive for an increase in health manpower training, the Health Rights Act improves the medical and nursing student loan programs under the Public Health Service Act to enable all qualified students the opportunity to attend schools of medicine and nursing. The loan repayment period is increased from ten to twenty years; the total amount of each loan is increased from $1,500 to the full cost of tuition, laboratory fees, and required texts and materials, plus a special living allowance of up to $1,000 per year.

The Health Rights Act also establishes a special program of yearly capitation grants to new and existing medical schools, for an initial period of five years. The capitation grants are designed to allow medical schools to increase their enrollment and to encourage them to shorten their required term of study. Medical schools will receive a direct Federal grant of $20,000 for each entering student who represents an enrollment increase over the prior year's entering class. In addition, medical schools will receive a direct Federal grant of $20,000 for each graduate who represents an increase over the graduating class of the prior year.

SAMPLE FIGURES FOR COST PROVISIONS UNDER HEALTH RIGHTS ACT

Family size	Family income	Family health cost ceiling for inpatient plan (on a scale of $0-$6,000)	Supplementary outpatient insurance plan			
			Insurance cost		Deductibles (per person)	
			Individual payment (percent)	Federal payment (percent)	Medical	Dental
1	$1,000	$80	0	100	$10	$10
	1,500	120	25	75	25	15
	2,000	160	50	50	25	15
	4,000	480	100	0	50	25
	6,000	720	100	0	50	25
	10,000	1,200	100	0	50	25
	14,000	1,680	100	0	50	25
	20,000	2,400	100	0	50	25
2	1,000	57	0	100	10	10
	1,500	86	0	100	10	10
	2,000	114	25	75	25	15
	4,000	342	75	25	50	25
	6,000	514	100	0	50	25
	10,000	857	100	0	50	25
	14,000	1,200	100	0	50	25
	20,000	1,714	100	0	50	25
4	1,000	36	0	100	10	10
	1,500	54	0	100	10	10
	2,000	73	0	100	10	10
	4,000	145	25	75	25	15
	6,000	327	75	25	50	25
	10,000	545	100	0	50	25
	14,000	763	100	0	50	25
	20,000	1,090	100	0	50	25
6	1,000	27	0	100	10	10
	1,500	40	0	100	10	10
	2,000	53	0	100	10	10
	4,000	107	25	75	25	15
	6,000	161	50	50	25	15
	10,000	400	100	0	50	25
	14,000	560	100	0	50	25
	20,000	800	100	0	50	25

Mr. CHAIRMAN. Our next witness is the Honorable Elliot L. Richardson, Secretary of the Department of Health, Education, and Welfare.

STATEMENT OF HON. ELLIOT L. RICHARDSON, SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. ROGER O. EGEBERG, ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS; STEPHEN KURZMAN, ASSISTANT SECRETARY FOR LEGISLATION; LEWIS A. BUTLER, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION; MRS. RUTH HANFT, PROGRAM ANALYST; AND ARTHUR HESS, DEPUTY COMMISSIONER, THE SOCIAL SECURITY ADMINISTRATION

Secretary RICHARDSON. I found it enlightening to listen to these presentations and the questioning of the committee.

Mr. Chairman, I am accompanied by Assistant Secretary for Health and Scientific Affairs, Roger Egeberg on my immediate right; our new Assistant Secretary for Legislation, Stephen Kurzman on his right; and on my left is the Assistant Secretary for Planning and Evaluation, Lewis H. Butler; and next to him, Mrs. Ruth Hanft, who is a program analyst, and has done a great deal of work in the development of our proposals and their financing; and next to her, and I am sure you all recognize the Deputy Commissioner of Social Security,

Arthur Hess. I think I can confidently say that they are likely to be able to answer most of the questions which I cannot answer.

Mr. Chairman and members of the committee, before proceeding, one more point. With respect to a substantial portion of my testimony in my prepared statement, I will omit it, but I would appreciate it, if there is no objection, Mr. Chairman, to having it included as if it had been read.

The CHAIRMAN. Without objection.

(Sceretary Richardson's prepared statement follows. Oral testimony continues on p. 85:)

PREPARED STATEMENT OF HON. ELLIOT L. RICHARDSON, SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman and Members of the Committee, today this distinguished Committee has begun what I feel sure will be regarded in the future as a historic dialogue on the financing of medical care in the United States. In the last session of Congress, an unprecedented number of health insurance proposals were introduced. So far in this Session, many of these same proposals have been reintroduced, and several more proposals are in the planning process.

The Administration's proposed National Health Insurance Partnership Act of 1971, S. 1623, was introduced last week by the distinguished senior Senator from Utah and companion proposals to increase and improve the supply of health manpower and to stimulate the development of HMO's have also been introduced. These proposals, the proposals you considered last year in H.R. 17550, and the proposal now under development by the Administration for regulation of health insurance, are all integral parts of a comprehensive national health strategy. The fundamental aim of this strategy is to improve the health status of all citizens in the Nation by expanding and improving the quantity, quality, and distribution of health care services and by assuring that no citizen is denied access to care for financal reasons.

What is the explanation for the sudden plethora of proposals? The subject of national health insurance has been broached from time to time since the Committee on the Costs of Medical Care reported its findings in the 1930's. Later a prolonged battle was fought to assure health insurance protection for just one part of the population, the aged. Why now the unprecedented interest from every sector of the public and the health industry itself?

Increasingly, words such as crisis, critical shortages, rampant inflation, are used to describe the status of the Nation's health and health industry. There is little dispute that unmet needs exist in the financial ability of some of the population to buy services, or that unmet needs exist in the availability and accessibility of services. There is also little dispute that in considering health care financing, the impact of the potential new demand created by additional financing must be anticipated and concomitant efforts must be made to provide resources to serve these new demands. There is little dispute that the design of financing programs has considerable impact on organization, delivery, costs, and quality of services. Health insurance proposals *should* be consciously designed to stimulate improvements in the organization, delivery, and distribution of services, constrain costs and improve quality.

There is much, however, to debate in the proposed solutions. Inherent in any decisions on a comprehensive national health strategy are underlying policy questions of health objectives, goals and priorities; public and private roles; rights and responsibilities; needs and the capacity of the system to meet the needs. The scope of choices among financing programs proposed ranges from what is essentially just maintenance of the status quo, through the extension of financing to meet discrete identified problems of discrete population groups, to the complete replacement of current programs; from a mix of public and private efforts to a preemptory Federal role; from providing a basic level of benefits to insuring against catastrophe only; from treating insurance as merely a method of payment to using insurance programs as a catalyst to create and improve services.

In developing the Administration's proposals we studied many alternatives, including those that have been proposed by others. Our approach seeks to match the cure to the disease, neither by over prescribing nor underprescribing; neither by experimental surgery on the one hand nor a placebo on the other.

I'd like to spend a few moments on what we regard as the shortcomings of two of the major proposals before you.

The Kennedy bill assumes that the only way to assure adequate health insurance coverage and to bring about needed improvements in the health care system is to have the Federal Government take over the entire system of health insurance in this country. We think on the contrary that the gaps and dificiences in the system can be resolved by less drastic means; building on what is already in place; by regulating health insurance and by concentrating public financing on areas of need; and by strong incentives to improve the organization and delivery of care.

There are significant advantages in a pluralistic approach to the management and financing of the Nation's structure of health insurance. As the President stated in his Health Message of February 18, 1971:

"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."

Even though the Kennedy bill allows lead time and provides funds for development of additional medical resources, it would in our judgment create large, virtually uncontrollable demands for services before the health care system could conceivably meet the demands. The design of the bill assumes dramatic and rapid changes in the present organization of the health care system, methods of delivery and payment for services. Not only are some of the methods of payment untested on a large scale but there could well be widespread unwillingness on the part of providers to participate, creating serious problems of supply of services. Desirable long range developments such as a gradual transition of manpower and organization to a "health maintenance" base should be phased in over time. The voluntary health insurance system can join Government in sharing responsibilities for innovations leading to evolutionary change.

Because the Kennedy bill would commit the Federal Government to extremely costly coverage and benefit provisions, it would require substantial increases in both payroll and income taxes. The sudden increase in Federal spending of such magnitude, largely but not entirely representing a shift from private to public financing, would make it more difficult to raise public funds to finance other desirable social goals.

In contrast, the Medicredit, AMA proposal is essentially a financing approach which would have little effect on the organization and delivery of medical care or on controlling rising costs. The proposal would inflate demand for services yet it does not promote appropriate ways to use the leverage of new funds to help influence the quality and efficiency of services.

The proposal furthermore would encourage the growth of costly individually sold private health insurance in contrast to group insurance. The type of insurance which would be available under Medicredit does not fit present group arrangements and could well upset employer-employee arrangements. Part of the insurance costs are now met and legitimately met, by employers. In sum, a Federal subsidy is called for with little public policy direction over the amounts spent or the effect on the health system.

As these hearings continue I'm sure we will have a further opportunity to discuss the merits and shortcomings of these proposals as well as of others.

Before detailing the Administration's health proposals, I would like to give you our understanding of the status of health in the Nation and the principal health problems and their causes.

STATUS OF THE NATION'S HEALTH

In all of the discussion and concern about health status, it is often forgotten that many indices attest that the health of Americans has been steadily improving. Life expectancy in the last 20 years has increased by 3.4 percent, infant

mortality has dropped by 2.3 percent, maternal mortality has declined by 66 percent, and neonatal mortality has fallen by 19.5 percent. Major breakthroughs have been achieved in the elimination of polio and the development of vaccines for the prevention of measles and rubella. Major advances have also been made in treatment of pediatric leukemia, other types of cancer, hypertensive heart disease, Parkinson's disease and mental illness, through the development of new drug therapies.

Other indicators show that resources have grown faster than the population. There were 12.4 hospital beds per 1,000 people in our civilian population in 1963; by 1968, there were 13.5. Between 1950 and 1966, the population increased by 29 percent; the number of people in health occupations increased by 90 percent, three times as fast as the population. The supply of physicians increased by 34 percent.

New forms of organization and delivery have been developed since 1965, particularly those designed to provide services in urban ghetto and rural areas where resources are in short supply. There are almost 600 Federally funded health centers serving over two million people. These centers include neighborhood health centers, maternal and child health centers and community mental health centers.

Expenditures for medical care have increased at a rapid rate, reaching $67.2 billion in Fiscal Year 1970, and may reach $100 billion by 1974. The financing of health care in the Nation involves a complex interdependent network of private and Government programs and payments. The private share of medical care spending has always been predominant, but since the enactment of Medicare and Medicaid in 1965, the public share of financing has increased. Until 1966, public spending accounted for 25 percent of the total, by fiscal 1970, public funds accounted for 37 percent of the total. Expenditures for health care under Government programs amounted to $25 billion in 1970, with Federal funds reaching $17 billion of which Medicare and Medicaid, the two largest programs, accounted for almost $10 billion. Almost all of the aged in the Nation are protected by Medicare. Medicaid will provide services to approximately 15 million people this year. Other Federal expenditures provide direct services to beneficiary groups including veterans, the military and their dependents, Indians and merchant seamen, and finance the various health centers' programs.

Since World War II, the development of fringe benefits and health and welfare funds through collective bargaining agreements has triggered the rapid growth of private health insurance. By Fiscal Year 1970, private insurance benefits amounted to $13.8 billion. By the beginning of 1970, 80 percent of the population under 65 had hospital insurance coverage contrasted with 50 percent, 20 years earlier. Seventy-nine percent had some surgical insurance. The proportions of persons covered for other types services is considerably less, but growing; 65 percent are covered for out-of-hospital X-ray and lab, 43 percent for physicians' home and office visits, 48 percent for out-of-hospital drugs.

In the last 10 years, the trend has been toward broader health insurance protection in terms of types of services covered and the degree of dollar protection. Major medical policies have been developed to protect against serious illness, up to maximums commonly set at $10,000, $15,000 or $25,000. About 43 percent of the population is now protected by major medical insurance.

Health insurance organizations fall into three broad types: Blue Cross-Blue Shield, commercial companies and independent plans. Blue Cross and Blue Shield plans are locally incorporated nonprofit corporations. In 1969, 75 Blue Cross plans covered 71 million people for hospital care, and 73 Blue Shield plans enrolled 63 million people for surgical care. There are about 1,000 commercial insurance companies selling individual and group policies, covering 122 million people. About 8 million people were enrolled in about 500 independent plans. Independent plans include the prepaid group practice plans, such as Kaiser.

The conclusion from these facts on health status and health financing, is that substantial progress has been made over the past 20 years and continues to be made. However, this aggregate progress masks some serious problems affecting subpopulation groups and the total Nation.

THE PROBLEMS

Even with the growth in private insurance and public programs, there are still unconscionable numbers of people who cannot pay for medical care or who cannot meet the costs of a catastrophic illness. Disproportionate numbers of children and

the poor are unprotected by private health insurance. Only 36 percent of those in families with incomes under $3000 and 57 percent in families with incomes between $3000–5000 had any insurance. Only 23 percent of the children in families with incomes under $3000 had coverage. Medicaid was designed to provide benefits to many of these low-income people, but by 1970, only one-third of the poverty population received some services under Medicaid.

Medicaid as a program, has serious structural defects as this Committee has often noted. The scope of benefits and income eligibility vary widely among the States. Two States have no programs at all. The working poor are often left out.

Female-headed families in some States receive protection, while male-headed families in similar circumstances obtain no benefits. Moreover, a work disincentive may be introduced by the fact that one additional dollar of earnings at a certain income level can result in total loss of Medicaid benefits.

For the population covered by private insurance, there are serious inadequacies in protection. While a large majority of the population has hospital protection, only a minority has coverage for out-of-hospital physicians' visits. The emphasis of private insurance on hospital-surgical protection and the lack of coverage for other services has distorted the pattern of care for the Nation: it has placed a premium on the use of expensive inpatient care when less expensive outpatient care of equal quality could be substituted.

Private health insurance payments, furthermore, met only 37 percent of consumer expenditures in 1969, with the remaining expenditures directly paid for by the consumer. Less than half the population has protection against catastrophic costs of illness, and this protection is most usually limited by dollar ceilings of $10–15,000.

Even where the consumer has the financial ability to purchase care, there is no assurance that the services will be available and accessible. I need not recite again the litany of the shortage of physicians, particularly primary care physicians, the shortage of nurses, the disparities in the supply of services between suburb and inner city, urban and rural areas. We learned the hard way that the addition of demand for health care services without provision for increases in the supply of services is seriously inflationary and creates promises incapable of fulfillment.

The shortages and maldistribution of health care resources are compounded by inefficiencies in the organization and delivery of health services and artificial barriers to improvements in organization and productivity. While the health maintenance organizations show promise of improved efficiency in the delivery of health services, most consumers do not have the opportunity to enroll, because most insurance does not provide real "free choice." Even if choice is available, as in the Federal Employees Health Benefits programs, restrictive State laws prevent the development of these organizations. The structure of insurance is such that the consumer is discouraged from seeking preventive care, early diagnosis and treatment and health maintenance.

All of these problems are reflected in indices that demonstrate national disparities in infant and maternal mortality as between white and nonwhite, between the nonpoor and the poor. For example, half of the poor children in the Nation are without immunizations when they enter school. We can no longer be sanguine about these inequities. We can no longer continue business as usual in the face of these problems. I do not doubt for one moment that regardless of individual interests, regardless of political affiliation, we share the same goals of ending these disparities in race, age. income, geographical location, and financial protection against illness.

Reflecting these problems and in turn, exacerbating them, are the continuously rising costs of medical care. Too often in recent months, oversimplified explanations have been given for this serious inflation, and oversimplified and untested solutions have been proposed. To cure the illness, a proper diagnosis is the first step.

The substantial rise in national health expenditures is the result of many factors—population growth, changes in age distribution of the population, rising costs per unit of service increased utilization of services and supplies, increased scope of services, and development of new services, new techniques, new drugs, and new treatments.

In the last 20 years, 47 percent of the increase in expenditures for health care services can be attributed to price increases, 17 percent to population growth, and the remaining 36 percent is due to increased use of services and the development of life saving, but expensive new techniques such as open-heart surgery and cancer chemotherapy.

The major services contributing to the rise in prices are the costs of hospital care and physicians' services. Let's look a little more closely at the factors involved.

The annual rates of increase in hospital costs since 1967 have been 16.6 percent, 15.4 percent, 13.2 percent, and 12.4 percent in Fiscal Years 1967, 1968, 1969, and 1970, respectively. The major part of hospital costs is labor costs, which account for three-fifths of hospital expenses. In February 1967, the minimum wage law was extended to hospital employees. At the same time, unionization was becoming more prevalent in the industry and pressures for well justified wage increases grew. The Nation can no longer justify subsidization of health costs for the general population through substandard wages for hospital employees.

The methods of reimbursement by private and public programs provide little or no incentive for encouraging improved efficiency and productivity. This Committee spent much time with us last year discussing the problems of retroactive reasonable cost reimbursement and experimentation with prospective reimbursement.

We do not yet know whether prospective payment will put a brake on the rate of increase in costs, but we must find the incentives to increase efficiency, reward economy, and encourage greater productivity. Unnecessary duplication of expensive equipment and overbuilding of facilities in some areas also contributes to the costs. The strengthening of areawide planning agencies and the withholding of interest and depreciation for disapproved expansion may well restrain these trends.

Also contributing to rising costs is improved technology—coronary care units and automated monitoring are expensive in terms of equipment and the higher skilled personnel needed to man the equipment.

Physicians' fees have not advanced as quickly as hospital costs, but have increased significantly. From 1966 to 1969, physicians' fees increased at an average annual rate of 6.5 percent, about twice as fast as other prices. During Fiscal 1970, fees increased by 7.2 percent, not much faster than general prices.

Part of the rise in fees which occurred in 1966 was probably in anticipation of Medicare. A more fundamental factor, however, is the increased demand for services without corresponding increase in the supply of services. Added to these factors are the ever increasing costs of malpractice insurance; increased wages for nurses and technicians; barriers to the effective use of new types of health professionals like pediatric nurse practitioners and physicians' assistants; and the lack of economies of scale

SOLUTIONS TO THE PROBLEMS

In evaluating all of the proposals before you, it is important to recognize two primary factors.

Financing of medical care and medical care alone does not assure better health status and a better quality of life. There are other national priorities that must weigh in the balance and that have as great, if not greater, impact on health and health status.

An adequate income to provide food, clothing, shelter, and some of the amenities of life. Malnutrition and inadequate diets are as important a factor in infant and maternal mortality as medical care. The family assistance program is as much a part of a viable national health strategy as the family health insurance plan.

Low density housing with heat, light, and adequate sanitation. Returning a child to a room with peeling lead paint can negate even the best medical treatment.

Other factors such as the environment, education, and life style play roles in health and health status.

In weighing the various approaches to health financing, we recognize that resources are never infinite and other social demands are as legitimate and may be equally important to health.

The second factor to bear in mind is that there are many things in health care and health delivery that we do not know.

International and national ratios vary widely with no apparent correlation with morbidity and mortality rates. How many physicians and hospital beds do we really need?

What is the most efficient method of organization and delivery? Will the most efficient be acceptable to providers and consumers?

Can planning be strengthened to prevent unnecessary duplication and overbuilding of beds and yet be responsive to innovation and changing patterns of care?

How can we assure value in terms of quality for the dollars spent? What are the most effective arrangements for peer review? Will the use of physicians' assistants and automated techniques lower quality?

What should be the role of the consumer in health care policy and the balance in skills and influence between consumer and provider?

Similar questions can be raised about methods of payment, incentives for redistribution of resources, and a host of other issues.

THE ADMINISTRATION'S APPROACH

I have tried to describe the problems we confront, their causes and their complexities. The Administration's proposals are addressed to the specific problems and seek to take into account the interrelationships between health and other social goals, cognizant of the fact that there is still much about the health industry and health care that we do not know.

The Administration's proposals are designed to respond to the problems of the consumer and the problems of the industry. They are based on the underlying thesis that although there is much that requires reform, there is much that is worthwhile in the existing system. They reflect the belief that national health insurance can be built on the solid foundation that exists, by expanding the present dimensions and shoring up the walls.

The Administration's proposals include not only the proposals introduced in this Congress, and the Medicare-Medicaid reforms proposed last year and discussed so extensively with this Committee, but a proposal being developed on the regulation of the insurance industry.

Since this Committee is particularly interested in the financing of medical care, I would first like to discuss the National Health Insurance Partnership Act, which is designed to assure that every family in America will have access to health insurance protection. There are two parts to the Act—the National Health Insurance Standards Act and the Family Health Insurance Plan.

NATIONAL HEALTH INSURANCE STANDARDS ACT

The National Health Insurance Standards Act will require all employers in the nation to provide basic health insurance coverage for their employees and the dependents of employees. In the past, we have assured workers a minimum wage, provided for disability and retirement benefits, and established occupational health and safety standards.

The benefits are designed to correct the failures of existing private health insurance, to change the focus and emphasis from hospital and surgical care toward preventive services, health maintenance, and outpatient care. They are designed to protect, also, against the catastrophic costs of illness that now so often impoverish families. The program is designed to broaden the choices among systems of care by making a Health Maintenance Organization Option available to all who want these services.

Specifically, the Act will require that all employers of one or more persons provide a minimum standard of health insurance for all their employees and their dependents. Excluded are Federal, State and local governments, ministers and members of religious orders.

The required benefits include inpatient hospital care, surgical and medical care, physicians' services on an in- and out-patient basis, laboratory, X-ray and other ancillary medical services, maternity care, well-child care and vision care for children. Outpatient drugs, psychiatric care and dental care are not initially required. However, we plan that within a few years benefits would gradually be extended to include outpatient psychiatric care, prescription drugs and dental care for children, as resources and techniques for utilization review are developed. The plan would be effective July 1, 1973, to allow time for development of additional services and for employers and employees to arrange for protection.

The benefits would be financed through premium payments by employers and employees. For the first two and one-half years, the maximum premium for the employee is 35 percent of the total, and 25 percent thereafter.

A maximum hospital room and board deductible of two days per person, a $100 deductible for all other services, and coinsurance of 25 percent of expenditures may be included in the plan. However, when an individual reaches $5,000 in

medical bills, there can be no further deductibles or coinsurance for that year and the next two years. Catastrophic protection of at least $50,000 per person is provided with automatic restoration of $2,000 in benefits a year.

Private insurance pools would be established to enable the self-employed, small employers and the nonpoor who are out of the labor market to buy this protection at group rates.

All consumers must be given the option of obtaining services on a prepaid capitation basis from Health Maintenance Organizations.

Requirements are included for cost controls, standards for providers, utilization review and peer review similiar to those currently required under the Medicare program and proposed in H.R. 1. Additional requirements are being considered as part of the future regulations bill.

FAMILY HEALTH INSURANCE PLAN

The second part of the health financing proposal is the Family Health Insurance Plan. As the President promised last June, we are proposing a replacement for Medicaid for families with children that would remove the inequities. I need not go into detail with this distinguished Committee on the problems and work disincentives in the Medicaid program. The Family Health Insurance Plan and the National Health Insurance Standards Plan resolve these problems. The Family Health Insurance Plan removes the current inequities in Medicaid as between male and female-headed families, the working and nonworking poor. It removes the uneven income eligibility among the States and the wide variations in benefits. And most important, it removes the problem of a sudden loss of all benefits.

Basic health insurance protection will be provided for low income families with children not covered by an employer plan. We estimate that three million families would be covered by the program. Income eligibility ranges from a maximum of $2500 for a one person family to $7000 for families with seven or more. For a family of four, maximum income would be $5000.

Benefits will include 30 days of inpatient care or equivalents of extended care or home health care; physicians' services, in and out of the hospital; maternity care and family planning; well-child care; vision care for children; laboratory and X-ray services; emergency services. Benefits would be the same for all low income families, nationwide. Here too, we expect to expand the scope of benefits as they are added to the employer-employee plans.

The plan would be financed by Federal funds and contributions from families in the form of premiums, deductibles and coinsurance that rise as incomes rise. For example, for a family of four, no cost sharing is required up to $3000 in income. Premiums start at $25 per family at $3000 and rise to $100 at the $5000 income. Deductibles and coinsurance also rise on a graduated scale. However, no deductibles or coinsurance apply to well child care, maternity care, or family planning.

Families would have the option of enrolling in a Health Maintenance Organization, as in the employer plan. Requirements under Medicare for reimbursement of providers, standards for providers, utilization review and peer review would apply to the Family Health Insurance Plan.

The Family Health Insurance Plan would replace Medicaid for families with children, effective July 1, 1973, but the current Medicaid program for the aged, blind and disabled would be retained.

The effect of these two proposals, combined with Medicare, the residual Medicaid program and other Federal programs, would be to provide a minimum standard of protection for almost all families with children and most individuals in the nation, without destroying existing private programs and collective bargaining arrangements. The structure of the benefits will begin to move the nation away from overuse of high cost inpatient services toward ambulatory care. For the first time, well-child care, vision care, and preventive services will be stressed in all insurance programs. Furthermore, free choice of the source of care will be available to all consumers. All mandated insurance and Federal programs must offer the consumer the choice of enrolling in an HMO.

Cost containment provisions and quality controls are an integral part of the proposals and additional requirements will most likely be incorporated in the pending regulatory recommendations.

MEDICARE IMPROVEMENT

Coverage of physicians' services under Medicare, as you well know, is provided through a voluntary program financed by premium payments by the aged,

matched by a general revenue contribution. The premium is scheduled to rise to $5.60 per month on July 1. The President has recommended that the premium payment required of the elderly be financed by employer-employee contributions so that this portion of the costs would be prepaid, just as is presently the case with Part A. Further, it is contemplated that there be some increase in cost sharing by providing for a copayment at an earlier point in the course of hospitalization than at present. Elimination of the premium would be the approximate equivalent of a 5 percent increase in social security benefits, and the saving to older people (as well as to States that in some cases pay premiums on their behalf) would be $1.4 billion. This, of course, would much more than offset the increase in copayment proposed to improve utilization.

COSTS

What are the costs of these new programs? In Fiscal Year 1974 we estimate that the cost to employers and employees for the National Health Insurance Standard Plan would be an additional $5–7 billion in premiums, over and beyond what would be spent under current private insurance programs. The Family Health Insurance Plan will cost $1.2 billion over and beyond the Federal share of the projected Medicaid expenditures for families with dependent children. The cost of the Medicare change, as noted above, would be $1.4 billion in the first year.

The Administration's health financing plan would accomplish the goals of providing financial access to care for almost the entire nation, improving the scope and direction of health insurance without completely replacing all that now exists. Those with broad protection could retain it. Those with inadequate protection would have improved insurance. Those with none would be provided with protection.

I have briefly summarized the major provisions of the health care financing proposals. I am sure that as these hearings continue, we will have an opportunity to discuss, in depth, the details of the provision contained in S. 1623, and I would therefore like to turn now to our proposals for increasing and improving the supply of health manpower and services.

HEALTH MAINTENANCE ORGANIZATIONS

As you will recall, we discussed and worked with your Committee to develop a Health Maintenance Organization option for Medicare and Medicaid. Health Maintenance Organizations can provide comprehensive services in an organized system for a prepaid fixed fee, providing consumers convenient access to the whole system. Strong linkages providing continuity of care can be developed between general practitioners, specialists, hospitals and clinics, laboratories, home health agencies and other services. Built-in incentives exist for controlling costs and efficient use of resources.

Prepaid arrangement in Health Maintenance Organizations, we believe, also provide incentives for prevention, early care, and treatment. Under these arrangements, HMOs will receive a contractually-fixed amount for the care of their enrolled members. If the HMO's health care staff pays little attention to prevention and continues with acute care in hospitals, then they will exceed the contracted amount for the care of each person. If, on the other hand, the HMO bends its concern to prevention—or, in other words, to lower cost care—its costs will be within the set amount. It will profit by maintaining the health of its members. Will this be sufficient incentive? We believe that there is convincing evidence to warrant that conclusion. When populations with similar characteristics are compared, those served by existing HMO-type organizations do better on measures of health than those who receive services under other auspices. This leads us to conclude that the quality of care is not sacrificed when health care providers consciously try to control costs

We are recommending a major new program to stimulate the development and expansion of these Health Maintenance Organizations which will provide:

Planning grants and contracts amounting to $23 million in Fiscal Year 1972.

Grants for operation, for up to three years, to HMO's serving predominantly underserved areas at a first year cost of $22 million.

Loan guarantees for HMO capital costs and working capital for private organizations and direct loans to public HMO's.

Contracts with HMO's for services to Federal beneficiaries will override inconsistent State laws on the organization of group practice and the delegation

of health service functions by physicians to other health personnel under the supervision of physicians.

We are also proposing the expansion of family health centers in underserved areas.

HEALTH MANPOWER

The basis of support of health manpower training will be changed, under the Administration's proposals, to provide incentives to increase the supply of medical manpower, shorten the training time and provide motivation to encourage health personnel to provide services in underserved areas.

The keystone of the program is capitation grants on the basis of $6000 for each graduate, to encourage the increased output of physicians and dentists, replacement of students who drop out and a speed up of the educational process. Special project grants would also be available primarily to stimulate enrollment increases, curriculum changes, and to give educational opportunities to disadvantaged students.

Scholarship aid will be available for low income and disadvantaged students and loan forgiveness programs are proposed for graduates who practice in scarcity areas.

In addition to this support for medical and dental education and stimulation of reform of health professional education, a major program is included, to increase the number of physicians' assistants, pediatric nurses and nurse midwives. Special efforts are being made to expand the MEDIHC program.

A series of area health education centers, to be established in medically underserved areas, has also been proposed. These centers would be satellites of existing medical schools. They would provide teaching centers for new health professionals and a focal point for continuing education of practicing health professionals and provide sophisticated medical services in remote and underserved areas.

We have also proposed implementation of the Emergency Health Personnel Act; expansion of cancer research; and research on sickle anemia; an increase in research and development studies and methods of treatment, rehabilitation and prevention of alcoholism and drug abuse.

The problem of medical malpractice is a major one and is reflected in price increases for medical care. For the past five years, malpractice insurance rates have been increasing at a rate of 10 percent per year. The threat of malpractice suits, in turn encourages defensive medicine—the ordering of additional tests, procedures and treatments—inhibitions to greater efficiency and economy of health care. We are in the process of appointing a National Malpractice Compensation Commission to study the costs and causes of malpractice and to propose legal and administrative steps to mitigate the effects of growing malpractice claims.

In summary, our proposals reflect the philosophy that there is much that is good in the health system in this nation—the pluralism, the ability to innovate, the value of competing systems and institutions. Our proposals target on the specific shortcomings and, in their totality, will help assure the achievement of our goals.

That the remaining financial barriers will fall;

That increased resources will be there to meet the rising expectations, and promises can be fulfilled;

That there will be continued flexibility in the system to innovate and improved care;

That sound and tested approaches will be used to constrain rising costs without reducing the quality of care; and

That adequate standards for and review of quality will become an integral part of health care for all.

Senator BENNETT. Mr. Chairman, I hope the Secretary will indicate to the committee where he is going to start and where he will pick up again, so if you omit specific sections we will be able to follow you.

Secretary RICHARDSON. I will do that, Senator. I may touch on topics that are covered in the portions omitted.

The CHAIRMAN. I can assure you, Mr. Secretary, that all the members of this committee, will thoroughly study your testimony. I understand why, for purposes of brevity you might want to leave certain

parts for the record, but the entire statement will certainly receive the full consideration of the committee.

Secretary RICHARDSON. Thank you, Mr. Chairman.

Today this distinguished committee has begun what I feel sure will be regarded in the future as a historic dialog on the financing of medical care in the United States. In the last session of Congress, an unprecedented number of health insurance proposals were introduced. So far in this session, many of these same proposals were reintroduced, and several more proposals are in the planning process.

The administration's proposed National Health Insurance Partnership Act of 1971, S. 1623, as you know, was introduced last week by the distinguished senior Senator from Utah, Senator Wallace F. Bennett, and companion proposals to increase and improve the supply of health manpower and to stimulate the development of HMO's have also been introduced. These proposals, the proposals you considered last year in H.R. 17550, and the proposal now under development by the administration for regulation of health insurance, are all integral parts of a comprehensive national health strategy. The fundamental aim of this strategy is to improve the health status of all citizens in the Nation by expanding and improving the quantity, quality, and distribution of health care services and by assuring that no citizen is denied access to care for financial reasons.

I am turning now, Mr. Chairman, to page 4 of my numbered text.

There is much, however, to debate in the proposed solutions. Inherent in any decisions on a comprehensive national health strategy are underlying policy questions of health objectives, goals, and priorities; public and private roles; rights and responsibilities; needs and the capacity of the system to meet the needs. The scope of choices among financing programs proposed ranges from what is essentially just maintenance of the status quo, through the extension of financing to meet discrete identified problems of discrete population groups, to the complete replacement of current programs; from a mix of public and private efforts to a preemptory Federal role; from providing a basic level of benefits to insuring against catastrophic only; from treating insurance as merely a method of payment to using insurance programs as a catalyst to create and improve services.

In developing the administration's proposals we studied many alternatives, including those that have been proposed by others. Our approach seeks to match the cure to the disease, neither by over prescribing nor underprescribing; neither by experimental surgery on the one hand nor a placebo on the other.

I'd like to spend a few moments on what we regard as the shortcomings of two of the major proposals before you.

The Kennedy bill assumes that the only way to assure adequate health insurance coverage and to bring about needed improvements in the health care system is to have the Federal Government take over the entire system of health insurance in this country. We think, on the contrary, that the gaps and deficiencies in the system can be resolved by less drastic means; building on what is already in place; by regulating health insurance and by concentrating public financing on areas of need; and by strong incentives to improve the organization and delivery of care.

There are significant advantages in a pluralistic approach to the management and financing of the Nation's structure of health insur-

ance. As the President stated in his health message of February 18, 1971:

> 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.

Even though the Kennedy bill allows leadtime and provides funds for further development of additional medical resources, it would in our judgment create large, virtually uncontrollable demands for services before the health care system could conceivably meet the demands. The design of the bill assumes dramatic and rapid changes in the present organization of the health care systems, methods of delivery, and payment for services. Not only are some of the methods of payment untested on a large scale, but there could well be widespread unwillingness on the part of providers to participate, creating serious problems of supply of services. Desirable long-range developments such as a gradual transition of manpower and organization to a "health maintenance" base should be, and it is fair to say can only be, phased in over time. The voluntary health insurance system can join Government in sharing responsibilities for innovations leading to evolutionary change.

Mr. Chairman, I am inserting an observation at this point. Reinforcing the observation made by the President in his message is, I think, the declaration by the Senator as proponent of this legislation that the establishment of a Federal budget for health care costs would put a lid on the increases of costs, and thus eliminate inefficiencies. A corollary, of course, is that there would have to be just that kind of determination of hospital costs, hospital by hospital. There would have to be created a mechanism for the gathering of cost data to be funneled into a central Federal Governmental process with a degree of complexity never envisioned in any Federal proposal to my knowledge previously submitted to the Congress. The contrast between such a proposal as this with medicare is dramatic. Medicare, of course, not only provides for a limited portion of the population, but it does so essentially on a reimbursement basis without undertaking to organize and establish cost ceilings for what will be paid for the services provided.

It is inconceivable to me that the enormous planning structure required to develop that kind of a budgeted system could be developed in anything less than a decade, and even then, it is hard to visualize how that kind of centralized budget in the direction of ceilings and telling the entire health care system of the United States to provide services for this dollar amount or else, could be administered in a way that would avoid gross distortions, inaccessibility, and potentially mass defection of health personnel.

Turning now to the problem of costs, it is, of course, as has been pointed out, essential to the proposals that there would have to be substantial increases in both payroll and income taxes. According to calculations, the program in the first year would require the tripling of taxes on an individual family for health care services. The increase would amount to an increase from $405 per family in 1974, to $1,271 per family in 1974. In addition to this——

The CHAIRMAN. Would you repeat those figures? I want to write it down. Would you mind repeating it; it would require an increase in taxes from what?

Secretary RICHARDSON. From $405 per family in 1974, to $1,271 per family in 1974. Also, continuing the inversion, Mr. Chairman, to point out that according to our chief actuary not even this would finance the benefits called for in the Kennedy program. According to our best calculations, there would be in 1974, a total deficit under the program of $18 million given the proposed revenue-raising formula for S. 3 and our cost estimate.

And this, of course, simply underscores the point that to undertake to require the health care systems of the United States to operate at a $18 billion deficit would inevitably create the kinds of difficulties that I referred to earlier.

In contrast, the medicredit proposal, which has just been summarized for the committee by Senator Hansen, is essentially a financing approach which would have little effect on the organization and delivery of medical care or on controlling rising costs. The proposal would inflate demand for services, yet it does not promote appropriate ways to use the leverage of new funds to help influence the quality and efficiency of delivering services. The proposal, furthermore, would encourage the growth of costly individually sold private health insurance in contrast to group insurance. The type of insurance which would be available under medicredit does not fit present group arrangements and could well upset many employer-employee arrangements. Part of the insurance costs are now met, and legitimately met, by employers. In sum, a Federal subsidy is called for under medicredit with little public policy direction over the amounts spent or the effect on the health system.

As these hearings continue, I am sure we will have a further opportunity to discuss the merits and shortcomings of these competing proposals as well as of others.

Before detailing the administration's health proposals, I would like to give you our understanding of the status of health in the Nation and the principal health problems and their causes.

At this point, Mr. Chairman, I would like to ask you to turn to page 24 of my printed text where we begin to outline our approach to solving these problems. I would like, however, in passing, to call your attention to one point discussed earlier this morning, to the second full sentence on page 22. This sentence reads: "The major part of hospital costs is labor costs, which account for three-fifths of hospital expenses." That statement is based upon the very full reporting done by the hospitals to the medicare system. We do have full access to their records and, of course, we also obtain access to those records in the course of auditing expenditures reimbursed by medicare.

Turning back then to page 24: "In evaluating all of the proposals before you, it is important to recognize two primary factors."

Financing of medical care and medical care alone does not assure better health status and a better quality of life. There are other national priorities that must weigh in the balance and that have as great, if not greater, impact on health and health status:

An adequate income to provide food, clothing, shelter, and some of the amenities of life. Malnutrition and inadequate diets are as important a factor in infant and maternal mortality as medical care. The family assistance program is as much a part of a viable national health strategy as the family health insurance plan.

Low-density housing with heat, light, and adequate sanitation. Returning a child to a room with peeling lead paint can negate even the best medical treatment.

Other factors such as the environment, education, and life style play roles in health and health status.

In weighing the various approaches to health financing, we recognize that resources are never infinite and other social demands are as legitimate and as important to the health of our people.

The second factor to bear in mind is that there are many things in health care and health delivery that we do not know.

International and national ratios vary widely with no apparent correlation with morbidity and mortality rates. How many physicians and hospital beds do we really need?

What is the most efficient method of organization and delivery?

Will the most efficient be acceptable to providers and consumers?

Can planning be strengthened to prevent unnecessary duplication and overbuilding of beds and yet be responsive to innovation and changing patterns of care?

How can we assure value in terms of quality for the dollars spent? What are the most effective arrangements for peer review? Will the use of physicians' assistants and automated techniques lower quality?

What should be the role of the consumer in health care policy and the balance in skills and influence between consumer and provider?

Similar questions can be raised about methods of payment, incentives for redistribution of resources, and a host of other issues.

The administration's approach, and I will cover it next, Mr. Chairman, is addressed to specific problems and seeks to take into account the interrelationships between health and other social goals, cognizant of the fact that there is still much about the health industry and health care that we do not know.

The administration's proposals are designed to respond to the problems of the consumer and the problems of the industry. They are based on the underlying thesis that, although there is much that requires reform, there is much that is worthwhile in the existing system. They reflect the belief that national health insurance can be built on the solid foundation that exists, by expanding the present dimensions and shoring up the walls.

The administration's proposals include not only the proposals introduced in this Congress and the medicare-medicaid reforms proposed last year and discussed so extensively with this committee, but also a proposal being developed on the regulation of the insurance industry.

Since this committee is particularly interested in the financing of medical care, I would first like to discuss the National Health Insurance Partnership Act, which is designed to assure that every family in America will have access to health insurance protection. There are two

parts to the act—the National Health Insurance Standards Act and the family health insurance plan.

Here again, Mr. Chairman, I might again interject a brief point. We do recognize, of course, that if we are to require health insurance coverage to be provided to all employees in the United States, there must, therefore, be created effective means whereby the Federal Government can assure both employers and employees that they are getting their money's worth. We think that such an approach can accomplish that end, and in so doing also it can incorporate effective means for utilization, review, and for standards of quality. This can be done without dismantling the mix of programs, the role of collective bargaining, and the other elements of a system which in many of its aspects has worked reasonably well.

I think it is interesting in this context to note one other consideration. As Senator Bennett pointed out a moment ago, it is true that the private insurance industry has not found any bonanzas in the underwriting of health insurance, and apropos of profits, moreover, it ought to be noted that 70 percent of all health insurance is written by nonprofit insurers; that is, if you combine the coverage provided by Blue Cross, Blue Shield, and the mutual companies.

The CHAIRMAN. Well, just a minute, now. Are you here to tell me that the mutual companies are not in business for a profit? Because if you are, I am going to correct you.

Secretary RICHARDSON. I would. Any profits that they make beyond the retention rates required for administration are redistributed to their policyholders.

The CHAIRMAN. Well, Mr. Secretary, I heard someone testify that these mutual companies belong to the people who hold the policies. That sounded good on the face of it. But, when I analyzed it for a while I began to ask this question: If I take out a life insurance policy with a mutual company, and I pay the premium, and I die, and they pay me off, they have a big chunk of my money left in the company.

Now, they have seen me come and go, and they are through with me. Where is the rest of that money?

Secretary RICHARDSON. Well, what they have done from year to year is to give you a dividend which amounts, in effect, to a rebate of premium. If they are doing well enough, the amount of the dividend depends on their gross business and whether their experience is more favorable than their actuarial assumption.

The CHAIRMAN. Mr. Secretary, it all sounded fine to me until we saw an argument before this committee, between the stock companies and the mutual insurance companies. At that point representatives of the stock insurance companies convinced me that the people in the mutual insurance business are just as much in it for the dollar as the people in the stock insurance business, and generally speaking, that they do just about as well.

Now, that may not be correct, but they pretty well persuaded me. Some companies have gone from stock to mutual, and others have gone from mutual to stock, and my impression is that if they are utterly candid with you and are completely frank, that they should concede that they are in business for the dollar. When they talk about "owning a piece of the rock" and that sort of thing, it just leaves me asking the question: If I buy the policy, when I am dead and gone, how much of the rock do my heirs have? I cannot see that they have any of it.

Secretary RICHARDSON. It is a question not of what he has sold.

The CHAIRMAN. Frankly, I just suggest that sometime you come down here and listen to the stock insurance people when they are fighting to defend themselves against the mutual insurance people. I think you will see about as well as I have the fact that they are both in it for the money, and they both succeed in making it.

I'm not being critical, that is what keeps this fine Government going. Every time they make more money we can collect some of it for Uncle Sam.

Secretary RICHARDSON. Well, I think the point, in any case, which I started out with is that we do believe that if the Federal Government is requiring a service to be provided, as it would be in this case, we should also move to make sure that it is regulated and, therefore, provided in a manner which serves the public interest, and we will submit legislation to do this. I think it should be noted further that there is, after all, a vast distinction between recognizing that health care should be a right accessible to all citizens on the same plane as education, and saying that the consequence should be a centrally administered Government system, because after all, although we have long recognized education as a right, we have consciously avoided the acception of total centralized governmental responsibility, and we have also avoided the total displacement of known public participants in the provision of education.

There are two parts, Mr. Chairman, and members of the committee, of the National Health Insurance Partnership Act. The first part is the National Health Insurance Standards Act, and now I am at the bottom of page 29:

This act will require all employers in the Nation to provide basic health insurance coverage for their employees and the dependents of employees. In the past, we have assured workers a minimum wage, provided for disability and retirement benefits, and established occupational health and safety standards.

The benefits are designed to correct the failures of existing private health insurance, to change the focus and emphasis from hospital and surgical care toward preventive services, health maintenance, and outpatient care. They are designed to protect, also, against the catastrophic costs of illness that now so often impoverish families. The program is designed to broaden the choices among systems of care by making a health maintenance organization option available to all who want these services.

Specifically, the act will require that all employers of one or more persons provide a minimum standard of health insurance for all their employees and their dependents. Excluded are Federal, State, and local governments, ministers and members of religious orders.

The required benefits include inpatient hospital care, surgical and medical care, physicians' services on an inpatient and outpatient basis, laboratory, X-ray, and other ancillary medical services, maternity care, well-child care and vision care for children. Outpatient drugs, psychiatric care, and dental care are not initially required. However, we plan that within a few years benefits would gradually be extended to include outpatient psychiatric care, prescription drugs, and dental care for children, as resources and techniques for utilization review are developed. The plan would be effective July 1, 1973, to allow time for devel-

opment of additional services and for employers and employees to arrange for protection.

The benefits would be financed through premium payments by employers and employees. For the first 2½ years, the maximum premium for the employee is 35 percent of the total, and 25 percent thereafter.

A maximum hospital room-and-board deductible of 2 days per person, a $100 deductible for all other services, and coinsurance of 25 percent of expenditures may be included in the plan. However, when an individual reaches $5,000 in medical bills, there can be no further deductibles or coinsurance for that year and the next 2 years. Catastrophic protection of at least $50,000 per person is provided with automatic restoration of $2,000 in benefits a year.

Private insurance pools would be established to enable the self-employed, small employers and the nonpoor who are out of the labor market to buy this protection at group rates.

All consumers must be given the option of obtaining services on a prepaid capitation basis from health maintenance organizations.

Requirements are included for cost controls, standards for providers, utilization review and peer review similar to those currently required under the medicare program and proposed in H.R. 1. Additional requirements are being considered as a part of the future regulations bill.

FAMILY HEALTH INSURANCE PLAN

The second part of the health financing proposal is the family health insurance plan. As the President promised last June, we are proposing a replacement for medicaid for families with children that would remove the inequities. I need not go into detail with this distinguished committee on the problems and work disincentives in the medicaid program. The family health insurance plan and the national health insurance standards plan resolve these problems. The family health insurance plan removes the current inequities in medicaid as between male and female-headed families, the working and nonworking poor. It removes the uneven income eligibility among the States and the wide variations in benefits. And most important, it removes the problem of a sudden loss of all benefits; the notch problem we discussed last year.

Basic health insurance protection will be provided for low-income families with children not covered by an employer plan. We estimate that 3 million families would be covered by the program. Income eligibility ranges 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 would be $5,000.

Benefits will include 30 days of inpatient care or equivalents of extended care or home health care; physicians' services, in and out of the hospital; maternity care and family planning; well-child care; vision care for children; laboratory and X-ray services; emergency services. Benefits would be the same for all low-income families, nationwide. Here, too, we expect to expand the scope of benefits as they are added to the employer-employee plans.

The plan would be financed by Federal funds and contributions from families in the form of premiums, deductibles, and coinsurance that rise as incomes rise. For example, for a family of four, no cost

sharing is required up to $3,000 in income. Premiums start at $25 per family at $3,000 and rise to $100 at the $5,000 income. Deductibles and coinsurance also rise on a graduated scale. However, no deductibles or coinsurance apply to well-child care, maternity care, or family planning.

I must just emphasize one point, Mr. Chairman, that as I think the testimony before this committee last year made clear, there is no way of eliminating the notch problem without requiring a progressively increasing contribution by the family itself to the cost of the health insurance coverage as the income rises; and so, we visualize here a program that meshes reasonably well with the point at which coverage would be taken over by the National Health Insurance Standards Act, the mandated employer coverage.

Families would have the option of enrolling in a health maintenance organization, as in the employer plan. Requirements under medicare for reimbursement of providers, standards for providers, utilization review, and peer review again would apply to the family health insurance plan.

The family health insurance plan would replace medicaid for families with children, effective July 1, 1973, but the current medicaid program for the aged, blind, and disabled would be retained.

The effect of these two proposals, combined with medicare, the residual medicaid program and other Federal programs, would be to provide a minimum standard of protection for almost all families with children and most individuals in the Nation, without destroying existing private programs and collective bargaining arrangements.

The structure of the benefits will begin to move the Nation away from overuse of high-cost inpatient services toward ambulatory care. For the first time, well-child care, vision care, and preventive services will be stressed in all insurance programs. Furthermore, free choice of the source of care will be available to all consumers. All mandated insurance and Federal programs must offer the consumer the choice of enrolling in an HMO.

Cost-containment provisions and quality controls are an integral part of the proposals and additional requirements will most likely be incorporated in the pending regulatory recommendations.

Beginning on page 38, Mr. Chairman, is a brief discussion of our proposal to finance the costs of part B, the physicians' services under medicare, on the same basis as part A.

On page 39 is a brief reference to the cost of these approaches. I point out in the middle of page 39 that there would be an additional premium cost to employers and employees under the national health insurance standards plan of $5 to $7 billion over and above current premium payments under private insurance programs. The family health insurance plan will cost $1.2 billion over and beyond the Federal share of the projected medicaid expenditures for families with dependent children.

The cost of the medicare change, as noted above, would be $1.4 billion in the first year.

Now, turning now, Mr. Chairman, to page 41 I would simply like to call attention to the fact, that, here follows a discussion of health maintenance organizations, which touches on the ways in which they can increase efficiency, contain costs, and emphasize prevention.

On page 44 and following pages are summaries for proposals to expand the supply of medical manpower and to increase the accessibility in scarcity areas.

We come now to the final page:

In summary, our proposals reflect the philosophy that there is much that is good in the health system in this Nation—the pluralism, the ability to innovate, the value of competing systems and institutions. Our proposals target on the specific shortcomings and, in their totality, will help assure the achievement of our goals:

That the remaining financial barriers will fall;

That increased resources will be there to meet the rising expectations, and promises can be fulfilled;

That there will be continued flexibility in the system to innovate and improve care;

That sound and tested approaches will be used to constrain rising costs without reducing the quality of care; and

That adequate standards for and review of quality will become an integral part of health care for all.

The CHAIRMAN. Thank you.

I call on Senator Byrd of Virginia.

Senator BYRD. Thank you, Mr. Chairman.

Mr. Secretary, would you give us a comparison of the costs of the program which you recommend and the program which Senator Kennedy recommends?

Secretary RICHARDSON. There are several ways of doing this, Senator Byrd. I mentioned earlier a comparison based on impact on the average household. I would like at this point, Mr. Chairman, with the permission of the committee, to insert a summary of this tabulation. It shows that for a household the present total tax bill, under existing law, is $405. Under the administration proposal it would be $466, and under S. 3 it would be $1,271.

The same comparison for the individual worker is, under present law, $223; under the administration proposal $271 per worker, and under S. 3, $559 per worker.

Comparing the totals on the basis of aggregate dollars, the total Federal expenditures under the administration bill, including existing Federal programs, would be $31.8 billion.

Senator BYRD. Excuse me, $31.8 billion?

Secretary RICHARDSON. Yes. That is not the cost of this legislation. I am giving you a total, comparison of total Federal expenditures for health, including veterans and so on.

The total Federal expenditures under the Kennedy program would be $86.7 billion, under the legislation itself. The administration proposal would cost in Federal expenditures $3.9 billion, and the Kennedy proposal would cost $77 billion.

Senator BYRD. Now, as I understand it, then, your proposal that you recommend would cost $3.9 billion over and above the cost of the present programs?

Secretary RICHARDSON. Yes.

Senator BYRD. Over and above the cost of the present programs?

Secretary RICHARDSON. Yes.

Senator BYRD. And Senator Kennedy's proposal, under your estimate, would cost $77 billion over and above the present system?

Secretary RICHARDSON. That is generally correct, Senator. The derivation of our figures, as I gave you a moment ago, the family health insurance plan, which as you know is a substitute for medicaid, would cost $1.2 billion more than projected medicaid expenditures for families with dependent children in fiscal 1974. Also the medicare change, that is the consolidation of part B with part A, would cost in the first year $1.4 billion, and this is it.

Senator BYRD. The figures you gave are for fiscal 1974. Do you envision—do you have estimates beyond that date?

Secretary RICHARDSON. Yes, we do. I would have to furnish these as I do not have them, Senator Byrd.

(Clerk's Note: At presstime, May 27, the material referred to had not been received by the committee. The following letter was received May 10, 1971:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C., May 10, 1971.

Mr. TOM VAIL,
Chief Counsel, Senate Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR TOM: I understand that your staff has talked with my staff in an effort to have Secretary Richardson's testimony of Monday, April 26, 1971, on health insurance prepared for print as part of the published transcript of those hearings. The staff of the Committee has been advised that DHEW is working on the inserts. The data setting forth the combination of taxes and premiums for different plans, however, will not be available until the week of May 19th. The state by state comparative analysis of the cost of Medicaid AFDC expenditures and the proposed FHIP AFDC expenditures will take longer.

If the hearings are printed before the inserts are forwarded to you, I would appreciate it if you could have this information noted where the inserts would have appeared of if you can have this letter printed in that space.

I assure you that I am doing everything I can to have the inserts forwarded to you as soon as possible. If I can be of help in any way, please do not hesitate to call upon me.

Sincerely,

STEPHEN KURZMAN,
Assistant Secretary for Legislation.

Senator BYRD. Now, in regard to the National Health Insurance Standards Act, as I understand it, for the first 2½ years the employee would pay 35 percent of the cost and the employer the remaining 65 percent?

Secretary RICHARDSON. Yes, that is the respective maximum and minimum.

Senator BYRD. And then you propose to phase that down while the employee pays 25 percent and the employer then would pay 75 percent?

Secretary RICHARDSON. Yes. The reason for that, Senator Byrd, was that it would give smaller employers, particularly, a longer interval in which to adjust to this new program.

Senator BYRD. How does the cost of your proposal compare with the cost of Senator Long's catastrophic insurance proposal?

Secretary RICHARDSON. As I recall, the cost of that proposal was about $2.5 billion in the first year.

Senator BYRD. As compared to your $3.9 billion?

Secretary RICHARDSON. Yes.

Senator BYRD. Now, this would apply, the National Health Standards Act would apply to all employers of one or more employees?

Secretary RICHARDSON. Yes.

Senator BYRD. Now, would it apply to domestic servants?

Secretary RICHARDSON. It would where they work for the employer for more than 25 hours a week. It would not cover temporary employees or part-time employees.

Senator BYRD. A full-time cook, for example, would be covered by this?

Secretary RICHARDSON. Yes.

Senator BYRD. In a private home?

Secretary RICHARDSON. Yes, he or she would.

Senator BYRD. What is that?

Secretary RICHARDSON. The cook would be covered, yes, he or she.

Senator BYRD. Thank you. I think that is all of the questions I have.

The CHAIRMAN. Senator Hansen?

Senator HANSEN. I have no questions.

The CHAIRMAN. Senator Ribicoff?

Senator RIBICOFF. Mr. Secretary, the President's health message of February 18 stated one of his four guidelines, guiding principles to be, and I quote: "Assuring equal access to the health care system."

Then why does the President's bill set a double standard for health delivery to employees and the poor?

Secretary RICHARDSON. Well, the coverage is quite comparable. The reason for presenting it in this way is simply that you cannot require health insurance coverage under the approach taken in the Health Insurance Standards Act for people who are not employed.

So the question then is, How do you provide coverage for these poor people? As our hearings developed last year we felt that any system of coverage for poor people who are not employed should mesh with the provisions of a program designed to give work incentives and, therefore, we concluded and then promised the committee that we would——

Senator RIBICOFF. Well, Mr. Secretary, I do not like to dispute you when you say the coverage is comparable, but let me read you the differences and let me see if you consider that coverage comparable.

Under your bill the employee plans have no limits on hospital care, but there is a 30-day limit for the poor. Is that correct?

Secretary RICHARDSON. Yes.

Senator RIBICOFF. Under the employees' plans there are no limits on outpatient physical services, but the poor are limited to seven doctors' visits; is that correct?

Secretary RICHARDSON. No; eight physicians' visits, not including child care, maternity, or vision care.

Senator RIBICOFF. The employee gets catastrophic insurance coverage and the poor do not; is that correct?

Secretary RICHARDSON. Yes.

Senator RIBICOFF. And within the employee plans there are equities, employees pay the same dollar amount of premium whether they make $7,000 or $30,000; is that not correct?

Secretary RICHARDSON. Yes; usually.

Senator RIBICOFF. Now, if we are going to have a health program in this country, and the poor need it, and certainly as much as the rich, then should we not have the same program for the poor as we do for the rich?

Secretary RICHARDSON. I think the answer to that is we should certainly undertake to do this by whatever practical means we can.

The other side of the coin is that the program for employed persons has substantially higher deductible and coinsurance componets than the program for the poor.

The value of the insurance package for the poor, under the family health insurance plan, on an actuarial basis, is higher than the value of the package under the mandated program.

Senator RIBICOFF. I know, but that is poor comfort for the poor person who needs more than 30 days of care, or who needs more than eight doctor visits or who has a catastrophic illness.

Now, if we are talking about health being a right that everybody should be entitled to, then it must be the same right for the poor as well as the rich.

Secretary RICHARDSON. Well, I think in principle this is clearly true.

Senator RIBICOFF. Well, if the principle is true, do we have the right, as legislators, or do you have the right as a Secretary, or does the President have a right as the President of the United States to have a different plan for the rich and a different plan for the poor, when it comes to health care?

Secretary RICHARDSON. I think the answer to that, Senator, has to be that in the value of the benefits for the poor it is greater in the aggregate, the question then is in terms of the financing of the proposal, and the incorporation of the means to graduate the families' share of costs in order to eliminate the notch problem. We have concluded that the family health insurance plan, as proposed, is substantially more adequate than medicaid is now in most States, and that where medicaid is more so that the State could be expected to maintain their existing program.

Senator RIBICOFF. Perhaps the President's plan provides more than medicaid, but now you are starting on a new health program and you are going to get rid of medicaid, and whether it is a Kennedy proposal, or Hansen proposal, or the administration proposal, you should strive to build a basis of equity which the administration bill does not contain.

Now, let us go to another phase: The private insurance industry, in the past, has not done much to keep insurance costs down. Why do you then propose that the private insurance companies take over the job of doing it now?

Secretary RICHARDSON. Well, I think the problem, Senator, with the private insurance industry, in the past, has been primarily a function of two things: One is the kind of benefits that they have provided, and these emphasize acute inhospital care and, therefore, higher cost care than could have been provided in many cases on an ambulatory or outpatient basis.

Beyond that, there has not existed up to now anw effective system for utilization review, for the maintenance of quality standards for cost controls. There is no general or comprehensive system of regulation in the private insurance industry now in effect. All of these would be provided for in the legislation we propose.

Senator RIBICOFF. Well, now, you told the Kennedy subcommittee on February 22 that the administration would send up a bill to regulate private insurance companies in this particular field. When do you expect such a bill to be sent up here, and what would such a bill contain?

Secretary RICHARDSON. I have touched on the general kinds of things that it would contain. We hope to be able to submit it in June, at least by the end of June.

Senator RIBICOFF. So before this committee would be wrestling with the problem in a legislative way we would have your proposal concerning the industry?

Secretary RICHARDSON. Yes.

Senator RIBICOFF. Now, you recently had an article under your byline in the New York Times in which you talked about reality and myth, and you state that the insurance companies retain less than 6 percent of premiums for administrative overhead and profit on group health insurance. Are you not, yourself, perpetuating a myth when you make such a statement in the New York Times?

Secretary RICHARDSON. These are Social Security Administration figures, Senator.

Senator RIBICOFF. Well, I have here the figures from the Social Security Bulletin of February, and your 6 percent figure could only refer to the date of which shows, and if you want a copy of it, here is a copy——

Secretary RICHARDSON. I have it right here.

Senator RIBICOFF (continuing). Claim expenses amounted to 94.1 percent of the premium income and you leave us with the idea the other, the 6 percent is administrative cost and profit. Now, should we not be looking at the operating expenses as a percentage of premium income and the data for the policies you mentioned shows 13.2 percent of premium income went for operating costs, so there is a variance between 6 percent and 13.2 percent.

Now, this is in your own bulletin.

Secretary RICHARDSON. Well, I would call your attention, Senator, just to make sure we are talking about the same bulletin, to "Private Health Insurance in 1969; a review," the Social Security Bulletin of February 1971. On page 17 there is table 21 showing retention of private health insurance organizations as a percent of subscription or premium income from 1948 to 1969. The statement I made referred to retentions which are defined in footnote 1 as amounts retained by the organization for operating expenses in addition to reserves and profit.

Senator RIBICOFF. Yes, but is not the issue, if we have to discuss the issue here in this committee, and it will be a big issue whether it should be done by Social Security or whether it should be done by the insurance industry, then we have to know because it will make a great deal of difference in the overall costs what the insurance industry overhead is in administering health plans as to what Social Security's point of view is, and on these figures, my figures show that 13.2 percent of the premium income went for operating costs.

Secretary RICHARDSON. I do not think you could be referring, Senator, to group policies. The group policy total shown for insurance companies for 1968 is 6.2 percent; for 1969, 5.9 percent is the amount retained by the insurance companies from the total premium income for the purposes of operating expenses, addition to reserves, and profits.

Senator RIBICOFF. I think we are talking about two different things. We are talking about not what is retained, but the 1970 rating, and the group insurance policies at $5.7 billion, claims expenses as a per-

centage of income 94.1, and then you concluded that was 6 percent, but if you went across the line you would see operating expenses as percentage of income is 13.2 percent. So my figures, taken from your figures, indicate for the operating expenses 13.2 percent.

You concluded what the retention was, operating expenses, but I do not want to go into a numbers game, but I am sure if you go into this with your people at Social Security from your own bulletin it will indicate the operating expenses are 13.2 percent.

Secretary RICHARDSON. I am not sure of any such thing, Senator. I have to say that I stand on the statement presented, that I used in the article, and I rely on the figures shown in table 21 for group policies.

Senator RIBICOFF. Well, you and I read the figures differently.

That is all, Mr. Chairman.

The CHAIRMAN. Senator Bennett.

Senator BENNETT. Well, Mr. Chairman, since I introduced the legislation, I have no reason to question its validity or its wisdom, so I am sure that will be done of me before the committee gets through with it, so I have no questions of the Secretary.

The CHAIRMAN. Senator Anderson.

Senator ANDERSON. Will you identify this figure, again, this $405?

Secretary RICHARDSON. Excuse me?

Senator ANDERSON. Would you identify again this $405 figure?

Secretary RICHARDSON. The $405 is the 1974 cost per household under existing law for all Federal expenditures for health programs.

This includes medicare and medicaid, Veterans' Administration, and all other health programs now funded by Federal taxes.

Senator ANDERSON. And the $1,271 figure?

Secretary RICHARDSON. That would be the comparable figure per household if S. 3 were enacted.

Senator ANDERSON. Who made these estimates?

Secretary RICHARDSON. These were made by a social science research analyst in the Department for the Office of the Secretary.

Senator ANDERSON. Who is the man who makes their estimates?

Secretary RICHARDSON. The present chief actuary is Charles Trowbridge.

Mr. HESS. Senator, these estimates are from the Office of Research and Statistics.

Senator BENNETT. Not from the Office of Social Security?

Mr. HESS. Yes; they are.

Senator BENNETT. Within Social Security, but not from the actuary?

Mr. HESS. Yes; not from the actuary.

Secretary RICHARDSON. The chief actuary is Mr. Charles Trowbridge; but as Mr. Hess says, they are not his figures but the Office Research and Statistics figures.

Senator ANDERSON. Whose figures?

Secretary RICHARDSON. The Office of the Associate Commissioner for Research and Statistics, Mrs. Merriam.

Senator ANDERSON. They indicate a very sharp rise.

Secretary RICHARDSON. Well, the aggregate taxes amount, in effect, to 3½ percent in payroll up to $15,000, payable by employers, 1 percent of the payroll up to $15,000 payable by employees, and a match-

ing amount out of general revenues so that if that were considered to be in effect a tax on payroll, the total financing of the program amounts to 9 percent of payroll and that, of course, represents a very substantial chunk of money taken out of the paycheck for the employee before the employee sees it.

I add, too, Mr. Chairman, and Senator Anderson, that apart from the problems inherent in trying to clamp a lid on total medical care expenditures in the United States, and use that mechanism of a central determination of total expenditures in order to try to hold down cost in utilization, there is the inherent problem that a lot of things would be paid for outside of the system, even if you did increase taxes in this way.

This has been the British experience, and I think we could assume in the United States that people would continue to want to pay bills and seek services outside of the Government system.

And, of course, that money would not have been included in the total expenditures. I do not think we can say, in fact, that under S. 3 you are just collecting the money and disbursing it in a different way. I think the effect would inevitably be to allocate substantially greater expenditures to health care as a whole.

Secretary RICHARDSON. Incidentally, just to identify the sources, the $77 billion figure that we attached to the overall cost of it, of S. 3, is a figure developed by the Office of the Chief Actuary, Mr. Trowbridge, the successor to Mr. Myers.

I would like to correct in that connection one misstatement I made in answer to Senator Byrd. I said that the $77 billion was all added costs. That was not correct. The $77 billion includes medicare and medicaid total projected for 1974. That projection is at least $22 billion, so that the additional costs would be at least $55 billion.

Senator BYRD. Thank you.

Senator BENNETT. Mr. Chairman, may I ask one question?

The CHAIRMAN. Go ahead.

Senator BENNETT. Mr. Secretary, you said that the effective cost of S. 3 could be stated as 9 percent of the total payroll?

Secretary RICHARDSON. Yes.

Senator BENNETT. What is the comparable percentage of total payroll now to support the entire existing social security system?

Secretary RICHARDSON. 10.4 percent, Senator Bennett.

Senator BENNETT. So, we are just about going to double the social security system if we adopt S. 3?

Secretary RICHARDSON. Yes.

Senator BENNETT. Thank you.

The CHAIRMAN. Mr. Secretary, which organization in your department would be responsible for the administration of the family health insurance program?

Secretary RICHARDSON. We think that it should be administered by a health insurance benefits agency within a new office where responsibility for social security, health benefits, and, if it is enacted, also family assistance benefits would be located. The commissioner of social security would be elevated to a position having responsibility for these three programs.

The CHAIRMAN. Well, would this be administered by the same people that you propose to have administer the family assistance plan?

Secretary RICHARDSON. No; it would be parallel and under the same overall direction, but it would be a different group of people.

The CHAIRMAN. I understand the bill to be introduced in the House will differ from the version that has been offered by Senator Bennett. Could you explain what the differences are between the two bills?

Secretary RICHARDSON. Yes. The difference concerns the requirement of carrying insurance as applied to small employers, and the House bill contains a provision under which many employers who have 10 or less employees, would be given the benefit of a subsidy of part of the cost of the premium; that is in case of employees for whom the total cost of the premium would exceed 4 percent of their gross pay. The idea behind it is to soften the impact on small employers of a requirement of providing this coverage and to avoid the possibility that this marginal increased cost might lead either to reduced employment or to refrain from adding to it.

I should correct one thing. It provides for the first 10 employees of all employers as a way of getting at the problem, and in order not to encourage employers to, in effect, split up their units into units of 10 or less to get the benefit of the subsidy.

The CHAIRMAN. The administration bill has two parts, a family insurance plan and a national insurance standards act. In his health message the President stated he proposed another bill to regulate the health insurance industry. Can you give us any information as to the timing and details of that legislation?

Secretary RICHARDSON. As I said earlier to Senator Ribicoff, we hope the timing will be before the end of June. I cannot tell you much about the details. I can only say that the kind of things that we are having this proposal cover would be in the first instance a requirement for the collection of data on a national base, provisions of uniform standards in order to judge the actuarial comparability of policies and the creation of mechanisms through which on a regional or areawide basis there would be consumer participation in review of costs and quality standards.

One of the problems we need to think through, and that will be reflected in the legislation, is the interrelationship within that process, the peer review proposal that Senator Bennett has already made, and the relationship of both of these things to the regional planning now provided for under section 314 of the Public Health Service Act. We think that there ought to be more effective integration of these functions; that is, of regional planning for services, peer review and consumer participation in quality and cost control than would exist if we submitted legislation calling only for the last of these.

At any rate, this is the kind of thing we want to cover.

The CHAIRMAN. In how many States would the Family Health Insurance Plan result in persons who are now on medicaid actually receiving less services or having to pay premiums, deductibles and coinsurance for services which they now receive free?

Secretary RICHARDSON. I think there are two or three States in which there are benefits now provided that would not be covered here. Part of the answer to that question is also a partial answer to Senator Ribicoff's point earlier, and that is that we would be eliminating a program under which the Federal Government now pays 50 percent of the cost and substituting a program under which we would be pay-

ing 100 percent of the costs and the States would, therefore, be in a position to supplement this program. We think it is appropriate that they should do so in every case where their coverage or their benefits are broader than we have proposed.

The CHAIRMAN. Would you be willing to submit a list to the committee pointing out the States, and in what respects they would be receiving less than they are receiving to date?

Secretary RICHARDSON. Yes. We have been conducting a State-by-State analysis of this, both from the point of view of answering the question of what benefits would not be covered, and also to try to determine just what the degree of fiscal relief in each State would be.

This has been underway for some time and should be complete within a few weeks.

(Clerk's Note: At presstime, May 27, 1971, the material referred to had not been received by the committee. The following letter was received by the committee May 10, 1971:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C., May 10, 1971.

Mr. TOM VAIL,
Chief Counsel, Senate Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR TOM: I understand that your staff has talked with my staff in an effort to have Secretary Richardson's testimony of Monday, April 26, 1971, on health insurance prepared for print as part of the published transcript of those hearings. The staff of the Committee has been advised that DHEW is working on the inserts. The data setting forth the combination of taxes and premiums for different plans, however, will not be available until the week of May 19th. The state by state comparative analysis of the cost of Medicaid AFDC expenditures and the proposed FHIP AFDC expenditures will take longer.

If the hearings are printed before the inserts are forwarded to you, I would appreciate it if you could have this information noted where the inserts would have appeared if you can have this letter printed in that space.

I assure you that I am doing everything I can to have the inserts forwarded to you as soon as possible. If I can be of help in any way, please do not hesitate to call upon me.

Sincerely,

STEPHEN KURZMAN,
Assistant Secretary for Legislation.

The CHAIRMAN. Mr. Secretary, one thing is fairly clear to me; as far as the average workingman is concerned, no matter which plan we adopt here, we are not giving him anything. He is going to pay for it.

Secretary RICHARDSON. That is right.

The CHAIRMAN. What we are really talking about is how he goes about paying and how much he is going to pay, and what benefits he will receive.

As far as the average working man is concerned, by any one of these plans, whether you use private insurance as required by your legislation, or whether it is done by instituting Federal taxes and providing health insurance protection directly, the average working man, is going to pay for what he is getting. Nobody is really giving him anything with any one of these bills.

Secretary RICHARDSON. No; that is absolutely true, and I think a very important point to emphasize because, once that point has been made perfectly clear, then you can consider the really important ques-

tions which have to do with what are the potential consequences of various forms and degrees of governmental intervention.

The CHAIRMAN. Let us just take the approach, for example, of the Kennedy bill.

As I recall it, the employee is supposed to contribute 1 percent on payroll, and the employer contributes 3½ percent, and then you proceed to tax the public on some other basis, an income tax or a tax on corporations or some other tax to provide the other half. Now, if any businessman is trying to provide this for his employees he has to deduct all of this from the salary check. Then he has to make enough money to pay a tax, and all of that becomes a part of his selling price. If he cannot sell his product for a profit over and above all of these taxes, whether they are withheld, deducted, paid on income, or what; if he cannot put all of that in the price of his product and still make a profit, he will go out of business.

Now; is that not correct?

Secretary RICHARDSON. Yes; it is.

The CHAIRMAN. So, in the last analysis, he has to pay all of these taxes and put it on the price of the product. Then when he sells the product, in the final analysis, the consumer, be he the working man, or the retired person who is living on his retirement income, will end up paying the taxes to pay for all of this.

Secretary RICHARDSON. Exactly.

The CHAIRMAN. It works out that way; does it not?

Secretary RICHARDSON. Yes.

The CHAIRMAN. So what we are really trying to do is provide the best deal we can get for the average citizen of this country. Whether we do it by private insurance, whether we do it by compulsory insurance, or whether we do it by Government taxes; we are trying to find the best way to provide additional health care for people.

The thing that has concerned me is that we have seen how providing health care up until now has cost about 100 percent more and is projected to cost 400 percent more, than what was estimated. One of the largest items in these increased costs is people receiving services that are not entirely necessary, people staying in the hospital for 6 days when 4 days would have been adequate, hospitals keeping people there longer because they have empty beds that they would not otherwise be paid for, and doctors who might be short on practice bringing people back for extras. All of these kinds of things are what the Finance Committee has been trying to reduce; payment for unnecessary services which might be desirable for the person receiving them in some respects, but which are not totally necessary.

Do you have some built-in provision to try to keep optional, but not entirely necessary, medical expenses low compared to the other plans that have been submitted?

Secretary RICHARDSON. Yes; the principal feature we rely on is the provision for deductible and coinsurance. I realize that the question of whether this is a desirable mechanism is highly controversial. We think that there are two reasons for including these provisions. One is that you reduce the overall premium cost, and the other is that you do incorporate a degree of deterrent against unnecessary services.

The CHAIRMAN. Well, now, Senator Kennedy spoke of the efficiency of the military in providing health care, and I would submit that even that could be improved upon.

I recall the days when I was in the military. I was at a naval base and I was a lieutenant, junior grade. There was a sickbay about midway between my quarters and the officers club, so that if I would have a head cold, on my way to the officers club it might be necessary to get my throat sprayed. So you just walked into the sickbay on the way to the officers club and you had your throat sprayed, and you did it again on your way back.

Now, that can be an inefficient use of medical care. When the Government pays for medical care the result is often that people find it convenient to make a demand which he would not make if he were paying for it on his own account.

I take it you agree with this. You suggest that a person should pay for at least the initial part of it, himself. Do you have a coinsurance feature thereafter?

Secretary RICHARDSON. Yes; we do, in the case of the very low-income people, under family health insurance it would not apply, but for everybody else it would involve coinsurance. Under health insurance standards, for example, coinsurance up to $5,000 in bills for an individual, and after that the insurance policy would take over for the whole balance up to $50,000.

The CHAIRMAN. Senator Anderson.

Senator ANDERSON. Well, I keep coming back to this $405 because I think it is not comparable to the $1,271. That is why I would like to have a breakdown of it.

(Clerk's Note: At presstime, May 27, 1971, the material referred to had not been received by the committee. The committee received the following letter May 10, 1971:)

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Sincerely,

STEPHEN KURZMAN,
Assistant Secetary for Legislation.

Senator ANDERSON. Now, currently these health expenses are being paid by the consumers, in addition to the $405, therefore, the figures are not really comparable.

Senator BENNETT. Senator, I suggest that we ask them to submit the details in their calculation so that we can see whether it is, in fact, comparable.

Senator ANDERSON. I would appreciate that. I appreciate what the Secretary has done, and I highly support him in what he has done, but I do think that these figures are not comparable.

Secretary RICHARDSON. I would be glad, Senator Anderson, as Senator Bennett has suggested, to submit a breakdown of it.

Senator RIBICOFF. One question, Mr. Chairman.

The CHAIRMAN. Senator, there is a vote right now, so we will have to go and answer the roll.

Meanwhile, I suggest that we hear the remaining witness at 2 o'clock this afternoon. I will leave it in your hands, Senator.

Senator RIBICOFF. Mr. Secretary, under the administration plan, a poor family without children would not be covered?

Secretary RICHARDSON. No; they would not.

Senator RIBICOFF. And if you had a student, or a married couple, single, or a couple without children they would not be covered by the plan?

Secretary RICHARDSON. They would not.

Senator RIBICOFF. That is all.

The committee will stand in recess until 2 o'clock.

(Thereupon, at 1:10 p.m., the committee recessed, to reconvene at 2 p.m. this same day.)

AFTERNOON SESSION

The CHAIRMAN. The hearing will come to order.

The next witness is Mr. David Mosher, president, and John Pickens, counsel, the American Nursing Home Association.

I would like to state for those who are present that Senator Harry Byrd is presiding over a hearing for a Subcommittee of the Committee on Armed Services, and he told me to announce that he will be along as soon as he can.

Will you proceed, sir?

STATEMENT OF DAVID MOSHER, PRESIDENT, AND JOHN PICKENS, COUNSEL, AMERICAN NURSING HOME ASSOCIATION; AND STANLEY WILCOX, PRESIDENT, VIRGINIA AMERICAN NURSING HOME ASSOCIATION

Mr. PICKENS. Mr. Chairman, I am John Pickens, counsel for the American Nursing Home Association; and I am accompanied by Mr. David Mosher, who is the president of the association, and who also operates three facilities in St. Petersburg with 339 beds—St. Petersburg, Fla. On my left is Mr. Stanley Wilcox, who is the president of the Virginia association and a governing council of members of the American association, as well as a member of our national health committee; and at the present time he operates a facility of 215 beds in Charlottesville, Va.

Mr. Mosher will present our statement, and all three of us will be available for questioning. We certainly appreciate the opportunity to appear before you.

Mr. MOSHER. Mr. Chairman, the association appreciates the opportunity to be here again before the Senate Finance Committee.

The announcement of these hearings indicated that the initial hearing would be concerned with the broad considerations involved or raised by national health insurance. As the association representing nursing homes, we are primarily concerned with those factors affecting the delivery of health services in the most efficient and economical manner, to individuals with chronic illnesses, regardless of age or delivery setting from acute hospital, extended care facilities, skilled nursing homes, intermediate care facilities, custodial care homes, and, finally, to home health services.

National health insurance or any total health care program, in our opinion, should reduce the catastrophic financial impact of the cost of health care on the patient. No one foresaw the severe strain on the Nation's health resources that has developed since the beginning of the medicare and medicaid programs in 1966. During the period of the 90th session of Congress, 1967–68, there was some realization of the problems developing; but full realization didn't come until 1969–70.

During the last session of Congress, this committee and its staff devoted much of its time and effort developing legislation which would eliminate abuses, stimulate better utilization of existing facilities, and improve the administration of the program.

The extensive work of this committee during the last session changed or added 61 sections of medicare/medicaid legislation: 10 of these sections were substantial modifications of the House bill, and 28 were new provisions. In order to clarify the concerns which I have expressed, I would like to review a few of those sections.

The first, section 232, provided additional funding for claims processing and information retrieval systems to improve administrative expertise.

Section 222 provided for reimbursement experiments in recognition of the fact that present reimbursement methods are not acceptable. Many other sections also dealt with this perplexing problem of administration.

Section 221 provided controls on capital expenditures for facility construction or expansion. The members of this committee are certainly aware of the fact that some communities lack health facilities, while others have an excess, and while still others have a severe duplication with no health care planning.

As an insert in the remarks, Senator Ribicoff this morning led me to comment that much of the overbuilding that has come to the attention of the health care industry came about because of a lack of health planning. Much of the duplication is for the same reason; and as you mentioned this morning in regard to another issue on the profit, that the nonprofit development or delivery of health care services, all the way up the ladder, has profit built into it; and in the end, the nonprofit facility often costs a great deal more than the proprietary facilities. This, then, is perpetuated by the tax structure because the higher cost facility has no taxes and the lower cost facility is taxed from that point on.

Section 239 was a recognition that health maintenance organizations may be a major improvement on the present health delivery system which would conserve our resources and reduce costs if properly structured with detailed standards in the act itself, and accompanied by compulsory regional health planning controls. There is a great amount

of optimism which we hope will be justified when we have more experience.

Section 245, introduced by Senator Bennett, will provide a major program for utilization control through professional standards review organizations. The organizations, in our opinion, have a potential for accomplishing more than any other single proposal toward achieving the goal of providing the right kinds of care in the proper setting while moving the patient through a continuum of health care.

These pending legislative proposals are illustrations of the severity of the existing problems. National health insurance proposals should be evaluated in terms of the increased demands on the health care system, and the possibility of making the necessary improvements in the system and its resources in time to meet those demands.

At this time, I would like to review the six bills before the committee in terms of the benefits contained in these proposals and current programs that are provided by the facilities that are members of the American Nursing Home Association. These evaluations of the proposals are based on the best information available to us at the present time, and the proposals are subject to different interpretations.

First, the benefits in these six bills comparable to present medicare extended care benefits: These benefits are defined and administered as an extension of hospital benefits which require a high level of skilled nursing services, over a short period of time. The maximum coverage is 100 days during a spell of illness. In practice, however, the average stay is estimated to be 25 days, with many stays of 10 days or less.

The first bill—that is, S. 3 (Senator Kennedy's proposal)—provides 120 days per spell of illness in a free standing facility and unlimited days in a hospital based facility. The benefit is available to all eligible residents covered by the program. Why, we ask, should the proposal discriminate against the free standing facility whose costs are lower, especially if we are looking for efficiency?

The second bill, S. 191 (Senator J. Caleb Boggs): There are no specific provisions for extended care facility coverage. Policies would be developed subject to approval of a Commission and may or may not cover extended care facility benefits.

The third bill, S. 836 (Senator Jacob K. Javits), provides an indefinite length of stay in an extended care facility if there is a medical necessity, and extends the benefit to all persons who elect to purchase the coverage.

The fourth bill, S. 987 (Senator Clifford P. Hansen), continues present medicare coverage for persons over 65 and adds tax credits for costs of insurance policies that may include benefits comparable to ECF.

The fifth bill, S. 1376 (the chairman's bill), provides for continuation of the present medicare ECF benefit for persons over 65 and provides most persons under 65 benefits following a hospital stay with no limit on the number of days. However, payment would be made only after the person had met a 60-day hospital deductible and was covered for at least 1 hospital day under the catastrophic program.

Before we proceed to total national health insurance, we should fill the need for the catastrophic situation and correct the present problems in medicare and medicaid. Until we improve the present program and correct errors in the law and errors in administration we are only seeking further trouble.

Everyone concedes that the reimbursement concept of "reasonable costs" is a failure and that we should have a prospective rate. Yet, except for a few innovative changes stemming mainly from this committee, we still keep "reasonable costs" with its astronomical administrative expense, its "audit overkill," its retroactive denials and other problems.

Senator Long's catastrophic illness bill should receive immediate consideration. The principal conditions which maim the elderly and bring on catastrophic situations are heart disease, stroke, and cancer. There are many others. However, we see no need for requiring 61 days of hospitalization prior to possible transfer to an ECF. This, in our opinion, should depend on the condition of the patient. Frequently, these catastrophic cases stabilize in the first 15 to 20 days and a less intensive type facility than a hospital, such as an ECF, will suffice at far less cost. Then, at some point in many cases, a transfer to an even lesser type care facility than an ECF may become feasible.

The sixth bill is S. 1490 (Senator Thomas J. McIntyre), provides 120 days of nursing home care for the poor and near poor and 60 days for those financially able to purchase an approved policy. (The limited number of days of coverage indicates that this coverage is intended to be comparable to the ECF level of care).

In summary, these six bills either provide extended care benefits which, under the present regulations are unusable, ill-defined, or, no benefits at all. By this we mean that if we provide 100-day benefits but in practice you can only get 10, 15, or 20 days, you really do not have and do not need a 100-day benefit. We believe that hospital and ECF days should be limited to a range of 50 to 60 days except in the case of certified catastrophic illness and that the co-insurance factor commence at the 20th day for both hospitals and ECF's. In the case of a catastrophic illness, the co-insurance should cease on the 60th day in either facility and become, in effect, a disappearing co-insurance factor. To legislate benefits far in excess of the average patient stay results in malingering and excessive costs. A patient should be allowed to exchange one hospital day for two ECF days. If the present definitions are continued, the number of persons who become medically eligible for the ECF benefit will be minimal unless patients are transferred from hospitals immediately at the end of the acute phase of their illness.

Section B, which is a comparison of the benefits to present title XIX (medicaid) skilled nursing home care: Skilled nursing home care patients require skilled nursing care but usually of less intensity than ECF patients and for a longer duration. The benefit must be included in State plans for the grant recipients but States may set the duration of the coverage. Incidentally, in general they cover the vast majority of the elderly.

In general, the six bills before this committee do not change the present medicaid coverage. S. 3, the (Kennedy) bill, appears to eliminate the benefit from title XIX. None of the bills appear to include a long-term institutional coverage other than as a continuation of the welfare program benefit. In addition, the bills do not provide coverage for mentally ill or mentally retarded except for short-term acute psychiatric care. Similarly, the bills do not provide an intermediate care facility benefit but S. 3 (Kennedy) may also eliminate this welfare program.

It is our opinion that we should proceed with these programs using extreme caution. If we have learned anything from 5 years of medicare and medicaid it is that—

(1) We should crawl before we walk, and walk before we run. We should set goals in the law that we know are obtainable within 2 or 3 years—goals that can be soundly financed. Let us err by giving fewer benefits for the first 2 years rather than giving greater benefits than we can afford and then have to cut back. In medicare this resulted in retroactive denials which harmed the beneficiaries and caused many good providers to phase down or phase out of medicare.

The States now in the most trouble with the medicaid programs are those that went in first, fastest, and farthest.

(2) We also learned from medicare that any program must have built-in procedures for administrative and judicial review for the providers as well as beneficiaries otherwise arbitrary regulations are spawned and capricious decisions encouraged. An administrator of any act or program always does better when someone is looking over his shoulder.

(3) We also learned from medicare that the Congress could spell out, in detail, the standards as well as the program rather than leave so much of it to the Secretary to fill in by rules and regulations. With five Secretaries in the first 5 years of the program, the mass of retroactive rules and regulations, most of which were not published in the Federal Register, as required by law, has tarnished the "halo effect" surrounding the "Secretary."

The present national health insurance proposals which are intended to lessen the financial impact of the costs of obtaining health care, fail to provide long-term institutional care for the unfortunate person with a chronic illness requiring continuous care that cannot be provided in a home setting. Very few persons have the financial resources to absorb the catastrophic impact of the long-term chronic illness. Failure to provide benefits for the less expensive types of care results in financial pressures on the patient to seek higher cost benefits that are covered by an insurance program. These pressures are transmitted to the physician and the health care system. The pressures are extremely difficult to resist and the ideal continuum of providing the necessary care by the most efficient and economical delivery method is broken. Unnecessary expenses are incurred and resources are wasted.

I do not want to give the impression that the American Nursing Home Association is opposed to national health insurance. In fact, the association recently announced that work had been started on a proposal for the care of the chronically ill through a national program entitled "Chronicare." We did this because all of the national health insurance proposals failed to provide for long-term care of the ill-elderly.

We urge that this committee give serious consideration to providing coverage for long-term chronic conditions, certified catastrophic illness, efficient operation with reasonable coinsurance incentives with a health care continuum, meaningful and usable benefits, standards written into the legislation, reasonable payment for services rendered on a prospective contractual basis, compulsory health planning, a health manpower training program and administrative and judicial review for the provider as well as the beneficiary.

Mr. Chairman, I thank you very much.

60-226 O—71——8

The CHAIRMAN. Thank you for a very thoughtful and useful statement. You made some very good suggestions.

I would like to ask you about Department of Health, Education, and Welfare audit reports which show substantial abuses by a considerable number of skilled nursing homes in medicare and medicaid. HEW has a voluminous stack of reports that suggest, in one respect or another, that there have been abuses. Do you think that this record would justify caution before expanding nursing home benefits?

Mr. MOSHER. I think the fact that there are abuses in the entire program, not just these, but other phases of it, too, should very well dictate caution in moving into anything bigger. And I might add that part of the reason that these abuses got started, and continued was that we did not have the control mechanism before we started passing out money. Now, incidentally, many providers, because there were no rules, did things that they did not know were wrong in 1967, because the rule was not written until 1969, and then they found out that they had done something wrong in 1969. So, it is not entirely a one-way abuse. However, there are abuses, no question about this. So, at this time, we had set out in the legislation, at least, the broad outlines of a new program and instead of going to this visibly reasonable cost of things with everything happening years later, if we went to a contractual program in the beginning and said, "Mr. Provider, you are going to get paid x dollars to do a job for 1 year, and then review it at the end of the year with a new contract, we would have eliminated a great deal of that.

Senator BENNETT. Well, Mr. Chairman, I think I would like to polish up the halo of the Secretary a little bit. On page 9, and I am quoting, you say:

> The massive retroactive rules and regulations, most of which were not published in the Federal Register, as required by law, has tarnished the halo effect surrounding the Secretary.

Are you aware of the difference between a rule and a regulation?

Mr. MOSHER. Yes, sir.

Senator BENNETT. Is a rule required to be published in the Federal Register?

Mr. PICKENS. Well, Senator, I think what he is referring to here is the fact that in the beginning you had the conditions of participation which went through the health insurance benefits advisory council, in which the various interested associations were consulted, and then it was published in the Federal Register. Now, thereafter, you had way over a thousand so-called State agency letters and way over a thousand so-called intermediary letters, each one of which modified the regulation, or each one of which modified the regulations that had been published in the Federal Register, and, of course, it is, I think, also our contention as well as most of the other associations in the health care field that every time you modify the conditions of participation that were published in the Federal Register the modification has likewise to be published, and this is what he referred to.

Senator BENNETT. I think this is a misunderstanding on your part of the way the system operates. If the matter is of sufficient importance that it become a regulation, it becomes a regulation under the authority of the Secretary and must be published in the Federal Register. But, with respect to particular problems that come up from time to time,

lesser interpretations of the regulations are published as under the title of rules. The counterpart of this in the Internal Revenue Service is the Secretary issues regulations, but on request the Service will issue a ruling, interpreting the regulation, and so I do not think the inference here is that the Secretary has violated the law, and I do not think you want that to stand.

Mr. MOSHER. No; no, that is not the inference we meant at all.

Senator BENNETT. The inference is, "which were not published as required by law and has tarnished the halo effect on the Secretary." Now, are you willing to agree with me that some of them were not required by law to be published in the Federal Register?

Mr. PICKENS. Well, those that were actually interpretations, but we are saying that many were of a substantive nature, that changed the conditions of participation.

Senator BENNETT. Can you furnish the committee with some examples or areas in which rules were issued which in your opinion should have been regulations?

Mr. PICKENS. Yes, sir; yes, Senator.

Senator BENNETT. I would like to have them, but I do not think you want the inference in your testimony to stand that five Secretaries have deliberately violated the law.

Mr. PICKENS. No; no such intention was meant.

Senator BENNETT. OK.

Mr. MOSHER. Perhaps this might clarify what we are talking about that in many instances instead of the committee or Congress writing details, they were left to the Secretary, and well, with the continual turnover of Secretaries, there is a feeling that the Secretary can take care of everything and yet, in fact, he is a man like all the rest of us and has not been able to, and it has been delegated to a thousand people.

Senator BENNETT. This is standard procedure. We could not sit here and write specific detailed language to cover every conceivable situation. If we did, that law would be so rigid that nobody could live under it.

Mr. MOSHER. That is correct.

Senator BENNETT. So, our job is to lay down what is the basic policy or program, and we have to leave the administrative officers the responsibility to interpret and apply those, and in the process you get applications at different levels. The Secretary is responsible for the general application, and usually the responsibility of someone below him is for what we would call a ruling or rule which applies to some particular program. Sometimes rulings become regulations, but not always. So, we would be interested if you can furnish us with some examples of things that you think should have been regulations rather than less significant forms of rulings.

(Clerk's Note: At presstime, May 27, 1971, the material referred to had not been received by the committee.)

Mr. PICKENS. We will, Senator, and I might add that had we had administrative or judicial review many of these things would have been corrected. Now, we think you came up with a very good provision for administrative review, which we have not had for the past 5 years.

Senator BENNETT. I have no further questions, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Tomorrow we will continue our hearings and our scheduled list of witnesses includes Mr. Leonard Woodcock, President of the United Automobile Workers on behalf of the Committee of One Hundred for National Health Insurance, the Honorable Jacob Javits, the Honorable Caleb Boggs, Andrew Biemiller, for the AFL–CIO, and Mr. Walter McNerney, president of the Blue Cross Association.

Thank you very much.

(Whereupon at 2:35 p.m., the hearing was recessed to reconvene on Tuesday, April 27, 1971, at 10 a.m.)

NATIONAL HEALTH INSURANCE

TUESDAY, APRIL 27, 1971

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to recess, at 10 a.m., in room 2221, New Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present: Senators Long, Anderson, Ribicoff, Bennett, Curtis, and Jordan of Idaho.

The CHAIRMAN. This hearing will come to order.

The committee is pleased to open today's hearing with Mr. Leonard Woodcock, president of the United Automobile Workers in behalf of the Committee of One Hundred for National Health Insurance.

Mr. WOODCOCK. Thank you, sir.

The CHAIRMAN. We are happy to have you with us today, Mr. Woodcock, and to have your views on this very important issue with which your organization, and you as a prominent member of it, have been extremely active down through the years. We congratulate you on the contribution you have made to better health in this country over the years.

STATEMENT OF LEONARD WOODCOCK, CHAIRMAN, HEALTH SECURITY ACTION COUNCIL, AND PRESIDENT, INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE, AND AGRICULTURAL WORKERS OF AMERICA; ACCOMPANIED BY DR. I. S. FALK, PROFESSOR EMERITUS OF PUBLIC HEALTH, YALE UNIVERSITY SCHOOL OF MEDICINE; MELVIN A. GLASSER, DIRECTOR, SOCIAL SECURITY DEPARTMENT, UAW; AND MAX W. FINE, SECRETARY, HEALTH SECURITY ACTION COUNCIL

Mr. WOODCOCK. Mr. Chairman, with me today are three associates of the Health Security Action Council, Dr. I. S. Falk to my right, professor emeritus of public health of the Yale University School of Medicine, Mr. Melvin Glasser, director of UAW Social Security Department, and Mr. Max Fine, secretary of the Health Security Action Council.

For the past 30 months I have had an intensive exposure to the growing health care crisis in America. As a member and now as chairman of the Committee for National Health Insurance, I have become well acquainted with the causes of the crisis. I have examined the various proposals for national health insurance to deal with the

problems. I have reviewed the dubious records of service of the health insurance industry. The union I lead has had a 10-week strike, and one of the issues that prevented a settlement was health care costs. Our members have been compelled to pump even more of their hard-earned dollars into wasteful and inefficient medical system through the conduit of a health insurance industry which is neither willing nor able to control the costs or quality of medical care.

That, Mr. Chairman, I believe to be the cardinal point in the crisis we face.

Mr. Chairman, my colleagues and I are well aware of this committee's increasing concern with the cost and quality of medical care. And we wish to express our appreciation to you for holding these hearings. We are confident the hearings will serve to separate myth from reality with regard to the efficacy of the various national health insurance proposals.

Most of the proposals are offered as a response to the chaotic state of today's health care, which is marked by chronic professional manpower shortages, and disorganized services, as well as by galloping inflation and resistance to quality improvements. Most of the proposals lament the lack of public accountability in the medical care system and the absence of consumer participation in the decision-making by providers of health services. Most of the proposals reveal in the health care delivery system methods which are outmoded, costly, often ineffective and semifunctional. Most recognize that solo practice, fee-for-service medicine is uneconomic, increasingly unproductive and likely to provide less adequate medical care than other types of delivery arrangements which are now available and will be tested. Most conclude that treatment after becoming ill is more costly and less effective than preventive medicine. Most demand change.

Mr. Chairman, only the National Health Security Act follows the problems where they lead. For example, there is no longer any question about the private health insurance industry as a major causative factor in the outrageous inflation of medical and hospital costs. And while we find much to comment in President Nixon's overall health proposals (our detailed comments are found in the testimony we are herewith submitting) we must challenge his "National Health Insurance Partnership" plan which would rely even more heavily on the private health insurance industry. And so would the other major health insurance bills.

Those of us in the labor movement have learned through bitter experience that we cannot rely on private health insurance. And if we do, we find it costly and nonresponsive to our needs. We have learned that exchanging dollars for benefits through the health insurance industry merely feeds the fires of inflation. Organized labor helped to make possible the growth of private health insurance. It is an industry which should be concerned with our interests as well as its own. But it is an industry that has failed. It has failed to guide or improve the delivery of health care or to provide the financial protection that legitimately has been expected of it. There is nothing in its history or its structure that suggests private insurance can or will do appreciably better in the future, especially in view of the more complex and more acute difficulties it has greatly helped to create.

It provides sickness insurance, not health insurance.

It fails to control costs or assure quality.

It supports practically no preventive health services and has minimized cost saving ambulatory care.

It has failed completely to make available health services to the poor and the medically indigent.

It has a large responsibility for having directed care away from appropriate, but uninsured methods of relatively low-cost care, and to high priced, but insured institutional methods whether necessary or not—thus having supported the unconscionable rise in those costs.

Despite some 30 years of private insurance company effort, over 30 million Americans have no coverage whatsoever. What coverage there is for others, is so limited that today, private health insurance covers barely over a third of consumer health expenditures.

And in terms of consumer needs, it continues to promote so-called major medical benefits where the use of deductibles, dollar corridors, and coinsurance functions as deterrents to early diagnosis and treatment so that the benefits may become relatively meaningless, except to people with substantial private incomes.

There is no question that many people are wiped out financially by the costs of a catastrophic illness. But the major medical, or as it is sometimes called, catastrophic illness insurance, provides the form but very little substance of coverage.

It usually sets no standards for providers of services, it pays only a portion of the bills, it assumes the covered individuals have adequate basic health insurance, it encourages inappropriate use of health facilities, and most important, since it contains no provisions for relationship with providers and no meaningful cost or quality controls it adds an especially inflationary factor to the costs of health programs.

The Nixon administration relies on the private health insurance companies as the foundation for all our aspirations in personal health care. But they are part of the problem, not part of the solution.

The administration's own bill, now that we finally have a look at it, reminds me of the old buffalo policy. There are deductibles, coinsurance clauses, exclusions, loopholes, and gaps—so much "fine print" that it resembles the policy that covers you only when you are run over by a herd of buffalos in downtown Detroit, at high noon. [Laughter.]

Two months ago Secretary Richardson said the administration would offer the "right-sized patch" to cover the health care crisis. The President himself said four of the major problems the legislation would be designed to deal with were: (1) many private health insurance policies cover hospital and surgical costs but leave critical outpatient services uncovered; (2) most private health insurance policies fail to protect beneficiaries against the cost of major illness and accidents: (3) most private health insurance cannot be applied to membership in a prepaid group practice plan; and (4) private health insurance has failed to help the poor.

We agree with the President's diagnosis of a failing health insurance industry. But his prescription fails to measure up to the size of the problem and the ingredients are subject to serious challenge. The "patch" is the wrong size and the wrong prescription.

This is the first time I can recall when a Republican administration is proposing to saddle business with greatly increased costs and representatives of labor are attempting to protect those business interests from these unwarranted impositions.

We must free ourselves of the notion that the present system can be patched together with band-aids and bailing wire. It needs a complete overhaul to provide the service the American people are entitled to receive.

The administration's health insurance partnership provides nothing for part-time or seasonal workers. No new benefits are proposed for the aged. Nothing for workers who are laid off or on strike. Nothing for employees of Federal, State, or local governments and certain other categories.

It provides nothing for anyone who must be hospitalized for a day or two. For the worker with a history of back pains, or any other so-called preexisting condition, who is hospitalized for that condition, it allows the insurance company to deny his claim for the first 6 months.

It provides no coverage for psychiatric care, nothing for prescriptions at the drugstore or on an outpatient basis, nothing for prosthetic divices, nothing for dental services. For the child up to age 12, it provides for an annual eye examination, but not for his parents or his older brothers or sisters.

The "patch" leaves other parts of the problem exposed as well. Even for the hospital stays which are covered, the patient must pay 25 percent of the total cost of $5,000 in addition to paying 100 percent of the hospital cost for the first 2 days. He must pay the first $100 of his own doctor bills and $300 of his family's and 25 percent after that.

For the working man and his family, Mr. Chairman, I submit the Nixon plan is a catastrophe.

I am particularly amazed that the administration's proposal is silent on maintaining at least what has already been achieved in private health insurance. It would seem that every labor union with a more adequate health plan than that proposed would be confronted with a new hassle in getting the employer to reaffirm contractual benefits. In the health security program we have provided for maintenance of employer effort.

Mr. Chairman, in the interests of time I will submit for the record a typical example of a worker and his predicament under the Nixon plan. Without any extraordinary or catastrophic illness, he would still have to spend over 25 percent of his total income for health care—even though supposedly covered by the insurance companies which are the real beneficiaries of this scheme.

(The example referred to follows:)

AN EXAMPLE OF A WORKER EARNING $7,000 PER YEAR

We have developed an illustrative case of a worker earning $7,000 per year, covered by the President's proposed standard insurance policy and experiencing a typical range of family health problems. The example we have submitted does not include a catastrophic illness, these are typical family health expenses. Under the President's program the worker would have to pay out-of-pocket more than 25 percent of his total annual income for health care.

The illnesses may not be catastrophic but the impact on the worker and his family is certainly catastrophic.

Assume typical family health expenditures:

Worker illness—10 days hospitalization, pays physician fees of $300.

Maternity delivery—6 days hospitalization, pays physician fees of $250.
Routine dental care for family of four, adults, $65, children $780.
Drug therapy for child with asthma—$165, physician visits for children $140.
Eyeglasses for worker, examination $20, glasses $26.
The family pays:

35 percent of premium	$116
2 deductibles of $100 each	200
2 days each—4 days—deductible hospital care at $80 per day	320
25 percent cost for 12 additional days of hospitalization	240
Drugs, incidentals for out-of-hospital care connected with worker illness and wife's pregnancy	200
25 percent of cost for physicians' fees	87
Family dental care	245
Drug therapy for child	165
Physician visits for children	140
Eyeglasses for worker	46
Total	1,759

Mr. WOODCOCK. I know that this committee is aware also of the failures of the insurance industry in the role of fiscal intermediaries in Government programs. In developing the health security program, our own technical committee long maintained an open mind as to the desirability of using fiscal intermediaries. Our investigation was thorough. We met with officials of the Department of Health, Education, and Welfare. We spoke with staffs or congressional committees directly responsible for programs utilizing intermediaries. We carefully perused committee reports, including the excellent staff report of this committee. We are indebted to your committee, Mr. Chairman, for the marked improvement by the Social Security Administration in administering medicare.

But all our investigations have failed to find any valid reasons for employment of fiscal intermediaries or carriers in any national health insurance program. As a matter of fact we fail to understand why efforts are not already underway to eliminate the fiscal intermediary role in the existing programs. The fiscal intermediaries—the fiscal agents—the insurance carriers—have not performed in the general public interest. Their interest is a special interest. They are protecting their territory, and they are doing so at public expense. Even more serious, their resources bulwark and support the weaknesses in the present system and they obstruct progress.

Mr. Chairman, there are some who counsel and advocate that we should deal with each cause of the health care crisis separately. This is a counsel of caution but not of wisdom. It will avail us little if we merely try to produce more manpower or facilities without assuring the availability of funds and a better system for utilization of the personnel. It is unlikely we can contain the skyrocketing costs without a better system for the containment of unit costs of service and for the assurance of reasonable economy in volumes of utilization.

It is not reasonable to expect that we can have or can afford either adequate health manpower and facilities or acceptable financing without a better system of delivery. Neither the health professions nor the public can go much longer without better protections of quality and adequacy of care. And merely providing more purchasing power for medical care—as vital as this may be in protecting the individual and the family—will only further strain the resources for service and will certainly increase the upward push of prices.

Consequently, whether we take shortages of resources, or costs and their financing, or system improvements, or quality assurances as a starting point, we must also look to all the others simultaneoulsy. If not, we will only deepen the crisis and give it a still higher price tag.

Of all the proposals currently before the Congress, or promised to it, only the National Health Security Act would deal with the interrelated causes of the health care crisis. All of the other proposals, and most assuredly those of the Nixon administration, the insurance industry and the American Medical Association, demand unwarranted compromises with the vested interests and the status quo and are likely to accomplish little or nothing of lasting value.

All of the proposals express concern with the economic delivery of health services and the need to prevent further runaway costs. Instead of the futility of encouraging so-called cost consciousness by patients, the health security program provides for prospective budgeting and closed-end payments for services. And only health security thus controls costs.

The Nixon administration and the private health insurance industry assert that strong incentives and impetus must be provided to change the health care delivery system. The administration's actual proposals would do very little indeed toward achieving the declared ends. Only the health security program provides adequate incentives and impetus both for the physician and the provider of services, on the one hand, and the consumer on the other. The health security program provides for the most rapid practicable development of health maintenance organizations, prepaid group practice plans and medical and dental society foundations.

Both the Nixon plan and the health security plan recognize the importance of health maintenance and the possibilities of reducing costs through early preventive care. Only the health security program provides consequential incentives toward this end and also gets rid of obstructive disincentives by removing all barriers to timely care, by eliminating deductibles and coinsurance, by assuring the patient that he will not be billed by the physician or hospital and by treating all persons alike.

Most of the proposals decry the lack of quality safeguards in the present system. But in most proposals, the system of quality controls is unclear, diffuse, and inadequate. Only the health security program includes significant provisions to safeguard quality of care, by establishing national standards for participating individual and institutional providers and by providing for effective professional review and competent peer judgments to assure a level of service delivery compatible with good medical standards.

Most of the proposals recognize the gaps in current manpower and facilities resources. Only the health security program establishes a resources development program with funds adequate to expedite closing the gaps. I would like to describe this special feature of the health security program in some detail in just a moment.

Mr. Chairman, for these reasons and others we urge your favorable consideration of the health security program which we have developed over a period of more than 2 years of intensive study. The health security program is not a theoretical model to replace our present medical system with another. It would proceed on an evolutionary course, not by striving for all its goals on an appointed day, but by

processes of gradualism. It is a program designed to achieve an end to financial barriers that obstruct the ready availability of good medical care for the population. It proposes to make the resources more adequate than they are and as adequate as they can be, while reducing wastes and avoiding extravagences. It would profit from our past experiences—building on the good, discarding the bad. It is a uniquely American plan, building on the strengths of the present system and providing maximum freedom of choice for both providers and users of health care services.

Our program starts with the basic proposition that health care is a right and a necessity, not a luxury. The fact that we are for health care as a matter of right means that all persons legally resident in the United States would be eligible for the benefits of the health security program. Eligibility would not require either an individual contribution history or any means test.

With four modest limitations, the benefits embrace the entire range of personal health services—including care for the prevention and early detection of disease, the treatment of illness, and physical rehabilitations.

On the basis of data from fiscal year 1970, the most recent year for which complete statistics are available, the health security program we are proposing would have paid for a total of $41 billion in personal health care services in the United States. Had the program been in existence in 1970, therefore, it would have paid approximately 68 percent of the $58 billion in total personal health expenditures for that year, or nearly twice the percentage medicare pays. HEW now estimates that by fiscal year 1974 national expenditures on health services will have increased to almost $100 billion; and if this projection is accurate, in its first year of operation health security will cost 68 percent of whatever that outrageously inflated cost turns out to be. The needed funds for the program would be derived from taxes on individuals and on employer's payrolls, with a matching contribution from Federal general revenues. These are not new dollars but rather a rechanneling of existing public and private expenditures.

If we wait longer before instituting a rational system of national health insurance and health security, while prices and expenditures continue to escalate, the costs will be all the higher.

Before closing, I would call your attention to one of the most useful and valuable innovations of the health security program—its resources development fund. During the 2 years after the program is enacted and before benefits become available, the resources development fund would begin to utilize $600 million new Federal dollars to improve and strengthen our health care system and to help assure the availability and the effectiveness of the covered services when the benefit program begins. After benefits become available, a fixed percentage of the overall program funds will be earmarked in the trust fund and used to strengthen the Nation's resources of health personnel and facilities and its systems for the delivery of care.

Since the time allotted for my oral presentation is drawing to a close, I would like to submit for the record our more detailed testimony on the health security program, along with a brief sketch of the program, with your permission.

(The material referred to follows. Oral testimony continues on p. 126.)

Summary of the Health Security Act of 1971

1. *Eligible Persons.*—Every individual residing in the United States will be eligible to receive benefits. There will be no requirement of past individual contributions, as in Social Security, or a means test, as in Medicaid.

2. *Benefits.*—With certain modest limitations, the benefits available under the program will cover the entire range of personal health care services, including the prevention and early detection of disease, the care and treatment of illness, and medical rehabilitation. There are no cutoff dates, no coinsurance, no deductibles, and no waiting periods. The principal limitations are:

Dental care, which is restricted to children through age 15 at the outset, with the covered age group increasing thereafter until persons through age 25 are covered.

Skilled nursing home care, which is limited to 120 days per benefit period. The limit does not apply, however, if the nursing home is owned or managed by a hospital, and payment for care is made through the hospital's budget.

Psychiatric hospitalization, which is limited to 45 consecutive days of active treatment during a benefit peroid; and psychiatric consultations, which are limited to 20 visits during a benefit period.

Prescribed medicines, which are not covered unless they are provided through a hospital or organized patient care program, or are required for the treatment of chronic or long-term illness.

In other respects, the program provides full coverage for physicians' services, inpatient and outpatient hospital services and home health services, and coverage for optometry services, podiatry services, devices and applicances, and certain other services under specified conditions.

3. *Compensation of Doctors and Hospitals.*—Providers of health care will be paid directly by the program. Individuals will not be charged for covered services.

4. *Financing the Program.*—The program will be financed out of a Health Security Trust Fund, acquired as follows:

50% from general tax revenues
36% from a tax of 3.5% on employer's payrolls
12% from a tax of 1.0% on employee's wages and un-earned individual income up to $15,000 a year.
2% from a 2.5% tax on self-employment income up to $15,000 a year.

5. *Cost of the Program.*—In fiscal year 1970, the benefits provided under the program would have totaled $41 billion, or 70% of the total personal health care expenses in the United States. None of the $41 billion in expenditures under the Health Security Program represents "new" money. Rather, this amount of money *is already being spent* by individuals, employers and governments for health care. The $41 billion actually expended in fiscal year 1970 consisted of $29.5 billion in private out-of-pocket payments and private health insurance payments, $11.5 billion in payments by Federal, State and local governments.

Under the new program, however, the same amount of money will provide more health services for more people by revitalizing the existing health delivery system and reducing the inflation in the cost of health care. In addition, under the new program, the relative contributions of employers and of the Federal Government will be increased, but the contributions of individuals and of State and local governments will be decreased. In fact, the program is a direct form of revenue sharing. It will relieve State and local governments of $2.5 billion a year in expenditures for health care, thereby freeing substantial State and local funds for other purposes.

6. *Administration.*—The program will be administered by a five-member Health Security Board in the Department of Health, Education, and Welfare. The Board will establish policy, standards and regulations for the program.

7. *Resources Development Fund.*—An essential feature of the program is the Resources Development Fund, which will come into operation two years before benefits begin. In the first year of this "tooling up" period, $200 million will be appropriated for the fund; in the second year, $400 million will be made available. Once the benefits begin, up to 5% of the Trust Fund—about $2 billion a year—will be set aside for resources development. These funds will be used to support innovative health programs, particularly in areas like manpower, education, training, group practice development and other means to improve the delivery of health care.

8. *Incentives.*—Financial, professional and other incentives are built into the program to move the health care delivery system toward organized arrangements for patient care, and to encourage preventive care and the early diagnosis of disease. Incentives are also used to guarantee quality health care in rural areas.

9. *Starting Date for Benefits.*—July 1, 1973. In the two-year tooling up period prior to that date, the Resources Development Fund will be used to prepare for the program.

TESTIMONY SUBMITTED FOR THE RECORD BY LEONARD WOODCOCK, PRESIDENT, UAW INTERNATIONAL UNION AND CHAIRMAN, HEALTH SECURITY ACTION COUNCIL

Mr. Chairman, I have accepted your invitation to appear today before the Finance Committee primarily to tell you about the Health Security program embodied in Senate Bill 3, introduced by 25 Senators on January 25, 1971. However, since the President's health legislation was finally introduced on April 22, 1971, and DHEW Secretary Richardson and associates testified before you yesterday on the President's program, I am obligated to indicate some comparisons and contrasts and to express some opinions on the issues specifically presented to you by these two proposals which, to be sure, have some elements in common but which pose a clear choice of the signpost the Congress should follow.

At the outset, let's be clear about the problems. We have a crisis, and there is now a wide consensus about the five major causes of this crisis .We will not acheive good health care for all Americans unless we deal meaningfully with the major causes of the health care crisis and with all of them.

These are:

1. Runaway health care costs. For 15 years now health costs have been increasing at twice the rate of increase in the general cost of living. We now spend over $70 billion a year for health care purposes—7% of our entire gross national product. And, under the present system there is no end in sight for these steeply rising costs.

2. National shortages of health manpower, particularly of physicians, continue. And there is no adequate remedy in our present resources and practices.

3. The system for the availability and delivery of medical care is grossly inadequate; it has long been failing the American people. And it will continue to fail unless strong and directed national measures are taken.

4. Quality of medical care ranges from superb to horrid and we lack necessary and sufficient controls for the assurance of that high quality of care which the American people have a right to expect.

5. Our system of medical care functions more and better for those who provide health care services, and for those who insure its costs than for those who use services. It should be restructrued to serve both equally and adequately.

Citing these five causes of crisis is not enough for the diagnosis as a basis for therapy and rehabilitation. We must also recognize that each of these five is inter-related with all the others. Consequently, a sound and adequate program must deal with all of them, simultaneously. And the dimensions and severity of the crisis, and the outlook that it will continue and worsen, dictate that we should deal with them now.

Two years ago, under the chairmanship of my predecessor, Walter P. Reuther, the Committee for National Health Insurance began to develop a program of National Health Security which would deal with all major causes of the crisis. A knowledgeable and expert Technical Committee, supported by specialists in the various areas of comprehensive health services, succeeded in developing a most thoroguh and complete program. It is a plan for an evolutionary movement in the health system. It is a plan for an improved system for the efficient deliver and financing of high quality, continuous, comprehensive health services for all in our nation. It is a plan for assured financial security for American families against the unpredictable costs of serious illness which can be crushing to almost any family and which can come unpredictably to almost any family. Most importantly, it is a single plan, it is not a piecemeal approach, it is not a hodge-podge of badly fitting mosaic pieces poorly related to the needs of the American people. It is not fragments of ideas developed to accommodate special interests rather than the general public interest. And it is a plan whose operation can be readily understood and utilized by the American people.

THE HEALTH SECURITY BILL

The Health Security program incorporated in Senate Bill 3 would deal simultaneously with selected aspects of the problems associated with manpower shortages, and with the basic problems of spiraling costs, unacceptable variations

and uncertainties in quality of care, and the root cause of all of these: lack of effective organization for the delivery of services.

This combined and comprehensive approach favors a rationalized system of national health insurance. Surely a country with the world's most advanced management skills and administrative capacities can expect these to be applied to health. The Health Security Bill envisages that the funds we as a nation can afford to provide will finance the essential costs of good medical care for the years ahead. At the same time, these funds will be building up our capacity for making the availability and delivery of medical care adequate, efficient and reliable on an evolutionary course of development in the years ahead.

The Bill would provide the framework for a living program, adaptable to emerging technology and delivery mechanisms. It does not propose nationalized or socialized medicine. It does not propose that the Federal Government take over the nation's resources for providing medical care—the hospitals, or the physicians, dentists, nurses and the personnel; nor would it arbitrarily compel the health professionals in our country to reorganize and coordinate their fragmented services into a more efficient and less costly health care system. It leaves the furnishing of medical care in the private sector, with wide choices and elections for patterns of practice carefully preserved.

The Bill proposes, rather, the thoroughly American approach of utilizing national economic resources to provide the financial and professional incentives and supports to improve the health care delivery system, with built-in quality and cost controls. It would provide viable and acceptable alternative payment methods to the fee-for-service system without excluding this traditional practice.

Thus, if the Health Security program is described as "nationalization" or "monolithic"—as some are doing, it should be clear that these horrendous words fairly apply to the basic, supportive financing. But they do not apply to the continuing private provision of medical care which preserves diversities, alternatives, voluntary actions of many kinds. Through this partnership of national governmental financing and private provision of the services supported by that system of financing, the Health Security Bill provides a sound foundation upon which this nation could build a modern medical care system. Its cornerstone is the recognition in official national policy that access to the best available health care is a fundamental right in a progressive society. Further, the program contains practical provisions to translate this promised right into reality.

The benefits of the Health Security program would be available to all persons resident in the country. Eligibility would not require either an individual contribution history or any means test.

With four modest limitations, the benefits are intended to embrace the entire range of personal health services—including care for the prevention and early detection of disease, the treatment of illness and physical rehabilitation. There are no restrictions on needed services, no cut-off points, no co-insurance, no deductibles and no waiting periods.

The principal limitations are:

Dental care, which is restricted to children through age 15 at the outset, with the covered age group increasing thereafter until persons through age 25 are covered; and with those who once become eligible remaining eligible thereafter.

Skilled nursing home care, which is limited to 120 days per benefit period. The limit does not apply, however, if the nursing home is owned or managed by a hospital, and payment for care is made through the hospital's budget.

Phychiatric hospitalization, which is limited to 45 consecutive days of active treatment during a benefit period; and psychiatric consultations, which are limited to 20 visits during a benefit period.

Prescribed medicines, which are not covered unless they are provided through a hospital or organized patient care program, or are required for the treatment of chronic or long-term illness.

In other respects, the program provides full coverage for physicians' services, hospital services, and coverage for optometry services, podiatry services, devices and appliances, and certain other services under specified conditions.

The Health Security program recognizes the necessity of moving rapidly, and concurrently with the proposed insurance mechanism, to increase and improve the nation's resources for the delivery of health services. A special feature of this Bill would provide a Resources Development Fund. A fixed percentage of overall program funds will be earmarked and used to strengthen the nation's resources of health personnel and facilities and its system for delivery of care.

This Resources Development Fund would supplement rather than supplant present governmental programs. It would give incentives and innovative support

to comprehensive group practice and other organizational means to achieve the efficient use of personnel in short supply and for the productive delivery of services. It would provide supplemental funds for education and training programs for new personnel—especially for those disadvantaged by poverty or membership in minority groups. It would also provide financial support for the location of needed health personnel in both urban and rural shortage areas.

All services covered under the Health Security Program will be financed on a budgeted basis. Advance budgeting will restrain the steeply rising costs and provide a method of allocating available funds among categories of covered services. Through this process, the Bill can support a range of basic and auxiliary services and modify the undue emphasis on high-cost services and facilities.

By a system of regional allocation of funds, annual budgetary review and approval of institutional service expenditures, and financial reviews and controls on service costs, this Bill provides the means of effecting important health cost controls.

The financial provisions for the Health Security Program carry out the declared intentions to provide adequate and assured financing. It is assumed that the fiscal resources would be geared to where we are with respect to expenditures for medical care in the United States at the time the Program becomes operational. The system would then operate on an annual budget basis, providing nationally an amount of money equal to what is being spent for the categories of covered services. In successive years, the budget amounts would be adjustable with regard for growth of population, changes in price levels, and other factors. The funds would be allotted geographically and by categories of services. Thus, budget provision and control would replace and put an end to open-end escalating costs.

Because of avoidance of waste, reduction of inefficiencies and many other factors our fiscal experts estimate that in the first year of operation the Health Security Program would cost no more to provide comprehensive health services to 210 million Americans than would be expended in that year for fragmented and partial services for fewer people. Furthermore, we believe this relationship of cost factosr would continue in ensuing years.

The needed funds for the Program would be derived in part from general revenues and in part from earmarked taxes on employers (3.5 percent of payrolls) and on individuals (1.0% of wages and salary income and on unearned income), and 2.5 percent on self-employment income. The precise allocation of the costs among these various sources is endlessly arguable. However, the use of the several sources is, we believe, completely sound.

Since the earmarked income for the Program would go into a permanently-appropriated Trust Fund—as in the Social Security insurance programs—the functional operations would have secure and stable financing.

The financial and administrative arrangements of the entire program are designed to move the medical care system toward organized programs of health services, utilizing teams of professional, technical and supporting personnel. Earmarked funds would be available to support the most rapid practicable development toward this goal. State statutes which restrict or impede the development of group practice programs are superseded by provision of the Health Security Program.

A key principle of the Health Security Program is guaranteeing new options in the delivery of health services. We believe the doctor and the patient should both be free to choose an organized health services plan as an alternative to solo service. In either case, there should be freedom of choice to select a doctor or accept a patient.

The Program includes significant provisions to safeguard quality of care. It would establish national standards for participating individual and institutional providers. Independent practitioners would be eligible to participate upon meeting licensure and continuing-education requirements. Provision is made for professional review and competent peer judgments to assure a level of service delivery compatible with good medical standards.

Consumers will be assured a meaningful role at every administrative level. A National Health Security Advisory Council, with a majority of consumer members, would work closely with the proposed Health Security Board in establishing policy and operating procedures. Consumer organizations will be given technical and financial assistance to establish their own comprehensive health care programs. For the first time, consumer organizations will be on an equal footing with even the most powerful of insurance groups.

Health Security builds upon the real strengths of American medicine today and establishes practical measures to eliminate the weaknesses. The Bill provides

a transition to new patterns of organizing, financing and delivering health services wholly within the context of our American value system.

Health Security will increase the opportunities available to doctors, hospitals, and other providers to extend the range and effectiveness of their services. The program provides a framework in which health professionals can improve conditions of practice, quality of education, and professional opportunities. Physicians will have improved support from other members of the health team, enabling them to reduce their heavy work schedules and enjoy additional leisure time.

Medical careers at all levels will attain a security and stability within the system and the program will serve as an attraction for increased recruitment into the various health careers. This will be especially true when adequacy of resources for good practice and easy communication within the system are added to the guarantee of decent income.

When considering a program of the magnitude of Health Security, especially remembering the experience of such federally financed programs as Medicare, Medicaid and CHAMPUS, it is easy to conjure up the specter of hospitals and physicians inundated by unremitting paperwork.

Providers struggle today with the conflicting eligibility and reporting requirements of more than 1800 private health insurance carriers and a score of state and federal programs. Many physicias spend much of their valuable time each day filling out insurance forms, and a significant amount of money for billing and financial record keeping. The burden on hospitals is even worse. The cost of this inefficiency is now somehow passed on to the consumer in higher health care and health insurance costs.

Rather than increasing this mountain of paperwork, the Health Security Program would reduce it. Under Health Security there will be one administering agency; both patients and physicians will welcome the change. Hospital billing would be vastly simplified or largely replaced by patterns of annual budgeting and auditing.

The Program would further simplify today's complex web of payment arrangements for many fragmented public programs for personal health services by incorporating into the Health Security Program all of Medicare, and almost all of Medicaid, and a number of other public medical programs.

The equally fictitious prospect of an enormous uncontrolled increase of administrators at the central office of a national health program can be disposed of as well. Health Security places most administrative responsibility at the regional and local levels. It will establish national standards and assure national financing, but the important decisions affecting allocation of resources and delivery of care will be made in the field. State governments will be actively involved in survey and utilization review programs.

Mr. Chairman, we strongly endorse the Health Security Program and Senate Bill 3. And we recommend its sympathetic study by your committee.

I turn now, Mr. Chairman, to President Nixon's programs, especially as elaborated by DHEW Secretary Richardson.

In his Health Message, the President said that he does not mean to allow each part of the health care system to go its independent way, with no sense of common purpose. But his programs are fragmented and far from being a comprehensive approach.

He stated that it would be wrong to ignore any weaknesses in our present system, and equally wrong to sacrifice its strengths. But his "insurance partnership" recommendations would support major weaknesses not strengths.

We welcome President Nixon's enlistment in the efforts to resolve our nation's massive health care crisis. Until now, this Administration has had little to look backward to with pride in the health field. Unfortunately, the President's new program discloses little to look forward to with hope. His is mostly a plan for the "fifties," not for the "seventies," or "eighties" despite the fact that his program includes some elements which we can warmly endorse.

Permit me to list these proposed supports for established or new programs.

1. To promote the development of health education centers;
2. To expand support for the training of MEDEX and similar types of physicians' assistants;
3. To create a new Health Service Corps under the Emergency Health Personnel Act of 1970;
4. To provide new—and we hope augmented—support for medical schools and other professional education and training institutions, and for students and trainees;
5. Continuing support for bio-medical research;

6. Inauguration of special programs to attack and conquer cancer and sickle cell anemia;

7. To help create a private health education foundation;

8. To implement the Occupational Health and Safety Act; and

9. To provide more generous financial support for the Family Planning and Food Stamp programs.

Further, I take special pleasure in complementing the Administration in placing emphasis on the need to support the development of HMO's—Health Maintenance Organizations. This term embraces Neighborhood Health Centers and Family Health Centers, and—what we and many others have for years known as group practice prepayment plans (GPPP's) and Professional Foundations (PF's).

We are however, deeply disturbed that the praiseworthy objectives for HMO's are not likely to be achieved because of inadequate financing proposals and an unrealistic timetable of organization in the framework of a National Health Insurance Standards-type of program. Indeed, the Health Security Bill gives even more emphasis to systems improvement, comprehensive and continuing care, quality and cost controls through incentives and supports for Comprehensive Health Service Organizations and Professional Foundations.

At this point, Mr. Chairman, I regret that I must cease to be friendly to the President's proposals.

A. He has proposed financial access to medical care for most of the population through a National Health Insurance Standards Act. This Act proposes a backward and intolerable imprisonment of medical care financing in the operations of the insurance industry.

We have developed an illustrative case of a worker earning $7,000 per year, covered by the President's proposed standard insurance policy and experiencing a typical range of family health problems. The example we have submitted does not include a catastrophic illness, these are typical family health expenses. Under the President's program the worker would have to pay out-of-pocket more than 25% of his total annual income for health care.

The illnesses may not be catastrophic but the impact on the worker and his family is certainly catastrophic.

Assume a typical family health expenditures:

Worker illness—10 days hospitalization, pays physician fees of $300.

Maternity delivery—6 days hospitalization, pays physician fees of $250.

Routine dental care for family of four, adults, $65, children, $780.

Drug therapy for child with asthma—$165, physician visits for children $140.

Eyeglasses for worker, examination $20, glasses $26.

The family pays:

35 percent of premium	$116
2 deductibles of $100 each	200
2 days each—4 days—deductible hospital care at $80 per day	320
25 percent cost for 12 additional days of hospitalization	240
Drugs, incidentals for out-of-hospital care connected with worker illness and wife's pregnancy	200
25 percent of cost for physicians' fees	87
Family dental care	245
Drug therapy for child	165
Physician visits for children	140
Eyeglasses for worker	46
Total	1,759

B. He has proposed a Family Health Insurance Plan (FHIP) which would preserve a separate exceedingly limited insurance plan for low-income families with children which would be less generous than Medicaid in many States and would result in *reduction* in eligibility and in benefits to many families through its income ceilings, deductibles and coinsurance.

C. He has proposed preserving a separate and limited Medicaid program for the poor and near-poor aged, blind and disabled.

D. He has proposed improving Medicare by combing Part A (hospitalization) and Part B (medical, etc.) and relieving the aged of premiums for Part B; but he has also proposed reducing the benefits—which have been less than adequate since the program's enactment; in effect, he is proposing savings for the elderly who are well and increased costs for those who are ill.

E. He has proposed separate private insurance pools for those not embraced by his national insurance program.

F. He has overtly included in the pattern something identified as a "partnership with the insurance industry"—with no specific assurances at this time that this would be a partnership in the public interest rather than for private exploitation.

This Committee is well aware of the failures of private health insurance both as risk-bearers and as fiscal agents for Federal and state governments. The Finance Committee 1970 staff report on Medicare & Medicaid documented the scandalous performance of these insurors as fiscal agents and the recently published HEW annual report on private health insurance does the same for health insurance companies in their private capacity.

The HEW report presents current available data on the performance of the health insurance carriers on whom the administration is placing primary dependence for the operation of its program. The report confirms the failure of private insurance not only to provide health security for the American people but also to operate very efficiently. And the performance of the commercial carriers in some respects is worse now than even 20 years ago. In the data year of 1969, the commercial insurance companies received $7.6 billion in premium payments for health policies, and returned only $6.3 billion in benefits—a takeout of 16.7% for administrative costs and profits.

For 41,469,000 Americans who purchased individual or family health insurance policies in the data year of 1969, the insurance companies retained 49.2 percent of their total premium income for operating expenses, additions to their reserves or profits! In other words, only $957 million of the $1.9 billion paid by individuals to health insurance companies—slightly more than half—was returned to them in the form of benefits.

The administrative records of Blue Cross and Blue Shield are considerably better, but few national organizations approach the low administrative costs incurred by the Social Security program.

Mr. Chairman, we have looked—but in vain—for the specifications we had a right to expect for cost controls to contain catastrophic and continuing escalations of costs; for protections and assurances of quality of care; for estimates of expected costs of the principal insurance program; for estimates of the impacts of those costs on employers—large and small, with high and low labor staffing; for estimates of impacts on families of various compositions, in various economic circumstances, in diverse employment situations.

We have tried to infer what we have not found in the available record. We can only report that the combination of what has been formally reported and what we can infer leads to the conclusion that the Administration's insurance program would be an invitation to disaster.

There is a basic reason for the unacceptability of major features of the President's program, especially those dealing with the financing of personal health care services.

In conclusion, Mr. Chairman, while President Nixon's strategy for dealing with the health crisis—which he himself decried 21 months ago—is to promote a health insurance industry that is no longer able to meet the nation's needs. We find his program an attempt to patch up the present system rather than to deal resolutely and adequately with the crisis problems and needs.

The Health Security program presented in Senate Bill 3, which we favor, offers the means of making comprehensive personal health services available to all Americans and the means to effect major improvements in the organization and methods of delivering care. We hope your Committee will study this program and that from your consideration will emerge further clarifications and improvements so that the needs of the American people can best be served.

We urge the Finance Committee and the Congress to give high priority to the Health Security program for legislative study and action lest the medical care crisis swell to the proportions of a massive disaster.

The CHAIRMAN. Senator Ribicoff.

Senator RIBICOFF. Mr. Woodcock, I welcome you here, with the men beside you, I know all of you to have been involved in programs such as this for many years.

I want to take this opportunity again to pay tribute to the UAW for your continuing deep concern with social problems which aren't necessarily confined to your membership alone.

There are a few statements here that are important because I don't think they are sufficiently understood by myself, the public or other members of the committee.

When you state these are not new dollars but rather a rechanneling of existing public and private expenditures, Senator Kennedy had his charts explaining what was going to happen with health expenditure dollars, and then the administration came in with its program and, the questioning seemed to indicate there was a fantastic gap between what the administration program would cost and Senator Kennedy's proposal would cost. I think the point that Senator Kennedy was trying to make was that if it came to direct taxation his program would cost more but if you took into account what the public was paying the overall cost would be the same. Either you or these economists with you, I would hope you would go into a little more detail to explain why in the final analysis the overall costs to the public are the same.

The chairman in his usual pithy way made his own remark that no matter how you slice it one way or another the public was going to pay for it, because there isn't any free lunch any more.

So will you explain Senator Kennedy's chart and the administration's chart and why it comes out the same as far as the general public is concerned?

Mr. WOODCOCK. I will try and I may need assistance of my good friend Dr. Falk.

It is a fact that there is a certain bill for our present health expenditures which is being paid in various forms, some in taxes, some in premiums, some in direct costs. The members of the UAW, I think, are among the more privileged so far as protection against health expenditures are concerned. Yet, nevertheless, our coverage is only about one half of total health expenditures.

In the General Motors strike, for example, an issue was the escalating costs of health care with the corporation saying to us we want those increased costs to be taken out of the wages of our employees, your members. We resisted that, but nevertheless they are paying it to some extent because in the cost of living escalator formula that was restored to the contract the arithmetic really should say for every three tenths of a point upward movement there should be a penny paid in wages. In fact the contract says it takes four tenths of a point upward movement to pay a penny additional in wages. And we accepted the four tenths.

Senator RIBICOFF. What did that amount to in dollars in your negotiation with General Motors?

Mr. WOODCOCK. All right, now, the cost of living has gone up on our escalator to the extent of 12 cents, it is not being paid but it has become due. That really should be 16 cents, so right now the equivalent of an $80 per year is being paid in an unseen form by General Motors workers precisely because of this escalating cost of health care.

Now the more cardinal point is this. Our program is the only one which has a viable method of controlling costs as well as controlling quality. Otherwise, we are going to have a runaway inflation. Some estimates go as high as 15 percent per year compounded, which will be an absolutely impossible burden to this nation or its employers or its citizens.

Senator RIBICOFF. If there is a general inflationary pressure on every item of goods or services in this country——

Mr. WOODCOCK. But this is twice the national rate.

Senator RIBICOFF (continuing).—How are you going to contain it in the health field.

Mr. WOODCOCK. The escalation of inflation in this field is more than twice the national rate of inflation, and where the other elements of inflation are now being to some extent moderated this is not true of the inflationary factor in health care, because there is no attempt to control it. There is no attempt to control costs and at the same time, there is no attempt to assure quality.

Now, we have talked about this endlessly. This is so frustrating a matter. We are so convinced of the soundness of our point of view, that this is the only viable method by which costs can be controlled and this monster reined in, but we don't seem to be able to get the point across.

Senator RIBICOFF. Because it is difficult. You are going to have to stay with it because when Senator Kennedy puts a chart up and says "my program is going to cost $68 billion dollars, the Administration comes in and says "my plan is going to cost four and a half billion dollars," immediately the public goggles, "$68 billion and $4 billion, you can't afford to pay $68 billion."

Aren't we really saying that the overall cost to the public is the same but the way it is being paid is different; that in the final analysis your overall cost is the same to the public.

Mr. Woodcock. Well, Senator, I don't agree with that.

Senator RIBICOFF. All right.

Mr. WOODCOCK. Given enough time of the existence of a rational program that begins to move the system toward a better method of delivering health care, with costs control as well as quality assurance, the overall sums being paid through taxes to support this system will be less than the overall dollars paid to pay for health care as long as the present form continues. This will be a less expensive program.

Senator RIBICOFF. Your contention is the administration program will not control rising costs.

Mr. WOODCOCK. Spokesmen for the administration have said, "Yes, we propose to control costs," but they have not made any proposals at all to that end. It is simply a promise for the future which has to date not even begun to be met.

Senator RIBICOFF. Now, also you make the point that the system has broken down, and this is one of the problems, and it is, the system of delivery, and you say your program, with its resource development funds, will alleviate the problem. But do you think 2 years are sufficient to be able to remedy or correct this system in such a way that the system will be able to take care of the increased demand that will be engendered by the passage of any health care program.

Mr. WOODCOCK. No, no. We say 2 or 3 years is a running start toward beginning to master the problem.

Senator RIBICOFF. All right, if we had reached that stage aren't we going to have to concern ourselves, responsibly, whether you or this committee, with trying to inventory what the system is, what its potential is, how we phase it in together with the services and the program and the system where we have to coordinate all of our activities in order to make sure we just don't get sunk with the health program. I think the greatest tragedy would be to have a pro-

gram, to pass a program, giving everyone the feeling of confidence or assurance they are going to have health care and find out we can't deliver it to them.

Mr. WOODCOCK. Well, we would share that concern and the 2 to 3 years lead-in time is not to solve the problem because it won't be solved in that short a span of time. The big part of the problem is the assurance of necessary professional and paraprofessional personnel to make the program viable.

Senator RIBICOFF. There have been many suggestions presented to the committee and they vary and many of them have very good points. How would you react to a series of pilot programs around the country incorporating the different programs that have been formulated and let's try them out and see which one works out the best? How would you react to that?

Mr. WOODCOCK. Well, our minds are not closed to anything which is experimental. We would be concerned if that were done to the end of delaying the necessary basic surgery that we think is required. The more we delay, the more the inflationary costs escalate, the greater the problem will be.

Senator RIBICOFF. One more question before passing to my colleagues and then I will come back for some more questions.

Do you feel the health insurance industry is beyond redemption?

Mr. WOODCOCK. Well, I don't want to use that harsh a term.

Senator RIBICOFF. Well, for practical purposes your indictment is pretty broad, and the abuses you cite, Mr. Woodcock, are justified, I think. But the administration now contends that if the health insurance industry became part of the system there would be national goals and national regulation, and you would have a different program and a different involvement for the health insurance industry than it ever had before.

Do you think then that the health insurance industry with those types of reforms and national standards could be used in a health insurance program?

Mr. WOODCOCK. Well, to date, of course, they make no attempt to control costs because that is not their business. Their business is to exchange, to take in premium dollars and to pay out those dollars for the services that are made, whether the services are needed, not needed or whatever. But they have to be concerned about that.

Senator RIBICOFF. That is the past.

Mr. WOODCOCK. That is the past.

Senator RIBICOFF. Do you think something could be worked out in the future?

Mr. WOODCOCK. Well, the very best they could do is the equivalent of what we propose and they would have to be paid an administrative cost which would be fragmented into, what is it, over 1,800 separate units which is quite uneconomic and unnecessary, plus those unduly high administrative costs and a profit on top of it. It is an unnecessary expenditure of public funds.

Senator RIBICOFF. That is all for now.

The CHAIRMAN. Senator Jordan.

Senator JORDAN. Thank you, Mr. Chairman.

Mr. Woodcock, you have made a very constructive statement. I don't think many of us disagree about our goals and objectives. The question is how best to achieve them.

The criticism all is pointed at the system—the delivery system for medicare, for medical attention and medical hospitalization, and so forth. What degree, in your opinion, of wastage is there in the present system. That is the thing we are trying to eliminate. Have you any idea, have your economists come up with a figure?

Mr. WOODCOCK. Before asking Mr. Glasser who, I believe, has some figures that go directly to your question, it is a fact, Senator, that there are 30 million Americans who for all practical purposes today are entirely outside the health care system. There are another 41 million who have to buy individual policies to get varying degrees of coverage, and for every dollar that they pay out they get back in benefits only 50 cents. The other 50 cents goes in administrative and overhead costs.

Senator JORDAN. These are the people we want to help. But how do we eliminate the wastage, duplication and inefficiency, and what percentage of the present cost of health care and services does that wastage constitute?

Mr. WOODCOCK. If I may I would like to ask Mr. Glasser to respond.

Mr. GLASSER. Senator Jordan, we did estimates based on the figures of 2 years ago which was the last data we had that were reliable, we thought, and our estimate is that approximately 20 percent of the total national expenditure for health, personal health services, is wasted, down the drain of unnecessary hospitalization, needless surgery, duplication of facilities, fragmentation and duplication of administrative costs. Of that 20 percent figure which 2 years ago was $14 billion——

Senator JORDAN. The 20 percent figure is $14 billion?

Mr. GLASSER. $14 billion 2 years ago. Our estimate is of the $1.7 billion spent by the private health insurance industry for competitive advertising, sales force, commission, duplicated administrative forms and the like, of that $1.7 billion, $1.1 billion was needless expenditures that made no contribution to the health of the American people.

Senator JORDAN. All right. No system operated by people is going to be perfect. What slippage or wastage do you calculate there will be in your program if it were implemented?

Mr. GLASSER. That there would be slippage and wastage there is no doubt, sir. But if one takes the medicare program, which has had its problems in getting started administratively, which we believe unwisely used fiscal intermediaries instead of direct administration, even under the medicare program we are running about 8-percent administrative costs whereas the private health insurance industry for group contracts is running around 13 percent for operating expense, and it is running close to 50 percent for the 41 million individual health insurance policies.

Senator JORDAN. Yes, 41 million.

Mr. GLASSER. So that the figures, sir, are not fine distinctions. They are gross differences in waste.

Senator JORDAN. Mr. Woodcock, you said in one place in your statement, I don't recall where, that it would take some time to implement your program. You suggest a process of gradualism in its implementation. How long do you suppose it would take, if we started in 1972, to get your program fully operative.

Mr. WOODCOCK. Well, the program contemplates a lead-in time during which necessary planning would be done. We would begin the necessary efforts to set up a proper budget system, to begin to repair the growing problem of the shortages of professional and paraprofessional personnel. It is our estimate, first of all, that there would begin to be immediate improvements but it would take the better part of a decade to bring the system to the point where it could yield its greatest benefits.

Senator JORDAN. As much as 10 years.

In your studies have you found that the overutilization of hospital services is offset somewhat by underutilization of other hospital capacity?

Mr. WOODCOCK. I don't believe that is so. Do you want to speak to that, Mr. Glasser?

Mr. GLASSER. We don't have any evidence to that effect, sir. But we do have very reliable studies made now over 9 years, I believe it is, of the Federal employees as well as UAW workers in the Greater Detroit area and the statistics are comparable, where when you have an organized program of delivery of service through a prepaid group practice we are using just about half as many hospital days, and the numbers, sir, in Detroit, sir, are impressive. For UAW members in a group practice plan: 500 days per thousand individuals. For UAW members in a solo practice system under Blue Cross, Blue Shield: over a thousand days per 1,000 individuals. Multiply a savings of 500 days by an average cost of around $86 and we are talking about a great deal of money.

Senator JORDAN. All right. Now that brings up a point—what incentive do you have that would shorten the hospital stay under your UAW program as compared with Blue Shield?

Mr. GLASSER. Two major incentives for it. One, the availability and encouragement of preventive health services.

Two, the availability out of the hospital as a covered part of the plan of physician services, lab and X-ray and all the other diagnostic and treatment services out of the hospital.

Senator JORDAN. Outpatient care?

Mr. GLASSER. Yes, sir.

Senator JORDAN. So you cut down the days in the hospital to the minimum by providing this out-of-hospital care.

Mr. GLASSER. Yes, and this is not idiosyncratic, it has been going on for years.

Incidentally, I should say, sir, that the studies also indicate dramatically reduced surgical rates which I neglected to mention, for major surgeries like hysterectomies, appendectomies as well as minor surgeries like tonsillectomies. The rates are dramatically lower when the incentive in the plan is to keep people healthy and the individual physician receives no added compensation based on the number of surgeries he performs.

Senator JORDAN. All right.

If the present personnel engaged in health services were operating more efficiently, and you had gained by reason of that increase in efficiency, how many new people do you calculate it would take in the healing arts to fully implement your plan?

Mr. GLASSER. The average—there is an average of one physician to every 650 people in the United States today. In the prepaid group

practice plans where the entire range of services is provided to patient, they serve somewhere in the neighborhood of one physician to 1,000 to 1,200 individuals. So that when one talks of the shortages in physician manpower, I think it should be realized if one effects a delivery system as the health security proposal indicates, we would immediately begin to make a sharp change in the shortage situation.

Senator JORDAN. In your experience has the lack of coinsurance or deductibles increased the use of health services?

Mr. GLASSER. In our programs in the UAW we have for many years opposed the use of coinsurance and deductibles and we do not have them. We do not believe it makes for misuse of the system. We believe it is in accordance with the lessons we have been taught by medicine, namely early diagnosis and treatment is not only good health care but is economical in that it prevents later more difficult problems and attempts to solve them.

Senator JORDAN. As I understand what you are saying you are more likely to perform preventive medicine or preventive work in the early stages, that would be put off if there was a coinsurance provision or if the patient had to put up some of his own money in order to get it.

Mr. GLASSER. We are confident that is the case.

Senator JORDAN. Thank you.

The CHAIRMAN. Senator Anderson.

Senator ANDERSON. No questions.

The CHAIRMAN. Let me thank you for a very fine statement Mr. Woodcock.

I would like to get one matter straight. Is it not true that whichever of these bills we pass, and we have eight of them before us at the moment, that the workingman and his family are going to end up paying for it? Isn't that particularly true of your members—that with respect to any workingman or his family in the United Automobile Workers he is going to pay for what he receives either as a taxpayer or as a consumer?

Mr. WOODCOCK. Well, Mr. Chairman, as I am telling our people, yes, that is true. To begin with, we have fully employer-paid coverage in most of our contracts. But when the costs to that employer continues to skyrocket, as they are now, it influences his decision as to what he is willing to do at the next contract termination, so whether they see it or not they are paying it, no question about it. They are paying it currently on the cost of living escalator in the automobile and agricultural implement contracts because those do not give full parity against the increases of those costs at present which are high because of the health care components.

But if we can begin to move toward a rational system which can control costs that no longer would be the case because as we control costs, as we rein in this monstrous inflation, then within a predictable period of time there will be a saving to our members and a saving to the citizens generally. This should be our aim.

The CHAIRMAN. The point I have in mind, and I have it in mind more for the people who are not presently insured as are your workers, in that when we put a program into effect, be it the one you are recommending here or be it something as modest as the catastrophic illness proposal that this committee voted out last year, in any event either directly or indirectly the real impact of the cost of this will be on the workingman and his family.

Now we are looking at a program that costs $77 billion initially by the administration estimate, and $68 billion by Senator Kennedy's estimate, neither of which takes into account that $2 minimum wage increase which is bound to pass sooner or later, in my judgment.

When that goes through it would raise the cost of hospital care because manpower expense in hospitals is the largest single item of cost.

If you taxed away all the money that is being kept by people making over a hundred thousand dollars you wouldn't raise enough to pay for 10 percent of the cost of your program. You are going to have to get most of that money by taxes where there are enormous numbers of wage earners and that means you are going to have to tax, either directly or indirectly, the workingman and his family. They are the ones who will be paying for it in the last analysis.

There is not much of it that is going to be paid for by the so-called wealthy man. Do you analyze it that way or am I at issue with you on that point?

Mr. WOODCOCK. No, Mr. Chairman, we don't disagree with that. We don't come in here with a scheme which says this is going to be entirely paid by the so-called soak-the-rich program. The program is based upon approximately 50 percent of it payroll taxes, the employers and the employees, and the other 50 percent from general revenues. The general revenues come as much from the masses as they do from the ruling class, but the important thing is ours, we sincerely believe, is the only program that will get into being a rational system which will reduce these escalating costs because if we keep going with what we have we are headed for a disaster.

The CHAIRMAN. Yes.

Well, now, I am reminded of a time when we were advocating a major program in Louisiana. Health was one feature of it, but pensions and welfare were the most expensive items. When we were challenged to say how we were going to pay for it, it was always popular to say we would pay for it by firing all the deadheads on the State payroll. My uncle confided to me that we undoubtedly could fire the deadheads but he said that we couldn't build a highway from Winfield to Dry Prong with savings from firing deadheads. He said in the last analysis we are going to have to pay for these programs with heavy taxes and that they were going to hit everybody in the State.

The same thing is true of your program. It is going to be the average working family which will pay for something of this sort. The way I tend to rough it out is to look at 70 million working people, and take those costs and divide by 70 million and that is about how much it is going to cost the average worker.

I don't think we ought to try to make him think we are giving him something for nothing.

Mr. WOODCOCK. We are in complete agreement on that, sir.

The CHAIRMAN. I am glad we are together on it. I think you people are entitled to a great degree of credit for medicare, as is Senator Anderson here who was the early author and sponsor of that program. I am proud that I voted for it when it became law and I am proud that I managed the bill of which medicare was a part on the Senate floor. I had predicted during the years we worked on medicare, even before I voted on the bill, that it was going to cost a lot more than anybody was estimating. What I had to say then has been borne out 100 percent by the facts.

This committee has done a great deal over the years to expose all sorts of unanticipated and unintended expenses that came into the picture, and has been a lot of help in holding down the costs. Despite that work, medicare faces the prospect of exceeding the original estimate by more than 2 for 1 in 1975—in spite of the fact that the estimate had built into it a 20-percent additional cost factor to allow for contingencies.

Now, I take it that you believe that people will not demand more days in the hospital and more treatment if the Government paid for care than they would if the Government does not pay for it.

Mr. WOODCOCK. With regard to medicare, Mr. Chairman, may I say that was a very necessary piece of legislation. The country is the better for its having been passed, but at the same time there was fierce opposition to it, and in the compromising that was necessary to meet the fierceness of that opposition, it was specifically legislated that nothing in the administration of medicare was in any way to affect the delivery of health care, so that it compounded unfortunately the inflationary factors. That is why we have such strong insistence on the question of quality assurance and cost control, and the cost control is absolutely—is an absolute necessity. Unless we have programs that go to the question of cost control we will simply feed in more dollars into the present situation. We will simply be compounding the inflationary factors, and instead of a 2-for-1 ratio which is the general ratio now not only in medicare, but in health care inflation as against general inflation, we will be moving up to the 3-to-1 ratio.

The CHAIRMAN. Right.

Now, you are concerned, and so are we, about the fact that doctors raised their fees when they saw medicare going into effect. We were very concerned about it and we have been concerned about some of the exorbitant fees that have been charged.

From the information just made available to me, based upon investigations we initiated here, there will be a recoupment of at least taxes that doctors owe on additional medicare and medicaid income not reported. About 15 percent of practitioners reviewed appear to have failed to report fees they earned.

About 47 cases are being investigated by Internal Revenue Service for possible criminal prosecution.

Now, where a doctor who is already making a large amount of income boosts his fees to make a lot more because of the extra demands for his service you have a right to complain and so do we. Nonetheless, a substantial proportion of this increase in medicare costs came from raising the pay of very low paid hospital personnel, janitors, practical nurses, and so forth.

I don't believe you would want to complain about that.

Mr. WOODCOCK. No; of course we don't. But then many of the supporting personnel in the health care field are still miserably paid and need to be better paid.

The CHAIRMAN. I would like to engage in some sort of program to control the costs of a great number of things. One of the most hopeful occurrences was to learn that George Meany had suggested sometime back that he would be interested in working out some kind of arrangement for wage and price controls which, to that point, had received no takers on the other end.

I was dismayed to see that the President did not take him up on it, and business appeared to have no interest in any suggestion of that sort.

It seems to me that sooner or later, if we are going to have some control on inflation, we will have to have the cooperation of you and Mr. Meany and the AFL–CIO in general. What is your reaction to that problem?

Mr. WOODCOCK. As I understand Mr. Meany's position as he articulated it if we have to have controls it can't be simply wage and price controls, it has to be a total incomes policy, control of all incomes no matter from what segment of economy the recipient operates.

We have had a long standing proposal from the UAW that in those industries where we have administered pricing, where one or two corporations dominate the field, as in automobiles through General Motors, for example, to a lesser extent Ford, they should be required in advance to reveal all of the facts that lead to a proposed price increase, that there be a hearing, not for the purpose of deciding can that increase go into effect, but simply revealing to the public all of the facts involved. And if their claim is, as it has been so often, that they are forced to this unpleasant necessity because of the demands of the UAW, that we be required to come forward and lay down the basis why we think these things should come to pass, and then let the force of public opinion operate in this sphere which it never has been able to.

The CHAIRMAN. Well, one group that doesn't have to rely entirely upon collective bargaining is the Congress. We are in position to fix our own pay. Once in a while we muster up the courage to increase our pay if we think facts and circumstances justify it. You have been very kind about that, may I say; if you hadn't, many of us wouldn't be back.

But I look at a group like the airplane pilots and see that some of them are being paid as well or more than we are. We are passing laws to give them the right of collective bargaining, and they apparently feel privileged to shut the airlines down until their demands are met.

If an airplane pilot is making as much as I am and he still feels that he ought to engage in collective bargaining, and he has the power that we voted to him to use collective action to obtain it, I wonder whether there shouldn't be at some point, two limitations on his demands, when he earns far above what the average person makes in this country. First, to the amount of inflation that has occurred in costs since his last negotiation and, second, to the increase in productivity. Now it might be that he is carrying a lot more passengers because he is flying a bigger airplane. It would appear to be no more work. It might even be more convenient than it was before, because he may be flying a bigger and faster airplane getting more people to a point in a shorter period of time.

What would yo ur reaction be to a proposal that where people make as much as twice the average wage in the country, that they ought to be limited to incre ases related to productivity and inflationary factors.

Mr. WOODCOCK. Well, Mr. Chairman, since the airline pilots don't pay my wage, it is very simple for me to say they should have this or that done to them.

Let me say——

The CHAIRMAN. I would like to get a categorical answer to that question.

Mr. WOODCOCK. Let me answer it in this fashion, if I may. We had to strike in General Motors to win the principle which you are stating, to get protected against future escalation in the cost of living, those to be wages only after the fact, so obviously they can't have an inflationary thrust until after the fact.

And the annual increase to be 3 percent which is less than the social or national productivity and much less than General Motors productivity.

Now, if the inflation can be restrained, as there is some indication that it is now moderating, General Motors then will have an advantage and so will the other companies and they should reflect that advantage in reduced prices not simply in maintaining the price, because only if they do that can that kind of a sensible system work.

We believe this, we have believed this for many years and we had to strike to implement this.

The CHAIRMAN. That is what you have in your contract. I would still like you to answer the question. How do you feel about applying that, let's say, to the airline pilots.

Mr. WOODCOCK. As a general proposition I think it would be good for the country. If we had a system where the wages were tied to the cost of living—consumer price index—as the automobile and agricultural implement industry wages are so tied, and to a social productivity, it would be good if this were a universal system, and since the prices would push up the wages, there would be a restraint on the big industries from raising their price because they would simply, if they had an inflationary effect, be pushing up their own costs in the form of their own wages, and I would hope the steel industry would have the wisdom to do this because I think it makes sense.

Now the airlines—obviously the economics of the airlines bother me when we have the big airline companies losing money the way they are, and the new jets coming on at as fast a pace as they are. I am very concerned about the economics of the whole airlines industry.

I am not, Mr. Chairman, competent to have a knowledgeable opinion as to whether or not the economic return to the airline pilots is improper or not.

The CHAIRMAN. It would seem to me that if we can agree upon the principle we are speaking of here, if we could agree that here is what we think the airline pilots are entitled to demand and fight for and exercise their collective bargaining rights to get, and what the public ought to be willing to pay if we can agree to that, we are in position to say what the wage ought to be, and how much they are entitled to negotiate and insist on, and how much the company is entitled to make or charge the public. If you are willing to apply that same principle with regard to your union, where your people are making more than the average wage paid in this country, thanks to the fine work you have done, may I say, then I think there might be some hope of having some control over inflation in this country. I believe we could apply that to many other situations. But I don't see how we can very well tell a doctor how much he can charge if we are in a position where you are exercising collective bargaining rights and unwilling to agree to a similar limitation or to a similar principle yourself.

It sounds to me though as if you are willing to agree to that sort of principle for your own people and, if you are, I think you can agree in good conscience to apply it to somebody else.

Mr. WOODCOCK. The doctor obviously is entitled to the economic return that his long years of training and his great skill entitled him to. These are attractions to the doctor as a human being in a group practice health maintenance organization type of program because he can have a civilized control over his hours which he does not have in solo medicine. True he sometimes gets excessively high fees but he puts in excessively long hours to do that, and there are attractive working conditions in this form.

The CHAIRMAN. Let me get to another item which won't put you nearly as much on the spot, Mr. Woodcock. There is a drug known as prednisone. You can buy a hundred tablets of prednisone, the brands manufactured by the Merck Co. or Upjohn Co.—both of them well regarded companies—you can buy it at about $2.00 per hundred wholesale. This drug is used in treating arthritis and other illnesses.

If you buy it from the Schering Co. they will sell you Meticorten, at a cost of around $11.00—five times as much.

Now, it would seem to me that if we are going to pay for this as taxpayers, we ought to say that if this drug is available from good manufacturers, and you can't prove that this Schering product is any better than that of the Merck or the Upjohn Co., we would not be willing to pay more than $2. What is your position on that?

Mr. WOODCOCK. Built into our program is the use of generics as appropriate.

The CHAIRMAN. I am willing to agree to buy the Schering Company's product and pay five times as much if they can prove that their product is in fact better than the other fellow's. But, if it is all the same thing and no impartial judge is willing to say their product is better, I don't see why we ought to pay five times as much.

Mr. WOODCOCK. I agree with you.

The CHAIRMAN. Thank you very much.

Senator BENNETT. I was not able to be here so I have no questions.

Senator CURTIS. I have no questions.

The CHAIRMAN. Thank you very much.

Mr. WOODCOCK. Thank you very much, Mr. Chairman.

The CHAIRMAN. Our next witness this morning will be the senior Senator from New York, the Honorable Jacob K. Javits.

Senator Javits, we are pleased to welcome you. I don't really believe it would be possible for this committee to hold a hearing on a health subject without scheduling you as a witness because of your consuming interest in the field. We will be pleased to hear your suggestions.

STATEMENT OF HON. JACOB K. JAVITS, A U.S. SENATOR FROM THE STATE OF NEW YORK

Sentor JAVITS. Thank you very much, Mr. Chairman; and as I said, my testimony shall be suggestions.

I would like the committee to feel that the bill which I have authored and introduced—the National Health Insurance and Health Services Improvement Act of 1971, S. 836—is in whole or in part suggestions. I am very hopeful and prayerful that you may find

legislative ideas in my bill which will be very useful to the composite product. I am a student of national health insurance just like you are, and I have a deep interest and have long worked in the health-care field. Indeed my mentor, Senator Anderson, is sitting to your right, Mr. Chairman. Senator Anderson and I had the honor of trying in 1960 to do what we hoped very much can be done in 1971 or 1972. Our efforts had some result, and you developed, with Senator Anderson's cooperation, the medicare and medicaid programs. We have learned a lot, but he and I certainly tried pretty much the same approach a long time ago. There were some historic confrontations with another Kennedy on the very same subject, so history in a sense is being to a small degree replayed.

The essence of my bill—and I only say "my" in the sense of if you want something, you have to present what you want and stick your neck out and do it in a tangible way—is a national health insurance plan based heavily upon the payment of premiums as an addition to the social security tax. It would be supported under the Socila Security Act with a 3.3-percent tax on employer and employee, and an upper limit of compensation to which that tax would apply for the employee's contribution of $15,000. We think in this field, at least I think in this field, the figure can be quite high because I think any of us, no matter how high salaried we are, have similar problems when it comes to medical care.

Senator BENNETT. Mr. Chairman, is that 3.3 for each?

Senator JAVITS. For each.

Senator BENNETT. That is 6.6 total.

Senator JAVITS. 6.6; exactly right. And the estimated overall cost in full operation of this measure is, we figure, $66 billion; other figures are $68 billion, of which two-thirds will be paid by the consumer through the social security payment, and one-third will be paid out of general revenue.

We assume that medicare and ultimately medicaid will be absorbed in this operation, and that the State and city contribution will be made by opting into the program, for those whom they wish to cover; for example, welfare clients, et cetera.

Senator BENNETT. This would then be a substitute for medicare?

Senator JAVITS. It would be—well, it would incorporate medicare.

Senator BENNETT. Medicare would disappear into this plan.

Senator JAVITS. Exactly. Indeed the plan is based on medicare because my belief is that the benefits, the basic medicare benefits, should be the basis for a national health plan, and so this plan starts with medicare as a base, and indeed for a number of years does not propose that others than medicare eligibles and the disabled, the only new group put in are the disabled, should participate and then as the system builds up, the years that I suggest are 1973, 1974, but I am not doctrinaire about the dates. That is something that the committee will have to decide. One of the big questions, and it is being considered by the Labor and Public Welfare Committee, of which I am the ranking member, is when will our health care delivery system be ready to deliver the care contemplated by a national health insurance scheme. As sophisticated people, we know that so many things lean on each other, and we believe that the new scheme for providing health care which this bill of mine, or some other measure which the committee may adopt, will provide more people with access to health

care but because of things which now seem very clear other factors must be considered. One, a generally universal system gives you the benefit of the actuarial support of people who don't use it. We have an analogy in the pension field, just as a slight diversion but it illustrates the point.

Much as I complained that the overwhelming bulk of the people who pay for private pensions and are cut out, to wit, getting around the 60 to 90 percentile figure which is too much, but the fact is unless 50 percent did not draw their pensions you cannot maintain actuarially a pension system because it just would be too expensive, and it is the same with this. You have to expect that the overwhelming majority will not be using the services for which they are paying in order to enable payment to cover within some reasonableness and encompass the other.

Now, having given that broad framework, Mr. Chairman, I would now like to give the differences between my bill and other legislative proposals because I think that is the one thing that you want pinpointed and makes it much shorter to understand the differences between my approach and that of Senator Kennedy, and what Mr. Woodcock, to whom I listened with the greatest interest and care as did the committee, set forth as the presentation of the UAW.

The differences are these: One, on the issue of deductibles, coinsurance, et cetera, and all of those permutations. My bill is built on medicare, and if you depart from medicare you do it in the same way that you would work out a timetable or phase in the different bodies of the constituency to be covered, and that is according to the readiness of the system to receive them.

For example, I can conceive of a provision which will say that the unemployed will come in in 1973, let us say, but that the Secretary can suspend or defer that date, perhaps even with a congressional veto, if he feels the system isn't ready to receive it. Some such adjustment mechanism is what I have in mind.

So the plan, one, is based on medicare.

Secondly, the plan is based upon using all existing agencies, organizations and institutions but endeavoring to bring them into meeting certain criteria, which the Federal Governmcnt will establish, so that you do drive down costs through the universality of coverage but use all the agencies, organizations, and institutions which can contract at or better than at those reduced costs.

I exclude nobody. I think that was the essence of what Senator Anderson always had in mind. We erect a standard but we don't exclude anybody from meeting that standard if they can, and indeed encourage it by loans, grants, guarantees and interest subsidies to go into this provision of preventive and ambulatory services—provide health not sickness care—and I consider that to be a very key difference between my plan and the Kennedy plan.

The other thing which is really a very important difference is again if a private plan, financed by employer and employee can meet Federal criteria and provide greater benefits then my bill excludes that plan and its participants, employer and employee groups from tax payments and the national health insurance plan. So that it is entirely possible that millions upon millions of Americans will be covered by health insurance under privately negotiated plans so long

as they meet what would for the beginning for example be the medicare criteria and those workers would not pay the tax, neither would the employer.

They would be completely excluded from the plan. That is a very very sharp difference between this plan and the Kennedy plan.

The last thing is that I provide for the organization of the National Health Insurance Corporation or corporations on the theory that if private providers cannot render the service then the Government would have an autonomous mechanism which could by contract or otherwise see that the service is rendered in given regions.

Other than that, I would say, that the plans have great similarity. There may be differences here and there which your staff will go into in detail but essentially it is based upon actuarially broad coverage, the concept of emphasis upon keeping people ambulatory, preventive care and the encouragement of group practice. Although I might note my bill calls for a rather close connection in new group practice units between those units and established hospitals, medical societies, et cetera.

In other words, it provides for some kind of sponsorship of the newly organizing group practice units. We think that will avoid a lot of mistakes, a lot of, perhaps even some fraud, et cetera, by requiring some relationship to established agencies, organizations or institutions for the provision of health care in the group practice units which are organized.

As I say, the two big things are, one, the connection with the present system of provision of health care wherever it can meet criteria and, second, the exclusion of the private plans, which meet the benefit criteria, completely from tax paying and from being under the Government tent, as it were.

That is the essential thrust of the plan which I would like to submit to the committee with the hope that a good deal of that may be found useful in the framing of the ultimate legislaion.

Senator BENNETT. Senator Javits, I want to—have you concluded?

Senator JAVITS. I am through and I would like to ask unanimous consent, Mr. Chairman, to include a section-by-section analysis of my bill prepared by the Legislative Reference Service of the Library of Congress, a description of the level of benefits of the bill and the full text of my prepared statement.*

The CHAIRMAN. I notice that under your proposal groups can opt out of the Federal health insurance program by obtaining comparable insurance coverage on a private basis. Could this result in the Government being stuck with many high cost risks while private insurance skimmed off the good risks?

Senator JAVITS. I do not believe so because to get comparable benefits at generally comparable costs you would have to have again a considerable element of mutuality across the board for the private insurance plan to really be effective and, secondly, there are so many self-employed, so many small employers in the country, so many professional people in the work force I would say, as we all know, the blue collar aspect of the work force is now minimum and, if my recollection is correct, something less than a third of the work force is blue collar.

* See p. 145.

So I believe that because of the need for coverage by so many millions outside those who would be eligible for group plans you would still have in both the broadness of coverage, and the attractiveness of this idea to me is that I am not all that in love with Government.

I feel it is essential but I don't feel that because Government does it it is necessarily the best, the most efficient, and the most economical, et cetera, and I feel that in this way by this rather simple arrangement you do give yourself a criterion both for Government and for private enterprise which, a check and balance, if you will, which, could be extremely valuable, and that is why if there is anything central to my thinking on this subject that is it.

The CHAIRMAN. A very interesting suggestion, Senator. I promise you I will study it carefully.

Senator Anderson.

Senator ANDERSON. I do want to say to Senator Javits: I appreciate his comments very much and his long fight for those things that he believes to be right. He has done fine work.

The CHAIRMAN. Senator Bennett.

Senator BENNETT. Mr. Chairman, and Senator Javits, following up the Chairman's question, as I listened to your explanation there was one point that was not clear in my mind and I would like to clear it up. It is obvious that if a group plan exists and is offered, people have a right to choose it instead of the Government plan. Earlier I thought you said that on the Government plan two-thirds would be paid for by payroll tax and one-third out of the general revenue. Will the private group plan have a subsidy of one-third out of the general revenue?

Senator JAVITS. No. The private group plan would also not have—you see, the private group plans I am talking about are employer-employee negotiated plans. It is not that the Mutual Life Insurance Co. will put an ad in the paper saying we are putting together a group like you subscribe to stock. The definition in my bill calls for an employer-employee negotiated group plan the benefits of which will be more than that offered by the Federal Government, and that will not be subsidized.

Now the reason that the competition still remains fair is because we will be putting into the Government plan, and Senator Long is absolutely right about this, with the aged, for example, those over 65, the disabled, a higher risk group, so you have to, if a Government plan is going to be viable at all—when I say a third you gentlemen always want estimates and you are right, but I don't know that it will be a third it may be very much less, I don't think it will be more, because actuarially it would not call for more but I believe that the competition then between the private sector and the public sector would not be unfair because undoubtedly the public sector would carry him in the higher risk category.

Senator BENNETT. Then your answer to the chairman in response to his specific question as to whether you thought the Government would have to carry a higher risk level than the private plan needs to be corrected?

Senator JAVITS. No.

Senator BENNETT. Because you indicated that there would not be—you didn't think there would be—any great variation in the level of

risk between the two but now you say that in order to justify an increase of 50 percent, turning it the other way around, in the financial support of the federally subsidized plan over the private group plan, you say that that is because they are going to have to carry higher risks.

Senator JAVITS. Senator, I think you are wishing on me an answer I did not make. My answer, I was very clear, and I will do my best to make it clear. Senator Long asked me whether this would result in the private plan skimming off the cream. I said it would not result in the private plan skimming off the cream because that was not the kind of private plan excluded from my bill. The only kind of private plans excluded from my bill were mass plans, employer-employee negotiated plans, which across the board would have so many people in it that they wouldn't necessarily represent cream skimming.

But it is undeniable that putting the aged into the Government plan which you do right away with those over 65 would represent a somewhat higher risk group by the millions in the Government plan, and we have to be prepared, I am not guaranteeing its 50 percent, and there is no 50 percent you are authorizing, we would have to be prepared for some Government contribution.

Now the outside figure actuarially if everybody went under the Government plan everybody and there were no plans excluded is one-third. Now that is the, I must state a maximum figure to the committee, but there is nothing that says the Government will pay one-third of the cost of its plan. All that I say is that the very maximum if everybody went under the Government plan we estimate it would be a third but we believe this way of approaching it which I have described is very likely to reduce very materially the amount of general revenue funds which are required if what we think will happen will happen, to wit, that an enormous number of workers, probably most of the blue collar workers, will come under the private plans.

When I said what I did, Senator Bennett, about the comparison, I was trying to answer your question, well how can the private plans compete unless they are subsidized too. I don't think that is necessary. I think private plans, considering the fact that workers start very young, as union members, beginning to pay, you know, 22, 23, 24, these are very low risk people, plus the fact there is greater likelihood, there is likely to be much greater efficiency in location and experience because so many of them have plans, now, that there should not be an undue amount of loss because of competition.

But remember that the individual worker and the individual union will have the right under my scheme to say "forget about our private plan, we will go on the Government plan" and then I said, Senator, that the maximum it could cost the Government from general revenue if everybody went in was a third.

Senator BENNETT. But you will agree with me my figure of 50 percent on the basis is equal to your one-third on the total.

Senator JAVITS. Yes, it is equal in mathematics, Senator Bennett.

Senator BENNETT. That is all.

Senator JAVITS. But you wish to impose upon me I am saying we are going to pay a third. We are not we are going to pay what it takes and I estimate it won't be over a third if everybody opted for the Government plan.

Senator BENNETT. We have to write it into a law.

Senator JAVITS. But we are not going to write the third into the law. All we are going to write into the law is we will finance with social security contributions and whatever revenues it takes a plan with these benefits. You have absolute control over whether it is a third or whether you make a profit on the deal. By writing the benefits, sir, you can control whether the United States makes a profit. It may very well do so if that is the way you write it.

Senator BENNETT. You are doing another thing now that this committee has resisted very very hard for a long time, you are mixing social security receipts with general revenues. You are injecting general revenues into the social security system, which we have vigorously opposed.

Senator JAVITS. Senator Bennett, I don't think I am doing that at all. I believe what I am doing for the social security system is to allow it to receive the amounts which are paid only because it is a very convenient addition. Every one of these plans that depends on that kind of financing at all does that. The general revenue figure is not being introduced into the social security system. The general revenues are being introduced into the national health care system but not into the social security system.

Senator BENNETT. But you are going to include the present medicare recipients now supported by the Social Security funds into your national health care plan.

Senator JAVITS. I am.

Senator BENNETT. And you are going to take social security funds or their equivalent out of the social security system and transfer them over. So you are now making a combination of social security funds and general revenue.

Senator JAVITS. I am not, sir. You are going to have an original new tax of 3.3 percent each paid through the social security system, especially earmarked for this purpose and no other. Perhaps my language was not as technical as it might be but certainly the meaning is very clear to me. The employer and employee are going to pay x percent on wages for medical care. Set up a separate trust fund. As a matter of fact, my bill provides for a separate trust fund for these payments. Forget about social security. Call it national health payment, that is fine with me, I am not asking you to call it social security.

Senator BENNETT. The employer and employee now pay a specific percentage of payroll into the social security system for health care. You are just expanding the coverage but when we face the realization that this program will not produce enough money to support the health care we increased the social security tax. You are now proposing to cover that by injecting Federal revenue into the system.

Senator JAVITS. No. You see we have no differences, Senator Bennett, with all respect, for I am not asking you to do any such thing. As far as I am concerned if the committee decides either by reduction of benefit or increase of the 3.3 that that is, that it wants it completely self-financed or even for the United States to make a profit, which we do in other things, but the way, that is fine. I am not quarreling with that.

My recommendation, however, is that the system, considering the equities to be served, deserves some use of general revenue funds, but the system that I—when I say the system, I don't mean the social security system, I mean the new system of national health care, that

you will pay some general revenue funds into if you follow my prescription, but the formula allows you to provide for no general revenue funds, even under my formula, if you reduce the benefits or it you increase the amount which is paid for the health care.

Senator BENNETT. I have one further question and obviously I have not studied your system, I am just reacting to your explanation.

Let's assume such and such union has a private plan. Are you assuming then that when its members reach 65 they would move over to the Government's plan because if they don't then they have all the risks of the aged and all the rest of them.

Senator JAVITS. I am not assuming that they will move over to the Government plan because equivalency in my mind is a plan which gives them everything a Government plan does, and as the Government plan covers them at 65, if there is to be equivalency then retired union members would have to continue to be covered for health, as they are now in most cases, by their own plan, otherwise there is no equivalency and, therefore, the plan would not qualify for exemption.

Senator BENNETT. Therefore, if I understand an earlier argument you indicated that private plans could probably survive without any Government subsidy because they would be covering people of lower age and without the medical risks that exist.

But now you are saying that it would be expected they would assume the risks of their members past 65, and doesn't that wipe out your argument?

Senator JAVITS. It does not because the present composition of work force under voluntary plans has a much greater component of the young. We have to in the Government plan accept all those over 65 now in excess of 20 million adults, whereas a workman's plan does not do that at all because most or those fellows will have already retired so the composition of the insured under a trade union plan is of a much younger group because they are the active workers.

Senator BENNETT. That is right. Under the present pattern but you are saying now that if they have the right to opt on a private plan they no longer have the right to say as they do now when you become 65 you go out from under our plan and go into social security.

I know this is the pattern and I am sure Mr. Biemiller will confirm it when we come to that time, but you are saying under a private plan they cannot go under social security their plan must cover everybody eligible for it under past retirement.

Senator JAVITS. Senator Bennett, you can determine it when you write this legislation. All I am saying is under my plan the plan cannot be exempted from a Government plan unless it gives equivalency and equivalency means active coverage not only for the worker but the fellow who is retired. If you want to change it you have complete authority to do it. As I understand it most present welfare plans for health, sure the worker goes on social security from the point of view of support but not health.

As I understand most of these plans they cover retired workers today and they would continue to do so in order to quality for exemption. Under the principle which I espouse which is that the private plan shall be the equivalent of the Government plan. But it is not—I mean it is subject to a change if the committee thinks that actuarially a change is feasible.

Senator BENNETT. I am not going to belabor this any more, Mr. Chairman, but it seems to me axiomatic that if you expect a private plan to exist at two-thirds the costs of the Government plan being without that support from the general revenue that you can't expect it to be made up of the same mix of population.

Senator JAVITS. Well, Senator Bennett, with all respect, I would say that you are giving me a competitive standard which is not the standard. Many people incidentally might prefer to pay a little more and still have that private plan but you fix it at a third which just isn't true. It doesn't necessarily have to be a third. It may be nothing or it may even be a plus. It depends upon what kind of a plan it is. All they have to do, all we ask is, that they give the equivalent benefits. If they do they are exempted, if they don't want to be exempted they go under the Government plan.

Senator BENNETT. But you have used the figure of one-third that the payroll deductions would cover two-thirds, and the Federal Government from general revenues would be expected to subsidize the plan, let's say, up to one-third.

Senator JAVITS. That is correct, and you control that by writing the benefits or writing the tax, you can make it nothing, you can make money on the deal.

Senator BENNETT. Mr. Chairman, I apologize.

The CHAIRMAN. Senator Jordan.

Senator JORDAN. Just one question. What flexibility, Senator, would a person have in moving from one private plan back into Government plan and maybe even out of the Government plan into another private plan? Does he have complete freedom of options there?

Senator JAVITS. Complete lateral freedom as I see it because when you are under a plan which is an exempt plan you don't pay the social security tax. When you revert again to a nonexempt plan or you are unemployed or you go into business for yourself you are under the Government plan.

Senator JORDAN. By his own declaration any time you could move.

Senator JAVITS. Well, it isn't so much his own declaration, it is much like income tax, you have to qualify by showing who you are working for. I mean it is his own declaration but it is a declaration which could be false or could be true depending on the circumstances.

Senator JORDAN. Thank you.

The CHAIRMAN. Thank you very much Senator Javits.

(Senator Javits' prepared statement with attachments follows. Hearing continues on p. 155.)

PREPARED STATEMENT OF SENATOR JAVITS

Mr. Chairman and members of the Committee, I thank you for the opportunity to testify before your Committee today on S. 836, the "National Health Insurance and Health Services Improvement Act of 1971." When I first introduced this bill in the 91st Congress, I said that "I introduce it as my own contribution to what I am confident will be a significant debate and, in my judgment, within a year or two, at the most, will result in the successful adoption of a national health program which will assure high quality health care to every American, whatever may be his economic need." Thus, I am most grateful to this Committee for taking the dialogue on national health insurance from university lecture halls to the hearing room of the Senate Committee which will have the ultimate jurisdiction over national health insurance legislation. We now truly mark the beginning of a journey toward the fulfillment of one of the great social needs of our people—the *right* to quality health care.

Almost 40 years ago President Herbert Hoover equated the right to public health with public education. In his inaugural address he said:

"Public health service should be as fully organized and as universally incorporated into our governmental system as is public education. The returns are a thousand-fold in economic benefits, and infinitely more in reduction of suffering and promotion of human happiness."

I quote President Herbert Hoover because he expressed a conservative point of view of which he was very proud; and because this is a conservative bill.

It is self-financed in the main, and insofar as it is not self-financed but requires a resort to the general revenues, it involves an enormous contribution to the health of the country. Therefore, it will generate an increase in its resources, as well as its tax take, because of the millions of people whom it will enable to do more and better work. The potential increase in production and gross national product of the UnitedStates due to accessible quality health care for all Americans is so great that it cannot be accurately estimated. However, one thing is certain: medical research and health care does pay off in lives and dollars. The decline in the death rate between 1944 and 1967 due to improved research has meant the saving of more than 8-million lives and of $102.5-billion in income by these wage earners and an estimated $12.8-billion in federal income and excise taxes paid on this income.

Mr. Chairman, I would like to confine my testimony to the most significant proposals in my bill and, with your permission, to submit for the record a more detailed analysis of the bill—a section-by-section analysis prepared by the Legislative Reference Service of the Library of Congress and a description of the level of benefits of the bill.

Basically, my bill would provide a national health insurance program by improving the health insurance program established by Title XVIII (Medicare and Medicaid) of the Social Security Act, and by establishing a new Title XX to that Act to provide comparable health insurance benefits to individuals not otherwise covered. Payment of premiums would be as an addition to the Social Security Tax. The bill would operate by extending the benefits, enlarging the coverage, and expanding the role of private carriers in the present Medicare plan.

We have learned from the post-Medicare escalation of the health-care crisis that merely to expand coverage of people and services to the necessary levels is not only inefficient, but counterproductive as well. The health care system as presently organized is already breaking down—it cannot possibly absorb the increases that "footing-the-bill" for eighty percent of each individual's health services—as contemplated by my bill—will entail. Provision is therefore made for the rational reorganization of the health-care delivery system.

The Secretary of HEW would enter into a variety of administrative arrangements with private, profit and non-profit comprehensive health service systems (i.e., prepaid group practice units, one or more providers of health services, health insurance carriers, or a combination thereof) for equivalent health insurance benefits. Each such organization would receive reimbursement for costs, and incentive payments to bring about a reduction of costs without impairment of services. These incentive payments would depend on the suppliers achieving an average cost for services which is less than the average cost for services for which payment is made, to comparable population groups under comparable circumstances in the local regional area. Thus, the incentives would represent the actual saving which lower costs produce.

Extre nely imporant in the scheme of my bill is the exclusion from the imposition of the tax on groups which have contracted with the Secretary of Health, Education, and Welfare to provide health services, at least equivalent to the standards provided under the bill for benefits, directly to the worker through the private enterprise system. Thus, my bill provides the health insurance industry with an opportunity to foster better organization of health care and to reshape financing mechanisms to facilitate progressive change.

I would hope that we need not establish a government bureaucracy and could utilize the health insurance industry's talents, experience and expertise. However, if the industry does not cooperate, then my bill authorizes the establishment of a National Health Insurance Corporation.

A new system of national health insurance should not serve merely as a conduit for funds which reinforces existing inadequacies. That is one of the big things that I am pointing out about too many plans. All they are doing is making the supply of health services shorter and complicating further the already inefficient system. We cannot simply pay doctor bills and reimburse hospital costs. Quite the contrary, those funds and the power of reimbursement should be used to improve the delivery and availability of health care.

The health profession's personnel and facilities are not presently adequate to meet the demand which could be established if the benefits of the bill were immediately made available to all Americans. Accordingly, my bill proposes that the level of benefits previously discussed be phased into the system, with a priority to the aged, the disabled, the unemployed and the poor. In the interim, we should allocate sufficient resources—provided for by my bill and through other Federal legislation—to seek to remedy the deficiencies in health personnel and facilities. I do not believe we in the Congress should make a promise which cannot be fulfilled.

To overcome the inequities of our presently outmoded health care system, my bill provides that the Secretary of HEW would be authorized to make loans and grants and provide technical assistance to enable comprehensive health service systems—perhaps now more commonly known as HMO's (health maintenance organizations)—to plan and develop comprehensive health care programs; and to assist them to become self-supporting and to develop their capacity to administer the program.

Criteria would be established for systems seeking financial and technical assistance from the Federal government for the purposes of developing comprehensive health-service systems. Such systems would be required, among other things, to enter into an agreement with the Secretary to provide or arrange to provide services authorized by Medicare. Comprehensive health service systems would have to develop preventive health-care programs, train and employ allied health personnel, be organized in a manner consistent with a state's overall comprehensive health-care plan, and emphasize local consumer and community involvement in its planning, development, and operation.

The Secretary would be authorized to make grants to public or nonprofit hospitals, medical schools, insurance carriers or nonprofit prepayment plans or nonprofit community groups to pay up to 80 percent of the cost of planning and development of comprehensive health-care systems. Applications for assistance under this title would have to be approved by a State health planning agency.

The Secretary would be authorized to contract with an approved comprehensive health-service system to pay as much of administrative, operating, and maintenance costs of such system as exceed its income for the first five years after approval. The contract would require the system to make efforts to enroll members, control costs and utilize services and otherwise maximize income and minimize costs. The Secretary could terminate a contract after giving six months' notice. The Secretary would be authorized to make grants to a system for the programs of capital development in an amount not to exceed 80 percent of non-Federal contributions otherwise required for construction and modernization of hospitals under title XI of the Public Health Service Act. The award of such a grant would depend upon approval of the proposed project by the responsible State health planning agency.

A comprehensive health service system would be identified as one providing health care to an identified population group in a primary service area on the basis of contractual arrangements which embody group practice established by a medical school, hospital medical staff, medical center or other entity among the participating providers of services. The system would be required to provide at least all services specified in title 18 of the Social Security Act—hospital and physician benefits—and annual physical checkups, provision for maintenance prescription drugs, and dental services for children under eight years of age. Other appropriate preventive and comprehensive health care services would be included, as required by the Secretary.

In closing Mr. Chairman, I would like to make one final point concerning the urgency of the need for national health insurance legislation which provides—as contemplated by my bill—comprehensive health care benefits; a restructuring of the health care delivery system including effective cost control over the skyrocketing cost of health care; a meaningful role in accomplishing these goals for the consumers of health care, the patient; and at the same time permits the health care system sufficient time to "tool-up" to provide the care to be delivered.

It will be argued that we cannot enact national health insurance because we cannot afford the cost and we do not have the ability to provide the care and therefore, in the interim, we must seek alternative measures, for example catastrophic health insurance. I agree that we do need some form of catastrophic health insurance protection, but I believe that it must be provided along with a program of national health insurance. Catastrophic health insurance is important for those who can afford care. I am deeply concerned about the millions of people, typified by witnesses before the Health Subcommittee, who do not have the money to pay

medical bills for necessary and basic health services; no less than for those whose total annual income is less than the total deductible provided for in catastrophic health insurance.

The country cannot lose this opportunity to provide major surgery to our failing health system; band-aids are not the answer. The testimony on the Health Care Crisis in America before the Health Subcommittee of the Committee on Labor and Public Welfare (of which I am ranking minority member) made one point all too clear. Not only are too many of our people sick, but they also become sicker because the quality of the care they receive is not as good as it could be. Even more tragic is that often they do not have the financial means to obtain health care, if it were available. Also, most distressing is that when they receive the bill for their medical services, they are even "sicker."

All too often the patient is lucky to become a doctor's patient. Many witnesses have testified that if they do not have health insurance coverage or the money to pay the bill, they will not receive any treatment at all, thus their perhaps minor episodic illness becomes a catastrophic illness; the simple cold becomes pneumonia.

Mr. Chairman, we are never going to stem the tide of rising health care costs unless we develop a system of health care designed to keep people well—not of sickness care primarily. We must pave the way towards that system of preventive, health care that is not only in every citizen's self-interest in terms of cost and quality of care provided, but in the broader social interest as well. We are dealing here with the lives and welfare of all Americans. The issue of adequate and accessible health care, therefore, has become an imperative of social justice.

It is an idea whose time has come!

It is the number one personal welfare issue of our time. The eminent British statesman Benjamin Disraeli said: "The health of the people is really the foundation upon which all their happiness, and all their powers as the state, depend."

LEVEL OF BENEFITS—NATIONAL HEALTH INSURANCE ACT OF 1971

The benefits provided to all citizens of the United States under my national health insurance bill—subject to existing coinsurance and deductibles—shall consist of no less than the following (effective for over 65 and disabled, July 1, 1972; for general public, effective July 1, 1974):

1. Up to 90 days—with a lifetime reserve of 60 additional hospital days—of bed patient care in any participating general care, tuberculosis or psychiatric hospital. When a bed patient in a hospital, some of the services paid for include:

Bed in semiprivate room (2–4 beds in a room) and all meals, including special diets;
Operating room charges;
Regular nursing services (including intensive care nursing);
Drugs furnished by the hospital;
Laboratory tests;
X-ray and other radiology services;
Medical supplies such as splints and casts;
Use of appliances and equipment furnished by the hospital such as wheelchairs, crutches, braces, etc.; and
Medical social services.

2. When the patient no longer needs the intensive care which hospitals provide, but still needs full-time skilled nursing care, he may be transferred—for up to 100 days—to an extended care facility—a specially qualified facility, staffed and equipped to furnish full-time skilled nursing care and related health services, which include:

Bed in a semiprivate room (2–4 beds in a room) and all meals, including special diets;
Regular nursing services;
Drugs furnished by the extended care facility;
Physical, occupational, and speech therapy;
Medical supplies such as splints and casts;
Use of appliances and equipment furnished by the facility such as wheelchairs, crutches, braces, etc., and
Medical social services.

3. After a stay in a hospital (or in an extended care facility after a hospital stay) if the physician determines continued care can be best given at home

through a home health agency, the individual will be covered for as many as 100 home health visits for further treatment of the condition for which he received services as a bedpatient in hospital or extended care facility. The home health services include:

Part time nursing care;
Physical, occupational, or speech therapy;
Part-time services of home health aides;
Medical social services;
Medical supplies furnished by the agency; and
Use of medical appliances.

4. Doctors' services no matter where he treats the patient—in a hospital, his office, an extended care facility, home, a group practice or other clinic—and included are:

Medical and surgical services by a doctor of medicine or osteopathy;
Certain medical and surgical services by a doctor of dental medicine or a doctor of dental surgery;
Services by podiatrists which they are legally authorized to perform by the State in which they practice; and
Other services which are ordinarily furnished in the doctor's office and included in his bill, such as: Diagnostic tests and procedures, medical supplies, services of his office nurse, drugs and biologicals which cannot be self-administered.

5. Ambulance services to a hospital when:

(a) ambulance services are medically necessary to protect the health of the patient,
(b) transportation by other means could endanger the patient's health, and
(c) the patient is taken to the nearest hospital that is equipped to take care of him (or to one in the same locality).

6. Outpatient hospital benefits which include:

Laboratory services such as blood tests and electrocardiograms;
X-ray and other radiology services;
Emergency room services; and
Medical supplies such as splints and casts.

7. In addition to "3" above, home health benefits—up to 100 home health visits each calendar year—even if the individual was not first hospitalized, if confined to home, a doctor determines home health care needed and periodically reviews the home health care plan. It would include:

Part-time nursing care;
Physical, occupational, or speech therapy;
Part-time services of home health aides;
Medical social services;
Medical supplies furnished by the agency; and
Use of medical appliances.

8. Other medical services and supplies for the treatment of illness or injury—furnished by a doctor as part of his treatment, or by the outpatient department of a hospital, or a medical clinic in connection with treatment, includes:

Diagnostic tests such as X-rays and laboratory tests;
Radiation therapy;
Portable diagnostic X-ray services furnished in your home under a doctor's supervision;
Surgical dressings, splints, casts, and similar devices;
Rental or purchase of durable medical equipment prescribed by a doctor to be used at home; for example, a wheelchair, hospital bed, or oxygen equipment, and
Devices (other than dental) to replace all or part of an internal body organ. This includes corrective lenses after a cataract operation.

9. Payment for maintenance drugs, a drug used for treatment extending over a period of 90 days or more and the withdrawal of which would be seriously harmful to the individual's health. The copayment shall be $1 until January 1975 and thereafter, an amount to be determined by the Secretary pursuant to the formula set up in the bill, effective July 1, 1974.

10. Payment of up to $75 for annual physical checkups, which include eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; ear examinations for the purpose of determining the need for hearing aids; and such diagnostic X-ray, laboratory and other tests as are likely to reveal defects, dis-

eases or conditions susceptible to effective treatment or control; including physician's services appropriate for interpretation, evaluation and analysis of such tests, for all over and under 65, effective July 1975.

11. Dental services for children under 8 years of age, including oral examinations and diagnosis, oral prophylaxis, fillings and removal of teeth, effective July 1, 1975.

THE LIBRARY OF CONGRESS,
LEGISLATIVE REFERENCE SERVICE,
Washington, D.C., April 13, 1970.

To: Hon. JACOB JAVITS,
From: Education and Public Welfare Division.
Subject: Review of the major provisions of your proposed National health insurance plan.

This is in reply to your recent request asking for a review and description of the major provisions of your proposed program of National health insurance for the United States. The description of the provisions of the bill, which is outlined below, is intended only to summarize the principal features of the legislation and in no way is it intended to constitute a comprehensive analysis of any single provision in the legislation. Because of the time requirements imposed on us by this request, we are unable to touch upon every aspect of the proposal. We have, therefore, confined this discussion to capsule statements summarizing the principal features of each part of the proposal. In the event you would like us to examine the bill in greater detail, please let us know.

PURPOSE AND ORGANIZATION OF THE LEGISLATION

The proposed "National Health Insurance Act of 1970" would create a National health insurance program for the United States by extending the benefits, enlarging the scope of coverage, and by otherwise revising the existing program of health insurance for the aged, commonly known as medicare (title 18 of the Social Security Act).

According to the findings outlined in the draft bill, Congress finds that the existing health care system in the Nation cannot guarantee the right to quality health care for every citizen regardless of economic status. The legislation states that the Government has, therefore, an obligation to encourage the development of systems of care which would eliminate economic and organizational barriers to health care for every American, including the aged, the indigent, the disabled and the unemployed.

Specifically, the draft legislation would seek to meet these objectives by means of five titles.

First, the existing Title 18 program would be revised, both as to its coverage of certain insured individuals and to the benefits provided by the program. Basic hospital insurance benefits (Part A of the existing Title 18 program) would be available under the bill not only to all older people but to the disabled, widows, and widowers as well. The supplementary benefits program (Part B of the existing Title 18 program) would be provided to such covered individuals without separate premium costs. Title I of the bill would also add, among the services covered by the newly expanded Title 18 program, the costs of certain maintenance drugs, annual physical checkups, and certain dental health services for children under 8 years of age. Other provisions provide for limitations on certain charges for services, for administration of the program and for means of stimulating improvements in the organization of health care in the United States.

Title II of the proposed legislation establishes a health benefits program for all persons not otherwise protected under the revised title 18 program. The benefit package provided for under this new title (a proposed title 20 of the Social Security Act) is identical with those benefits provided to the aged and disabled under the revised title 18 program.

Title III of the proposal provides for the financing of the National health insurance program by expanding upon the current payroll tax mechanism used to finance retirement, survivors, disability and hospital insurance benefits in the present Social Security Act. Changes in the tax rates and earnings base, to which such rates are applied, are provided for in the legislation. In addition to the Wage-related financing provisions authorized by the bill, however, a separate source of income for the program is authorized by requiring the Government to meet one-third of the total costs of National health insurance out of general revenue funds.

Title IV of the proposal provides for financial and technical assistance through programs of loans, grants, and supplementary financing to institutions and to other organizations for the purpose of stimulating and developing improved comprehensive systems delivering and providing health care to the public.

Title V of the proposed Act calls for the establishment of national health insurance corporations which would be federally chartered and operate as agencies of the U.S. under the guidance of the Secretary of Health, Education and Welfare. Such federal health insurance corporations would operate under contract with the Secretary in a manner similar to contract agreements entered into between the Secretary and various private health insurance carriers, non-profit organizations, etc.

Selections of the Draft Proposal

Title I—Amendments Relating to the Present Title 18 Health Insurance Program

Title I of the proposed legislation contains seven parts designed to revise the scope of coverage of the title 18 program to groups of persons in addition to those now covered by law, to expand the scope of benefit coverage provided by the existing program, and to provide for improved health care administration in connection with a National health insurance program.

Part A

Sec. 101.—*Changes in Entitlement to Health Insurance:* revises Sec. 226 of the present Social Security Act, relating to who is entitled to hospital insurance benefits under medicare (title 18, Part A), by including all persons aged 65 and older (including those not presently insured) and all others receiving benefits based upon their disability (including those 18 and over with childhood disabilities). In addition, entitlement is established for widows aged 60 and over and for widowers aged 62 and over. The existing provisions relating to entitlement for certain uninsured persons are repealed by the bill.

Sec. 102.—*Changes in the Name of the Title 18 Program:* the present Health Insurance Program for the Aged is renamed the "Health Insurance Program," and the program description is changed to refer to the disabled as well as to the aged. The phrase "for the Aged" is dropped from the names of the present Hospital and Supplementary Medical Insurance Programs.

Sec. 103.—*New Supplementary Medical Insuranec Program:* deletes reference of this program solely for the aged and makes entitlement to supplemental benefits solely a matter of entitlement to the Part A, or hospital insurance program. Repeals certain provisions of the present supplementary program and transfers to a Federal Health Insurance Fund the assets and liabilities of the Supplementary Medical Insurance Trust Fund now used to finance current Part B benefits. Eliminates references in the present medicaid law (title 19) to the present Part B, or supplementary program.

Sec. 104.—*Coordination with the Railroad Retirement Act:* Coordinates provisions of the Railroad Retirement Act with the expanded title 18 program and includes the disabled railroad retirement employees among those entitled to health insurance benefits, in a manner similar to those disabled covered under the Social Security Act.

Sec. 105.—*Effective Date:* The effective date of the Part A provisions would be July 1, 1971.

Part B

Sec. 110.—*Coverage of Drugs under the New Health Insurance Program:* expands the benefit coverage under the new title 18 program to include protection against the costs of certain maintenance drugs appropriate to the treatment of certain long-term conditions. Provides for the cost-sharing by beneficiaries for such maintenance drugs available on an outpatient basis. Establishes the conditions for which drugs are to be included, how drug costs are to be paid, and other standards for administering and supervising a drug benefit under the program. The inclusion of a maintenance drug benefit would be effective with respect to drugs dispensed after June 30, 1973.

Part C

Sec. 120.—Coverage of Physical Examination: adds a new benefit to the revised title 18 program by covering the costs of physical checkups to include eye examinations, ear examinations, and such other diagnostic tests or examinations which

would be likely to reveal defects, diseases or conditions susceptible to effective treatment and control. Checkup services would also include the costs of physicians' service appropriate for the interpretation, evaluation or analysis of these tests. The deductible provision, now applicable to the Part B program, would not apply in the case of expenses incurred for checkups, except that limits are placed upon the maximum charges which would constitute incurred charges for checkups. These additional benefits would become available after June 30, 1974.

Part D

Sec. 130.—Dental Services for Children: amends the new health insurance program to provide for routine dental care for children under 8 years of age. As in the case of physical checkups, the deductible provisions of the present Part B program would not apply. These benefits would become available after June 30, 1974.

Part E

Sec. 140.—Limitations on Certain Charges for Services: amends effective January 1, 1971 the current "reasonable charges" section of the present Part B program and substitutes the phrase "appropriate and reasonable charges."

Sec. 141.—Physicians' Qualifications: Revises under Title 18 of the Social Security Act the definition of the term "physician" by imposing certain qualifications for physicians providing services under the health insurance program. Such qualifications would be related to standards for 1) continuous professional education 2) national minimum licensure requirements 3) performance of various specialty services. Any physician or specialist failing to meet such standards would not be recognized as a "physician" for purposes of the program, although the Secretary of HEW would be required to notify the physician of any deficiency and allow for a "reasonable opportunity" to correct it.

Part F

Sec. 150.—*Agreements with States for Administration:* amends Title 18 of the Social Security Act to allow the Secretary of HEW to arrange for State administration of the health insurance programs established pursuant to Title 18 of the Act. Reimbursement to the States for costs of carrying out such agreements would be made by the Secretary of HEW.

Part G

Sec. 160.—Improvement in the Organization of Health Care: amends medicare program) by adding a new "Part D" to the program. The purpose of this part is to encourage the rational organization of health care services and facilities so as to provide greater continuity and comprehensiveness of care of the individual, to provide greater consumer education and participation, and to emphasize preventive, diagnostic, and early therapeutic services, to control the costs of services paid for under the title and to stimulate diversity and innovation in the provision of health insurance protection. Part D would authorize the Secretary to develop, by means of contracts and by other methods, the growth of "comprehensive health service systems." Such systems would agree to provide the basic benefits provided for in the revised health insurance program and also agree to carry out appropriate utilization and cost control responsibilities in connection with the provision of benefits. Such systems would have to be consistent with comprehensive health plans developed by each State. The Secretary would be authorized to use various means of reimbursement (other than a reasonable cost system) to pay for benefits provided by comprehensive health service systems, and could develop special incentive provisions for these systems if their costs were generally less than costs otherwise experienced by the health insurance program. A special employer-employee health plan option is authorized where employers provide for their employees' health care benefits under a qualified plan in lieu of benefits otherwise provided by the new program. The effective date for the new Part G program would be July 1, 1971.

TITLE II.—AMENDMENTS RELATING TO HEALTH BENEFITS FOR THE GENERAL PUBLIC

Title II of the proposed legislation would add a new title 20 to the Social Security Act to provide for the entitlement to benefits of the revised title 18 program for all persons not otherwise so entitled by reasons of other provisions in the law. The new title 20 is composed of two sections:

Sec. 2001.—*Entitlement to Benefits for the Uninsured:* provides that any person, who is a resident and a citizen (or an alien lawfully admitted for permanent

residence), not otherwise entitled to the revised title 18 program (by reason of Sec. 226 of the Act) would be entitled to the same benefits of that program on July 1, 1973. Special provisions would govern the manner and period during which such entitlement would be established.

Sec. 2002.—*Trust Fund Account for the Uninsured:* creates within the new Federal Health Insurance Trust Fund a special account known as the "Special Account for the Uninsured." Benefits provided for the persons entitled under title 20 would be paid from, and only from, this Special Account. This section also specifies the manner in which funds are to be appropriated to the Special Account within the Health Insurance Trust Fund.

TITLE III.—FINANCING OF HEALTH INSURANCE

Title III of the proposed legislation is divided into five parts which identify and explain the taxing mechanism devised to provide the financial resources with which the national health insurance program will operate. The new title includes amendments to the Internal Revenue Code relating to payroll deductions for the purposes of health insurance:

Sec. 301.—*Wage and Income Bases for Purposes of Health Insurance:* amends those sections of the Internal Revenue Code of 1954 (relating to definitions for the purposes of Federal Insurance Contributions) by adding new subsections setting forth definitions of wage and self-employment income bases for purposes of health insurance. The wage and income bases on which taxes are imposed in connection with the financing of health insurance benefits provided under the proposed Act would be set at $15,000 rather than $7800 per annum. with respect to the tax paid by employees on the self-employed. No ceilings are placed on the wages with respect to taxes paid by the employer. The bill indicates that the effective date of the tax change and wage base would begin with taxable years ending after December, 1970.

Sec. 302.—*Definition of the Term "Employment" for the Purposes of Health Insurance:* amends Internal Revenue Code so as to include only within the framework of the revised taxing mechanism, certain additional categories of employees and employers formerly excluded from taxing provisions used to finance benefits under Title 18 Social Security Act. Additional categories of employees to be included for taxing purposes are: individuals engaged in family employment; federal, state and local government employees; ministers; railroad employees, individuals in employ to tax-exempt organizations; individuals in employ of registered subversive organizations. Employers of these individuals in above-mentioned categories would also be included in the taxing mechanism for medicare with the exception of employers falling into the categories of state and local governments and churches and religious orders. Effective date of this section will be 12/70.

Sec. 303.—*Exemption of Certain Employment for Health Insurance Taxing Purposes:* provides that employment which includes the performance of service by an employee for an employer, who has in effect a contract with the Government relating to a comprehensive health service system, is excluded for purposes of health insurance taxation.

Sec. 304.—*Rate of Tax for Medicare Purposes on Employees, Employers, and Self-Employed Individuals:* amends Internal Revenue Code by establishing new tax rate schedules for health insurance purposes applicable equally to employers, employees, and self-employed individuals as follows:

[In percent]

Calendar years	Employers	Employees	Self-employed
1971	0.7	0.7	0.7
1972	.9	.9	.9
1973	2.0	2.0	2.0
1974	3.1	3.1	3.1
1975 and thereafter	3.3	3.3	3.3

Sec. 304.—*Appropriations to Federal Health Insurance Fund:* provides that in addition to funds appropriated to Federal Health Insurance Fund through taxing mechanism described above, there shall also be appropriated from general revenues an amount equal to 50% of the amount deposited in the Health Insurance Fund

collected by means of the payroll tax mechanism and any additional amounts that would have been appropriated if no agreements had been authorized for employer-employee health plan options (as provided for in Part C, Title I of this bill).

TITLE IV.—FEDERAL AID TO ESTABLISH LOCAL COMPREHENSIVE HEALTH SERVICE SYSTEMS

Title IV is composed of seven sections which emphasize the need for a reorganization of the present health care system and provisions of Federal financial and technical assistance to affect the desired changes:

Sec. 401.—*Findings and Declaration of Purpose:* in keeping with its findings that present programs of health services fail to provide for continuous, efficient, and comprehensive health care, Congress declares that a system of national health insurance must be established in a way that will increase purchasing power, equalize access to quality care, and affect a change in the health care system. Declares that the purpose of this title is the provision of financial and technical assistance through the awarding of grants and loans to health service institutions and organizations in order to stimulate the planning, development, and implementation of comprehensive health service systems.

Sec. 402.—*Basic Authority:* authorizes the Secretary of Health Education, and Welfare to make such loans, grants, etc. as are provided for under this title.

Sec. 403.—*Systems Eligible for Financial and Technical Assistance:* establishes the criteria for systems wishing to receive financial and technical assistance from the Government for the purposes of developing comprehensive health service systems. Such systems must, among other things, enter into an agreement with the Secretary to provide or arrange to provide services authorized my medicare. In addition to certain requirements concerning enrollment of beneficiaries in such systems, comprehensive health service systems must develop preventive health care programs, train and employ allied health personnel and be organized in a manner consistent with the State's overall comprehensive health care plan.

Sec. 404.—*Financial and Technical Assistance for Planning Comprehensive Health Service Systems:* authorizes Sec. of HEW to make grants to public or non-profit hospitals, medical schools, any insurance carriers or non-profit prepayment plans, etc. to pay 80% of the cost of planning and development of comprehensive health service systems. Applications for assistance under this title must be approved by a State health planning agency.

Sec. 405.—*Financial and Technical Assistance for Operation of Approved Comprehensive Health Service Systems:* authorizes Secretary to contract with approved comprehensive health service system to pay so much of administrative, operating, and maintenance costs of such system as exceed its income for the first five years after approval. The contract shall require the system to make efforts to enroll members, control costs and utilization of services, and otherwise maximize income and minimize costs. Secretary may see fit to terminate contract after giving 6 months notice. Secretary is authorized to make grants to system for programs of capital development in an amount not to exceed 80% of non-Federal contributions otherwise required for construction and modernization of hospital, etc., under Title 6 of Public Health Service Act. The awarding of such a grant depends upon approval of the proposed project by the responsible State health planning agency.

Sec. 406.—*Appropriations:* authorizes appropriations to carry out contracts pursuant to Title IV.

Sec. 407.—*Definitions:* the term "comprehensive health service systems" is intended to identify a system providing health care to an identified population group in a primary service area on basis of contractual arrangements embodying group practice, are established by a medical school, a hospital medical staff or medical center among the participating providers of services. Describes comprehensive health service systems as those which provide at least all services specified in Title 18 Social Security Act as amended by this Act.

TITLE V—FEDERALLY CHARTERED HEALTH INSURANCE CORPORATIONS

Title V of the proposed Act is composed of one section which amends the Social Security Act by adding new sections authorizing the Secretary of HEW to establish various national health insurance corporations which will operate under the guidance of the Secretary.

Sec. 501.—National Health Insurance Corporations: Authorizes the Secretary of Health, Education, and Welfare to establish and contract with one or more

Federally chartered health insurance corporations for provision of health benefits under Title 18 of the Social Security Act. Health Insurance corporations so organized will act as agents of the U.S. Government under the guidance of the Secretary of HEW.

The CHAIRMAN. Senator J. Caleb Boggs of Delaware has submitted a written statement in lieu of his personal appearance, and I will place it in the record at this point.

(Senator Boggs' statement follows:)

PREPARED STATEMENT OF SENATOR J. CALEB BOGGS

SUMMARY

Washington, D.C., April 27, 1971—Sen. J. Caleb Boggs, R–Del., today said that his Catastrophic Illness insurance legislation would free families "from choosing second-rate treatment and care just because it is less expensive."

Boggs' bill would provide for establishment of insurance coverage over and beyond that provided by ordinary health insurance. It would be designed to cover costs of major illnesses.

Under it, each state would be encouraged to establish an insurance pool for catastrophic illness similar to those that exist in many states for flood and riot insurance. The Federal Government would encourage private insurance companies to participate by re-insuring them against substantial loss.

Boggs' remarks today were in testimony before the Senate Finance Committee, which is considering a number of proposals dealing with health services.

"The case of a young married couple forced to deprive themselves and their healthy children of the fruits of their labors in order to keep one child alive is not uncommon," he said. "They must often go far into debt, bearing this financial burden as well as the emotional burden of a sick child. Nor is it uncommon for the elderly, often living on low fixed incomes, to face financial ruin as a result of catastrophic illness."

"Until medical science can counter the causes of catastrophic illnesses, we cannot avert these tragedies," Boggs added. "We must, therefore, do all we can to soften their effects. It is time that we provide some relief for these financial and human disasters."

The Delaware Republican also pointed out that his proposal is not intended to be a substitute for normal health insurance. Rather, it is an extension of coverage most Americans already have.

STATEMENT

Mr. Chairman, it is a great pleasure for me to appear before the committee today to testify on behalf of S. 191, the National Catastrophic Illness Protection Act of 1971, which I have introduced along with the Senator from Maryland, Mr. Beall, and the Senator from Texas, Mr. Tower. I appreciate the opportunity to review with the committee the major points of this legislation and to point out what I believe to be its many desirable features.

It is not necessary for me to dwell too long on the need for legislation to relieve a measure of the burden that befalls a family when a catas-

trophic illness strikes one of its members. The committee has already taken note of the pressing need, as has President Nixon in his health care proposals.

I would like to take a few moments, however, to remind the Committee of the great tragedies which result not only for the victim of a catastrophic illness but for all the members of his family. The case of a young married couple forced to deprive themselves and their healthy children of the fruits of their labors in order to keep one child alive is not uncommon. They must often go far into debt, bearing this financial burden as well as the emotional burden of a sick child. Nor is it uncommon for the elderly, often living on low, fixed incomes, to face financial ruin as a result of catastrpohic illness.

Although the incidence of catastrophic illness is probably highest among the young and the old in our population, the fact is that it may strike anyone at any time during his life. When the victim is a husband and father, the tragedy is compounded, for it touches each member of his family by shaking his security and jeopardizing his entire future.

At this point I would like to stress the nature of catastrophic illness. It need not be rare or exotic; it need not lead to permanent disability. An illness is catastrophic only in the sense that the cost of treatment exceeds what normal insurance coverage will pay. This may result from a common heart attack requiring long months of intensive hospital care, an injury requiring extensive rehabilitation, a costly operation or a birth defect. The list is virtually endless as is, unfortunately, the catalogue of major human affliction.

Until medical science can counter the causes of catastrophic illness, we cannot avert these tragedies. We must, therefore, do all we can to soften their affects. It is time that we provide some relief for these financial and human disasters. I believe, it is within our power to do so. It is my hope that the Committee will act to fill this most desperate need.

Since catastrophic illness strikes at random—young and old, black and white, rich and poor—I believe extended care insurance should be made available to all who desire it. Under the legislation that I have proposed, such would be the case. Every individual and every head of household would have the option of obtaining this type of insurance. Because the penalty for being caught without this protection is so great—as great or greater than being caught without fire or automobile insurance—it is expected that participation would be widespread. In this manner, the risks to insurers would be spread out and the cost of the insurance could be kept low, encouraging still more participation.

In recognition of the fact that private insurance companies are far better equipped to operate insurance programs than the federal government, the National Catastrophic Illness Protection Act would maximize involvement of private insurers and minimize the federal role. Under the overall authority of the Secretary of Health, Education, and Welfare, each state would be required to divise a statewide catastrophic illness insurance plan utilizing private insurance companies. The private insurance companies could, if they desired, enter into insurance pools similar to those that have made flood and riot insurance feasible. The state insurance authority would be charged

with carrying out the plan in his state. No state resident could be denied coverage if he made appropriate application.

The federal role would be limited to encourage private insurance companies or pools participating in a statewide plan to offer this type of insurance by reasuring them against losses in those instances where they paid out more in benefits than they took in in premiums. As the insurance industry acquired experience in setting rates and planning, the number of losses should decline to the point where they cease to exist. Under the reinsurance arrangements, a National Catastrophic Illness Insurance Fund would be established. This fund would receive premiums from participating insurance companies which would then be held in reserve to offset possible losses.

Premium rates would be set on the basis of a study of the risks involved and accepted actuarial principles. These rates would be promulgated by the Secretary of Health, Education and Welfare for use by the States and insurers. Rates might vary somewhat according to the number of persons covered by a single policy and differentials in risk.

This type of insurance protection, I would like to stress, is in no way intended to be a substitute for normal health insurance. It is simply an extension of that coverage which most Americans already have. For this reason benefit payments under this program would begin only after a certain level of cost had been exceeded. In other words, the benefits of a catastrophic illness protection policy would not begin until a point is reached at which it is calculated according to a formula that normal health insurance has been exhausted. This deductible level rises with income so that low income policyholders would receive benefits sooner than higher income policyholders whose normal health insurance would be somewhat greater.

Catastrophic illness expenses often create the greatest financial strain for middle income families because those in the lowest income levels rely on the state and state institutions to bear these expenses and those at upper income levels can absorb the costs themselves. Thus families in the middle incomes would be most benefitted by this program.

An example may help to clarify how the program works. A family with a gross income of $10,000 a year would, during a year, have to incur medical expenses up to $8,500 or have basic insurance coverage equal to this amount before he could receive catastrophic illness insurance benefits. This figure may seem high when one thinks of the average amount that any family pays out for medical care in a single year. However, the expense of a catastrophic illness normally runs well above that figure and may go as high as $50,000 or $75,000.

Once again I would like to emphasize to the Committee the enormous benefits of this insurance program. It would free families, already living with extraordinary emotional burdens, from the fear of destitution. It would free them from choosing between the welfare of one of their children and the welfare of the others. It would free them from choosing second-rate treatment and care just because it is less expensive. These are difficult choices which few of us here today have had to make. We can make them much less difficult by enacting legislation such as I have proposed.

Again, my thanks to Chairman Long and the members of the Committee for inviting me to discuss my bill today.

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The CHAIRMAN. Our next witness will be Mr. Andrew Biemiller, director of legislation for the AFL–CIO. We are pleased to have you, Mr. Biemiller.

Mr. BIEMILLER. Thank you, Mr. Chairman.

The CHAIRMAN. We welcome your suggestions.

STATEMENT OF ANDREW J. BIEMILLER, DIRECTOR, DEPARTMENT OF LEGISLATION, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS; ACCOMPANIED BY BERT SEIDMAN, DIRECTOR, SOCIAL SECURITY DEPARTMENT, AFL–CIO

Mr. BIEMILLER. I am accompanied by Mr. Bert Seidman who is director of the Social Security Department of the AFL–CIO. We appreciate this opportunity to appear before your committee in support of S. 3, the national health security program.

The AFL–CIO is no johnny-come-lately in the struggle to bring quality health care to all Americans. Organized labor has been fighting for national health insurance for more than 30 years. We were delighted to work with Senator Anderson and others in the medicare fight. So we bring to your committee the best of credentials our long concern with health care—and the added fact that we are the largest organization of health consumers in this Nation.

We in the AFL–CIO do not pretend to be doctors. We don't want to practice medicine. We don't want to make medical decisions. These matters are in the hands of doctors—where they rightly belong—and S. 3 would not change that one iota.

S. 3 is the health consumer's bill. It is not organized medicine's bill. It is not the program of the insurance carriers. It is the consumer's response to the health care crisis. We believe it is time that the people who pay the bills—the health consumers—have a means of controlling the inordinately high cost of health care and a method of gaining accessibility to medical care for the millions of Americans who do not now have a chance to get it.

The AFL–CIO is proud to support S. 3. There is good reason for this pride. Of all the measures thus far introduced only health security tackles all the real problems: quality care for all Americans, financing, cost controls, development of new health care delivery systems, and restructuring of the present wasteful, inefficient system.

Under health security, Congress would have—for the first time—a national oversight of health care delivery. And this committee's past hearings into the reasons for soaring health care costs have shown the need for such a national oversight.

What America needs as the heart of its medical care philosophy is a single primary goal—good health for all its people. The profitmaking philosophy of the marketplace—to make money for those who provide and finance medical services—is not an acceptable philosophy for medical care.

Clearly, there are many problems with America's health care delivery system. President Nixon has said there is a medical care crisis in America. He said that 20 months ago, and repeated that statement on February 18 of this year in a message to Congress.

And just this past week, the administration finally introduced its bill. What has happened during all the time it took for the administration to offer a measure which it says is designed to meet the crisis the President referred to 20 months ago?

Well, medical care costs continued to climb. In fiscal 1970, they rose 12 percent; in the 2 months since the President's message, the costs have increased 1.5 percent—.7 percent in February and increasing to .8 percent last month.

I would have liked to have given this committee a comparison of national health security with the administration program. But since the administration did not introduce its bill until just before these hearings, I am forced to confine my remarks to a discussion of the major objectives of S. 3 and why the AFL–CIO supports it.

We believe that health care is a right of every American—man and woman, rich and poor, working and unemployed, young and old. Health security delivers that right. It doesn't just pay lipservice to it.

Health security would provide the most comprehensive health benefits of any program that has been introduced. It would provide:

Full payment of all physician and surgical services, including preventive care and physical examinations.

Full payment of all hospital services, hospital-affiliated nursing home care, outpatient services and home health care.

All medicines provided by a hospital or prepaid group practice.

Other services including optometrists, podiatrists, pathology, radiology, and ambulance.

Dental care for those under 15 with extensions to later cover the entire population.

A broad program of active mental health treatment, including 20 consultations with solo practitioners, 45 days of inpatient care, 60 days in mental health care centers, and unlimited care when provided through a prepaid group practice-type setting.

Because deductibles, coinsurance, exclusions for pre-existing conditions, cutoff points and waiting periods discourage persons from seeking early medical treatment, Health security has no deductibles, no coinsurance, no exclusions, no waiting periods and provides minimal limitations only when needed to guarantee the benefit can be provided.

S. 3 is comprehensive. It is health insurance, not sickness insurance. And by providing the complete range of benefits, there is no need for a separate catastrophic plan as a companion to health security.

There is a school of thought, Mr. Chairman, that says a catastrophic plan coupled with present private insurance is all that America needs.

We do not agree.

It is deceiving to consider present private insurance as comprehensive. The gaps in benefits provided are glaring. For example, 34 million persons under age 65 have no health insurance whatsoever. Only two in every five have insurance that pays doctor's bills outside the hospostal. More than 38 million have no surgical coverage. Only four people in 100 have insurance for dental care. Because of gaps like these in present insurance coverage, many families—although "insured"—are wiped out financially by medical bills.

And catastrophic insurance does not fill the gaps. What's a catastrophe? To you and me, Mr. Chairman, a $250 medical bill, while an

annoyance, certainly doesn't qualify as a catastrophe. But to an $80 a week worker, $250 is a catastrophe.

But catastrophic insurance requires that an $80 a week worker would pay out of his own pocket exactly the same dollar amount as we—you and I—would pay before he could receive any benefits.

Health Security would eliminate catastrophes by providing all necessary benefits.

I wish to turn now to the financing of health security. The program would be financed similar to the social security system. The cost would be established and—I emphasize—budgeted annually. This is very important—a lid on costs. The health security trust fund—similar to the social security trust fund—would be established. Money would be raised from the following sources:

Fifty percent from Federal general revenues, for fiscal 1970 that would have been $20.5 billion, and the Federal Government spent more than half that amount in 1970 on personal health care.

Thirty-six percent from a 3.5-percent tax on employer payrolls.

Twelve percent from a 1-percent tax on the first $15,000 of income.

Two percent from a 2.5-percent tax on the first $15,000 of income of the self-employed.

The medicare tax—presently 0.8 percent of the first $7,800—would be eliminated. A saving of more than $3 billion of State and local government health care expenditures would be realized because health security would eliminate much of the need for a separate, costly health care program for the poor.

Administration of the program would be similar to social security with regional and local offices. These local offices would approve institutional budgets, coordinate planning, and generally administer the program. Health security would have consumer participation at various levels through advisory councils.

S. 3 incorporates all existing payment methods—fee for service, capitation, and so forth. While we in the AFL–CIO believe there is a much better way to providing health care than through the cottage industry concept of solo practice and fee for service—in other words, prepaid group practice—pains have been taken to provide maximum freedom for doctors to choose how they want to practice medicine.

Financial incentives are provided to restructure the organization and delivery of health care. Indeed, the principal aim of our program is restructuring the system. Success, however, of any health program will depend on an adequate supply and the appropriate distribution of health manpower.

To do this, S. 3 establishes a resources development fund with a fixed percentage of the trust fund—beginning at 2 percent and rising to 5 percent. Even before health security benefits would begin, the resources development fund would be started with $200 million for the first year and $400 for the next year.

This money would supplement existing health manpower programs and would strengthen the Nation's resources of health personnel and facilities in specific areas. This includes funds to encourage health manpower to locate in medically deprived areas; increased training for paraprofessionals; money to expand the training in medical and dental schools.

This Nation must reorganize and improve the delivery of health services and expand their capacity. This is not an "either, or" proposition. We have to do both. We have to do both now.

There are those who say that national health insurance must wait because the present system is incapable of delivering more health care. But America will never reorganize the delivery of health services or control its costs under the present methods of paying for sickness. Medicare, medicaid, and Blue Cross-Blue Shield and other insurance programs have proved this.

What the apostles of delay and those who advocate leaving the present system intact overlook is that the method by which America finances health care must create the necessary leverage to restructure the system—bringing about a rational system of quality care at reasonable costs for all Americans.

S. 3—alone of all the bills introduced in this Congress—will do this, We believe it will benefit all Americans: doctors, patients, hospitals—everyone. And we are convinced that now is the time to do it.

The CHAIRMAN. Thank you for your statement, Mr. Biemiller.

Just as one member of the committee, I am not ready to buy your program at this time. I am willing perhaps to buy some of it but not willing to buy all of it.

What you and I are both interested in is to try to provide the working man with the best health care we can obtain for him at the best cost. We have that objective in mind generally, don't we?

Mr. BIEMILLER. I would agree that is the basic objective, not just for the working man, for all Americans.

The CHAIRMAN. Right; you propose here that the Government should pay all medical expenses, as I understand it, with no deductibles; is that correct?

Mr. BIEMILLER. That is, the health security trust fund should.

The CHAIRMAN. Yes; well now, let's just take the kind of case which ordinarily is not covered by health insurance. I am part Irish so I guess I am privileged to say this. I generally take the attitude that every Irishman is entitled to celebrate St. Patrick's Day.

Let's just say for the sake of argument that an Irishman goes out and he really celebrates St. Patrick's Day, and on the following day he finds that he has had what is known as an Irish accident—he just feels horrible. He feels as though he is going to die. You and I know if he does nothing about it he will recover, but that is not how he feels at that particular time.

Now, one way for him to handle it is to just drag it out through the day and on the following day he ought to feel better. Another way would be to go to the doctor and get a big shot of vitamins and a big shot of tranquilizers, an ice pack and a lot of professional advice, and he might feel better a little bit sooner. As a practical result, on the following day he will feel the same way whether he has the shot of vitamins and the tranquilizers and the aspirin tablets and all the rest of it.

Now, is that really an expense that his neighbor ought to be required to pay for should he have to bear that himself?

Mr. BIEMILLER. Let me refer that to Mr. Seidman who has some experience.

Mr. SEIDMAN. Mr. Chairman, I have the personal experience of belonging to a prepaid practice plan where we have no such deductible.

Ordinarily I woudn't give any advice to doctors, but I would think that under those circumstances if this gentleman you speak of came into Group Health Association here in Washington, he would have to come in through the urgent visit clinic because he wouldn't have an appointment since he could not anticipate this situation. I think the chances are very good that they would tell him to go home and sleep it off.

It is not—in other words, what we are saying is that by and large when people seek medical care they really need it. If they seek it under other circumstances than the professionals are able to deal with them effectively, it seems to me.

The CHAIRMAN. But the reason we have had so much additional cost, the reason that the cost of medicare is exceeding the estimates by more than 2 to 1, is in good part due to providing additional service that a person could get by without. It is a difference between the person staying in a hospital 3 days when he could have gone home after 2 days. It is a difference between his seeking or being provided this additional care which is not entirely necessary.

Mr. SEIDMAN. Mr. Chairman, the experience of those plans that do not have the deductibles and do not have the coinsurance and do have the comprehensive care is just the reverse. As Mr. Woodcock mentioned when he was testifying before, the experience of the prepaid group practice plans is not only that they have a lower utilization of the most expensive type of care, that is in-hospital care, but also that they have a lower ratio of physicians to patients.

The reason for this is that when you do have comprehensive care and can treat people at the earliest stages of illness and you do have preventive care then you are, in effect, using resources more efficiently rather than more resources.

The CHAIRMAN. Well, I see a lot of merit to the kind of operation that a number of industries have—and I am sure in many instances they have it because labor fought for it and bargained for it—in having a little clinic on the premises with a doctor and a nurse, so that a person can receive first aid treatment and such medical advice and preventive services as helps avoid major medical expenses later on. That is a good thing and perhaps we ought to provide for it.

Yes, he can see a doctor and have care, even if it really wasn't needed. When I was a lieutenant, junior grade, and the sick bay was midway between our quarters and the officers' club, it was convenient just to pass by the sick bay on the way to the club and have them hand you a fistful of pills, paint your throat, spray your nose if you had a cold, but it really was not necessary.

If the sick bay had been on the other side of the quarters we wouldn't have been in there at all. But that type of care costs money.

Mr. SEIDMAN. Mr. Chairman, it is true that the program does cover prescription drugs, but it does not cover the type of non-prescription items that you are talking about. These would continue to be at the individual's expense. But I think the broader question that you raise is whether, in fact, if you do have comprehensive care available to people you get a higher degree of utilization. I think the experience of the prepaid group practice plans and all the studies that have been made of them and I am sure you are quite familiar with them, are just the opposite. I think it is also because of their experience that there is this

heightened interest in health maintenance organizations, and that is only another name for a prepaid group practice plan, because their experience has been good in providing quality care, comprehensive care and still at lesser costs than under the traditional forms of the delivery of health care.

This has been, by and large, in these plans without the deductibles or the coinsurance. They have not found deductibles and coinsurance necessary in order to reduce what you might consider to be unnecessary utilization but they have found instead by getting at people at the earliest stages and by preventing illness they have been able to reduce their costs and provide a higher quality of medical care at the same time.

The CHAIRMAN. Well, you and I can agree that preventive medicine is a good thing. I am for it just as you are for it. This committee has indicated that it likes the idea of properly established health maintenance organizations.

I do find myself asking though if it is not going to cost us money where we have the Government paying for something to the extent that it takes away from the individual the cost incentive of keeping his health costs low. There is the matter of a fellow going home from the hospital after 2 days if he has to pay for it—but if the Government paid for it his stay might be 3 days. That is the experience we had in our State hospitals as far back as I can recall.

The average hospital stay in a State supported hospital in Louisiana exceeded the stay in a private hospital by 50 percent for given illnesses.

Mr. SEIDMAN. Mr. Chairman, as a member of Group Health Association, the amount that is paid for me is no greater whether I stay in the hospital 4 days or 5 days, but the amount that is available to the whole organization is affected by this. The doctors recognize this and they see to it that patients go home when they no longer need the hospital care. I think we ought to place this responsibility where it belongs, not on patients who have very little control over this and moreover don't have a very good judgment on it, but on the medical profession which is qualified to make these judgments.

The CHAIRMAN. You heard what I said with regard to the drug costs problem to Mr. Woodcock when he was testifying as a witness. Could I ask you what your reaction is to this matter of the Government paying $11 to buy Prednisone under the name of Meticorten rather than simply saying we will pay what it costs to buy that drug from quality manufacturer who sell the drug at lower prices and that is all we propose to pay.

Mr. BIEMILLER. We have always supported the efforts of yourself and many other Members of the Senate and House to try to get the principle of the use of generic drugs established. We are in complete agreement with you on that point.

The CHAIRMAN. I have done what I can about these costs. We discovered some shocking cases of doctors abusing the public, overcharging, and also hospitals and nursing homes abusing the public by charging us far more than necessary as well as providing unnecessary services and things of that sort. The suspicions I had to begin with at medicare's start have been borne out.

What greatly increases the costs of a program of the medicare type is not the flagrant case where the abuser should be put in the peniten-

tiary, it is this nickel and dime thing, or it is the matter of paying a little too much for this or a litle too much for that and keeping people in the hospital a day too long or 2 days too long when they could have been discharged earlier.

It is just the good housekeeping that makes the difference between something costing altogether too much and a reasonable price.

Mr. BIEMILLER. You and the other members of this committee, Mr. Chairman, have rendered the Nation a signal service in the hearings that you held on this question of medical costs and we are delighted that you did it. But I want to point out this is exactly one of the problems we are trying to get at in S. 3. By establishing budgeted items for the various districts, by controlling costs, by having peer review of doctors' decisions, we hope to cut down on many of the things that you are speaking of and we are convinced we can cut down on them through the mechanisms provided in S. 3.

We couldn't agree with you more that one of the things we are after is controlling the unnecessary costs.

The CHAIRMAN. Since you mentioned peer review, I think we ought to make reference to the fact that it took a great deal of courage and statesmanship on behalf of the ranking Republican member of this committee, Senator Bennett, to offer his amendment for peer review and to stand his ground against the onslaught of some medical societies as well as many of the hospitals. I think his statesmanship in this area has been recognized by now to the point where most of them are willing to support it. But it is the courage to do something before it becomes popular that I think we should admire in public servants and in that regard I think we all owe a debt to Senator Wallace Bennett, who sits on my left, for what he has done in that area.

Senator Anderson.

Senator ANDERSON. Thank you, Mr. Chairman. On page 3 of the statement you mention deductibles. Do you have any figures to show that deductibles are harmful or good?

Mr. SEIDMAN. I don't think, Senator Anderson, that we would have figures to show this exactly but what we do know is that deductibles keep people, particularly people with low incomes, from getting the services when they need them. We have had this experience in medicare, and we have seen this also in private arrangements.

Senator ANDERSON. You say you have seen this in medicare. You must have some figures then.

Mr. SEIDMAN. There are not—I have not seen actual figures. In other words, I don't know of any surveys which have been taken which have shown that a certain percentage of people have been unable to meet the deductible but I have seen interviews, which I regard as being authentic, with people who have said they have been unable to obtain the care they need because they have been unable to meet these deductibles.

Senator ANDERSON. Well there have been many cases of a similar nature. Deductibles in automobile insurance have been helpful and important and I just wondered if you do have figures that would show the effects of deductibles in health insurance. I would be very much interested in any data because we had divergent groups in the Ways and Means Committee and in the Finance Committee with different ideas about this and we finally decided to use deductibles. I am only asking you to give me any figures you can.

Mr. SEIDMAN. We are collecting information, Senator Anderson, from our members throughout the country. We are developing information as to the burden of costs which results from the fact that they have medical costs, not necessarily those that are described as catastrophic, but large medical costs which are not met in the programs under which they are covered, Blue Cross, Blue Shield, private insurance, whatever they may be. We do have such information, we are developing such information and we will be glad to make it available.

Senator ANDERSON. Yes. I think it is a very important area and solid information could contribute to the success of the various programs.

I have no further questions.

The CHAIRMAN. Senator Bennett.

Senator BENNETT. Mr. Chairman, I have no questions. But in view of your kind words, I am led also to express my gratitude to Mr. Biemiller and the AFL–CIO for their support of peer review and, as Mr. Biemiller knows, he and I have been on opposite sides of questions for many years, and I am delighted we have found one important one in which we are in agreement and I hope you will stand your ground because the fight is not over.

Mr. BIEMILLER. Well, thank you, Senator. I think you have seen enough of us over the years to know that just because we disagree on some items does not mean we cannot agree on others.

Senator BENNETT. I am delighted we have come to one on which we can stand together.

The CHAIRMAN. Senator Jordan.

Senator JORDAN. Just one question, one statement Mr. Biemiller that needs clarification, at least to me. When you are talking about the costs—the financing of health security—you said the cost would be—and I emphasize that these were your words—budgeted annually. This is very important—a lid on costs. I hope you are not saying that if you budgeted a certain sum of money and ran out on November 15 you would close down the hospital and deny any more health services to people.

Mr. SEIDMAN. No; we are not saying that. What we are saying is that the amount of money that would be available would be determined by the amount that went into the trust fund on the basis of the financing arrangements which have already been described; that this would then be distributed among the various regions and various districts on the basis of what the needs were in those areas, and this would be based, in turn, on the information developed during the previous year. But if you had a particular emergency in one area that was completely unforeseen, that money would be—there would be enough of a reserve in the trust fund to deal with that situation. For the country as a whole, you would have to try to keep within the budget for the year just as you do in other types of programs.

Senator JORDAN. Suppose you did not. Suppose you did not in the country as a whole; suppose you ran out before the end of the year.

Mr. SEIDMAN. I think this would be a problem which would at that point—I do not anticipate that this kind of thing could occur, but if it were to occur, this would be a problem which would have to be brought before the Congress to deal with, it seems to me.

Because this involves precontracting for services to be provided, which we do in many other fields, it seems to me very unlikely that

this would happen, whereas at the present time what we have on a cost-plus basis of contracting is runaway costs because there are no controls over them.

Senator JORDAN. Thank you.

The CHAIRMAN. Let me just get to the one point here that I did not cover, but I would just like to touch on it and see how you feel about it. You referred to the catastrophic proposal indicating that it did not meet the needs of an $80 a week worker.

Now, it does not make any difference whether that man is making $80 a week or $500 a week; we can anticipate that the medical expenses of catastrophic illness are going to be the same whether he is a high-paid worker or a low-paid worker. We agree on that, don't we?

Mr. SEIDMAN. The medical expense may be the same, Mr. Chairman, but I think we have to recognize that whether or not he would be able to meet the very large deductible, $2,000, for example, would depend on whether he would be able to take any advantage of the program at all.

The CHAIRMAN. Let us agree that somebody has to pay it.

Mr. SEIDMAN. The difference between a catastrophic insurance plan and the kind of program we are talking about is that in the latter you do not have that initial deductible. In other words, S. 3 contains complete catastropic protection, but it would make it available to everybody.

The CHAIRMAN. I understand all that, but I am trying to get an answer to a very limited situation. In other words, I am assuming, just for the sake of argument, that most people do have—and I think it is a correct assumption that the overwhelming majority of your workkers do have some kind of insurance for either all or most of the first 60 days of hospital care. I am just talking about the fact that the $80 a week worker is subject to having the same hospital expense that a $200 a week worker or $500 a week worker has. All are liable for those costs, are they not?

Mr. SEIDMAN. He certainly is liable for the expense. He is much less likely to have good private coverage than workers at higher wages are.

The CHAIRMAN. Yes, I understand that.

Now, the $80 a week employee would get the benefit of the same help and the same protection when his hospitalization went beyond those first 60 days, as would anybody making more than that.

A person making, let us say, $10,000 or $15,000 a year, which is not unusual for skilled workers nowadays, would be paying more than twice as much in taxes, in order to have the same benefit we would be providing for low-paid workers in terms of catastrophic insurance, would he not? What I am saying is that in terms of dollars, it is just as good a buy as what you are recommending because that worker is on the low-paying end, but he is privileged to draw down the same benefits as the other fellow.

Mr. BIEMILLER. May I suggest, Senator, that possibly we have gotten off on the wrong approach. You are seizing upon our illustration.

The point we are making is that what is considered a catastrophe in the normal definition of the term is not the real problem that most worker are up against. They are up against a smaller cost but the repetitive smaller cost is what causes them problems.

We are trying to get the figures that would show what the effect of a catastrophic bill is, and let us for the sake of argument assume a $2,000 cutoff, what it would be on the total medical cost of the country. We think it is quite small, an that the real bulk of medical costs do not come into the catastrophic illnesses; that is not where the real problem of the country rests. This is the point that we are going to make wherever we go, that what we are trying to get at are lower medical costs and not just the exceptional cases.

The exceptional cases, I recognize, dramatize very easily, and all of us, I think, make the mistake, including myself—I find every now and then when I make speeches I talk about the catastrophic illness and forget it is the day-to-day across-the-board costs, the short hospital visits, which have such a tremendous impact.

After all, there are many workers in America who still have no hospital insurance whatsoever. There are many people in America who do not, and these are the kinds of people that we are concerned with.

The CHAIRMAN. In drafting a catastrophic illness bill, I thought seriously of proposing that the deductible test should be a percentage of a man's annual income which would, of course, tend to make the triggering point lower for a low-paid worker than a high-paid worker. The person who sold me on not doing it in that way was Mr. Robert Ball, who feels that the idea departs too drastically from the social insurance principle. The idea being that it is a far better buy for a person in the lower income brackets than it is for a person who is up at the higher end of the wage scale. Both of them, get the same benefits, but the man who makes $10,000 pays anywhere from two to three times what the other fellow pays.

In any event, it seems to me that we ought to have a program covering catastrophic illness even if Congress is not ready to go along with you on your proposal to cover everything.

How do you feel about catastrophic coverage? Do you think we ought to have nothing until you can get the whole thing, or do you believe we ought to provide at least part, looking at the catastrophic proposal, for example? Every bit of that is included within the program that you recommend. This is a matter of covering the cases of crying need. In Senator Kennedy's illustrations of yesterday, almost every case he had was a castastrophic illness situation.

How do you feel about the catastrophic illness proposal? If you cannot get your full program would you be against anything until such time as you can have everything?

Mr. SEIDMAN. I think we would have to recognize if you were to use whatever resources you have for a catastrophic insurance approach, that you would be using those resources for people at higher income levels, primarily, those people who could afford to meet the original costs; and, as Mr. Biemiller said, what is a catastrophe for a person at low income is at a very much lower dollar figure than what is a catastrophe for a person who is at a much higher income.

The second thing is, it seems to me, this catastrophic insurance program could do nothing which would in any way move in the direction of restructuring the system toward emphasizing prevention, early diagnosis, early treatment, and so on.

Quite the contrary, it would tend to divert the resources primarily into the areas where you have very acute cases which required hospitalization and so on.

I recognize those are tragic situations for the people involved, but there are just as tragic situations for people who have lower incomes and are paying very large amounts of money week by week, month by month, and year by year.

The CHAIRMAN. One thing I ask myself repeatedly in trying to act as a legislator is whether this is a good bill as far as it goes, and that is about all you can say for any bill. Every time we see some piece of legislation that seeks to correct something that appears to be wrong, if somebody does not like the idea and wants to be against it, it is par for the course for him to say, "Wait a minute, it does not do this, does not do that, or it does not do something else." I find myself saying time and again, "It is a good bill as far as it goes, and that is about all you can say for any bill."

It might be that your bill would correct everything that is wrong with the whole medical system. I would be a very surprised man if it did; we will still have problems, even if your bill becomes law, and I simply would like to know, so far as catastrophic illness protection is concerned, whether you favor that concept until such time as you can have all those things that you would like to have. How do you feel about it?

Mr. BIEMILLER. Well, very frankly, Senator, we do not think that a catastrophic illness bill gets at any of the real basic problems bearing on the distribution and cost of medical care in this country, and, for that reason, we are going to continue every kind of agitation we can to get an across-the-board bill. That is what it boils down to as far as we are concerned.

The CHAIRMAN. Yes; but what I would like to know is whether by the time we get through with all this and we approve the various things which can muster a majority vote in this committee, and then go to the Senate and vote on all the amendments people want and assuming that by the time we are through with all this we do not have your whole package but instead have some very fine features of it in there; for example, suppose we have both the catastrophic insurance and preventive care parts. Would you be asking us to vote against the bill because it does not have more?

Mr. BIEMILLER. That is a quality judgment we will have to make when we are provided with it at the time, and presented with it at the time. Senator Anderson will recall in 1964 we consulted with him and we agreed together and we took a gamble and let a social security bill die because it did not have medicare in it.

We, however, were pretty confident that the 1964 election was going to turn out all right, and in 1965 we got medicare and reinstated the social security benefits that had been passed by both the Houses, but in conference we agreed to just let the thing die.

Now, these are the kinds of judgments you have to make when you are confronted with the actual facts. You are asking me to make a judgment on something I do not know. I do do not know what the bill will be that will be reported. First of all, by Ways and Means and then later by your committee. When we see that bill, that is when we would have to make that judgment.

The CHAIRMAN. Thank you.

Any further questions?

Senator ANDERSON. I just want to express again the wish that you would very carefully consider deductibles because I think they are

very important. I was in three different hospitals last year for medical care. One session because of diabetes; another was glaucoma; and the third involved Parkinson's disease. I did not enjoy any of those. I just hope we get those figures on the relative merits of deductibles because I think it is important to this issue.

Mr. BIEMILLER. Thank you very much.

The CHAIRMAN. Thank you very much. We are always proud and happy to hear representatives of a very fine and great organization testify before us.

We will now hear from Mr. Walter J. McNerney, president of the Blue Cross Association.

STATEMENT OF WALTER J. McNERNEY, PRESIDENT OF BLUE CROSS ASSOCIATION

Mr. MCNERNEY. Mr. Chairman, I am Walter McNerney, president of the Blue Cross Association, the national association of 74 nonprofit Blue Cross plans serving the country, and I appreciate this opportunity.

If I might, I would like to submit our written statement for the record at this point and simply go on and summarize, following which I would be glad to answer any questions you might have. Do I have your permission?

The CHAIRMAN. Please do that, sir.*

Mr. MCNERNEY. I think we in Blue Cross feel that the delivery and financing systems in this country have a great deal of good as well as some problems. There is no question that this is one of the most impressively healthy nations in the world. There is equally no doubt that we still have some serious access and cost problems along with it. These must be addressed boldly, building, I think, on what is good and improving what is not, and facing up to the needs for improvement. Let me urge that any approach to a universal health program assures all citizens of adequate health care. Secondly, a more vigorous public policy is needed to give the present health system better direction and coordination, but it does not follow that our health problems will yield to a single all-embracing solution. A variety of policies are needed.

In that regard, let me say the problems we face are complex. There is no simple remedy any more than there is one potion that will cure all patient ailments.

I think a monolithic solution to either delivery or financing is limited in potential. In the end I think it will be conservative rather than innovative; that there is a great danger of underfinancing connected with it and, ultimately, in order to make it work there would have to be a takeover of the delivery system. Furthermore, I do not think the delivery system can be swung on a wholesale basis such as proposed.

Further, we feel any health financing program that may be adopted must incorporate strategies to improve both access and productivity. I am not talking about preserving the status quo. Health systems are simply not self-regulating. They must be managed. To pour your money into the present system without changing that system, I think, would be disastrous.

* See p. 171.

Although the broadest benefits possible should be made available, we feel this should be a phased process that takes into account the existence of limited resources and alternative needs. The public is tired of unfilled promises.

The job of fashioning a flexible, responsive health care system will require the effort of both the public and the private sectors. We feel strongly that neither can do it alone in terms of money or in terms of expertise.

I have cited the considerable accomplishments of our system today.

Let me point specifically to the FEP program as a distinguished and enlightening partnership between the private and public sectors, in regard to financing of care. I think it is irresponsible to talk of one sector or one part of one sector being entirely to blame for the problems we face today. We need new programs for carriers. Blue Cross must be strengthened, but this will not be effective unless there is parallel action by the Government in its organization and in its determination to impact the delivery system.

It is important, incidentally, to deeply involve the consumer in the process of change through key policy in advisory roles.

We feel that the primary role of Government should be that of protecting the public interest through determining feasible national goals, formulating realistic policies, developing adequate performance standards, and accurately evaluating results. Implementation of changes in financing and delivery can be accomplished, we feel, effectively to a significant extent through private sectors, both through performance contracting and in letting that sector take its own initiatives.

In determining the proper blend of public and private efforts of centralization and decentralization of authority and responsibility, a major need for flexibility exists. In the face of biomedical and social change, financing and delivery systems must structure and restructure themselves in order to meet changing problems. In an era of rapid change, the capacity to adapt as well as lead assumes growing importance in all of our institutions and there is no doubt that the fields of medicine is rapidly changing.

We are confident that Blue Cross, as an example of a private sector institution can rise to this challenge. We clearly have accumulated skill and system resources that have proved responsive to changing needs and demands. Ninety-seven million Americans can't be all that wrong.

Blue Cross, I might say, parenthetically, operates nationally, regionally, and locally. I think it has had a good social record of not canceling benefits of transferring people from group coverage to individual coverage, and of transferring people from one section of the country to another without loss of benefits. In terms of our economic responsibilities we have not simply been a conduit for money.

We have negotiated rates with hospitals, a pattern that the Government has followed with medicare. We audit those costs, and we cooperate closely with areawide planning. We are now deeply into experiments with prepaid group practice.

Six of our plans are now directly involved, 20 imminently. We have for years practiced the process of recertification. We are providing profiles to hospitals interested in utilization review, and I think it is important to point out that in 1969 Blue Cross paid more in outpatient

plans by number than inpatient claims. Whereas the number of inpatient claims per thousand Blue Cross subscribers, has gone down 17 percent since 1965, the number of outpatient claims has gone up 50 percent.

Also, I think you will find that as an example of a private effort, we are accountable. The concept that we compete for profits and not service is unwarranted. We feel it is unfounded.

Not only are we not for profit, but 80 percent of our business is directly under the surveillance of Government authorities in terms of rates and contracts. To fail to exploit the assets of the private sector would waste existing investment of human and material resources but, more importantly, it would ignore the basic American philosophy of blending private and public abilities in the accomplishment of our national goals.

The problems that exist can be solved if we approach them with a rationally planned program based on a thorough understanding of the nature of the Nation's health problems and the ramifications of various interventions that may be proposed.

We know that careful consideration will be accorded the several legislative proposals before your committee. Although we have not supported any of them in toto, each has various strengths that deserve your attention. We are confident that there will emerge from the legislative process a viable and comprehensive health program that will address the very real problems that exist without inflicting the disabilities inherent in some of the more extreme positions currently being espoused.

In behalf of the Blue Cross system, Mr. Chairman, I thank you for this opportunity.

(Mr. McNerney's prepared statement follows. Oral testimony continues on p. 175.)

STATEMENT OF THE BLUE CROSS ASSOCIATION, PRESENTED BY WALTER J. MCNERNEY, PRESIDENT

Mr. Chairman, members of the Finance Committee, I am Walter J. McNerney, President of the Blue Cross Association, the national organization of the 74 nonprofit Blue Cross Plans serving the United States.

I appreciate this opportunity to discuss with the Committee the status of health care in our nation and the ways it can be improved. Blue Cross is vitally concerned not only with the steeply rising costs of health care but also with problems of providing access to health facilities and services for all who need them. We are equally concerned with ensuring that the services delivered are of the highest possible quality. The Blue Cross system, for many years, has been an active partner in the search for ways to improve the quality of health care in America.

THE ROLE OF BLUE CROSS

Since its founding in 1929, Blue Cross has grown to its present status of covering more than 71 million Americans in the private market. Also, over 20 million are served by the Blue Cross system in its administrative roles for Medicare, Medicaid, and other government programs.

The 74 non-profit Blue Cross Plans represent a confederation which is responsive to both local and national needs. Each Plan is deeply involved in its community, yet all the Plans are united in a national system to serve our mobile society.

Blue Cross governing boards are composed of a host of community representatives, as well as provider representatives, all of whom serve without pay and devote many hours each month to ensuring that Blue Cross is meeting the needs of its subscribers. Indicative of our responsiveness to public need are the facts

that Blue Cross does not cancel subscribers' coverage because of high use, that group subscribers are permitted to convert to individual coverage if they leave the employ of their firm, and that subscribers who leave a Plan's area are guaranteed coverage by the Plan in their new location anywhere in the country.

Mr. Chairman, I could speak at some length about the many instances in which Blue Cross is experimenting with and implementing new methods of cost and quality control and new ways of delivering health care. I have previously documented a number of these approaches in appearances before this and other Congressional Committees and would be happy to again submit them should you so desire. But let me move on to what I believe is the question before this Committee today—the shortcomings of our current health system and the kinds of steps we as a nation must take to correct them.

THE NATURE OF OUR HEALTH CARE PROBLEMS

Of immediate importance is the knowledge that the United States has not been standing still in the health area. We have the third highest doctor to population ratio in the world. Twelve new medical schools have opened in the past five years. We have in recent years created over 400 community mental health centers where formerly there were none. And the advances of our medical scientists are unparalleled. Significantly, the achievements of the health system have, in turn, led to added public confidence, it it, and increased demand for health care among all economic groups.

We now realize that despite the excellence of our doctors and facilities, they are poorly distributed in several areas. The morbidity and mortality rates among our underprivileged citizens are unconscionably high and the poor are becoming understandably frustrated in their efforts to secure adequate health care.

Our health care system, essentially, is strong, but it suffers from a lack of sophisticated management and adequate organization of human and material resources. A major result is that it also suffers from severe cost inflation. Health costs are rising twice as rapidly as the rest of the economy. During the past three years only about 30 percent of the new money poured into the health system went to purchase new services or cover persons not previously protected. The other 70 percent was eaten up by inflation.

It is clear to everyone that our health care delivery system must become more productive and more accessible; that the disadvantaged must be assisted in gaining badly needed care, and that the financing of health services must be improved, both in terms of protective benefits for the public and positive impact on the delivery system. But there is much less consensus on how these goals can or should be achieved.

PROPOSED SOLUTIONS

The term *national health insurance* has come into widespread use and is now used generically to embrace so many points of view and such an assortment of proposed programs that it no longer has a specific meaning, if, indeed, it ever did have one.

The advocates of the various proposed solutions are diligently working to convince our national leaders and the body politic that their specific program is the one unique approach that the nation should adopt.

It becomes increasingly apparent that the nation must not blindly rush into some well intended but ill conceived program that will either have insufficient impact on our problems or will be so drastic an intervention that the virtues that do exist in our present system will be stifled.

Our purpose should not merely be to impose order on what appears to be an excessively fragmented system. Order, beyond a certain point, can be stultifying and in any event should not be an end in itself. Our goal must be to get results, by whatever means are found to be best with due regard for the nature of our economy, the capacity of the health system, and the needs of our people. The means will not be easy. The problems are complex and they do not lend themselves to simplistic solutions. Further, we need to establish new delivery patterns and evaluate them with an innovative spirit. One pattern won't fit all circumstances and there is a great deal we don't know about the relative merits of varying patterns in similar situations.

Certainly, a massive dose of new money cannot, by itself cure our problems. New programs for corporate and areawide planning for facilities and services, incentive reimbursement formulas, utilization review, modified professional standards and a rapid increase in the number of doctors may well have a bene-

ficial effect on the system. Their impact, however, will be blunted unless they are backed by a vigorous public policy that fosters flexibility and innovation and rewards improvements in quality and cost control.

BASIC PRINCIPLES

As we prepare for a careful appraisal of the various health programs that have been proposed, several basic principles concerning health care in America must be kept in mind:

The current extraordinary inflation of health care costs will gradually decelerate, but, realistically, during the next few years, it will continue to exceed the general rise in private income. As a result, there will be further hardships for those with marginal means.

Everyone should have access to adequate health services and the ability to buy them; the good health of individuals and communities is a basic component of the economic, social, and political well-being of the nation. Present government programs do not completely meet the needs of those they serve. Benefits and assistance need to be improved and the methods of determining eligibility for government assistance must be made dignified and simple for both the beneficiary and the administering agency.

The financing of health care and the delivery of services to the patient are inextricably related. Health care is delivered through a personal service system with high manpower requirements. This, like any similar system, has an almost limitless capacity to absorb money without increasing its effectiveness.

In developing new health financing programs we must not lose sight of this reality. Medicare, Medicaid, growth in private benefits, and such associated activity as minimum wage legislation introduced large amounts of money into our health system without due regard for the burgeoning demand for care or the need for reorganization and employment of new technology. The intense inflation that resulted should be kept in mind as we consider further changes in the system.

Unlike some areas of our economy, the health system basically is not self regulating. Several major disciplines of a free market are either missing or seriously compromised, including competition, and the impact of knowledgeable consumers. Substitute incentives and controls must be created that promote productivity and cost control without being overly manipulative or oppressive. The emphasis must be on results with a flexible attitude concerning the means of achieving them.

The amount of money put into the health system must be sufficient to motivate the best efforts of key professional and institutional groups, but the consumer must participate in policy making inorder to prevent the delivery or financing systems from becoming excessively self serving.

The public must be offered the broadest range of benefits feasible. Alternative modes of care should be encouraged and afforded every chance to prove their worth. Only with broad benefits can the physician exploit the vastly underutilized possibilities of preventive care and select services for his patient on the basis of both need and economy.

The quality of care must be safeguarded through the establishment of high performance standards and thorough professional review.

During the last twenty years we have placed great emphasis on expanding the boundaries of medical knowledge through biomedical research. Too little emphasis has been placed on improving the administration of health services at either the institutional or regional level. Any new health financing system will require a clearer enunciation of our national health goals, strong evaluative measures to safeguard against deterioration of quality, prenegotiated rates which create the risk of loss for the provider as well as the patient, and a decision making system that is sufficiently decentralized to be close to problems where they occur.

With these premises accepted let us consider proposed solutions to our problems in the area of health care.

THE MONOLITHIC APPROACH

We hear increasingly that the private sector cannot deal with the magnitude of the nation's present health problems. A new order must be imposed. A universal financing scheme, administered by government, is suggested as the only way to

harness the necessary legal power and the power of the purse to whip the health system into line.

Yet, historically, we see that large, monolithic systems tend inevitably to become conservative in spirit. Decentralization is talked about but occurs only cyclically. And, eventually the monolithic finance system finds that costs can only be controlled by taking over the delivery system as well.

THE PLURALISTIC APPROACH

In our view, the quest should not be to fashion a rigidly organized monolithic structure. We feel that the size and unique complexities of our country suggest that such a system would prove difficult to organize and administer and beyond the resources of either government or the private sector to operate alone. We finally believe that a planned confederation of mutually reinforcing programs employing the strongest features of both government and the private sector would have a greater chance of success.

For this concept to succeed, government must play a strong leadership role in employing its evaluative, regulatory, and financial resources. The accent must be on Federal leadership in the formulation of policies, establishment of objectives and fashioning of incentives to affect not just Federal programs but the whole health care system and the entire population.

Government should not attempt to embark on extensive administrative operations which it is less designed and equipped to conduct than the private sector. It should, instead, use methods such a performance contracting, which emphasize results rather than methods, to capitalize on the existing assets of the private sector in a carefully paced partnership designed to meet the needs of the population for services of adequate quantity and quality while avoiding the corrosive inflation that has diluted current efforts toward improvement.

There would be a great deal of creative friction in the partnership. Diversity in systems for the delivery of care and in sources to finance that care would stimulate innovation and guard against the stagnation that inevitably sets in when we allow ourselves to believe that there is one best way to get things done.

With regard to having only one source of funds for health care, there is also the danger of underfinancing. In a political setting, more compelling problems may force the government to sacrifice its commitment to health for the sake of meeting what appear to be more immediate pressing demands.

SUMMARY

Mr. Chairman, to quickly summarize, let me say that we urge that:

Any approach to a universal health program should assure that all citizens have adequate health care.

A more vigorous public policy is needed to give the present health system better direction and coordination—but it does not follow that our health problems will yield to a single all embracing solution. A variety of policies and programs will be needed.

Any health financing program that may be adopted must incorporate strategies to improve both access and productivity. Health systems are not self regulatory—they must be managed.

Although the broadest benefits possible should be made available this must be a phased process that takes into account the existence of limited resources.

The job of fashioning a flexible, responsive health care system will require the effort of both the public and private sectors. Neither can do it alone, in terms of money or expertise. And let us not forget that consumers as well as government, providers, and professionals must be involved in the process in key policy and advisory roles.

The primary role of government should be that of protecting the public interest through determining feasible national goals, formulating realistic policies, developing adequate performance standards, and accurately evaluating results. Implementation of changes in financing and delivery can be accomplished effectively to a significant extent through the private sector.

In determining the proper blend of public and private effort, of centralization and decentralization of authority and responsibility, a major need for flexibility exists. In the face of biomedical and social change, the financing and delivery systems must structure and restructure themselves in order to meet changing problems. In an era of rapid change the capacity to adapt as well as lead assumes growing importance in all of our institutions.

We are confident that Blue Cross, as an example of a private sector institution, can rise to this challenge. We clearly have accumulated skill and system resources that have proved responsive to changing needs and demands. To fail to exploit the assets of the private sector would waste existing investments of human and material resources. But, more important, it would denigrate the basic American philosophy of blending public and private efforts in the accomplishment of our national goals.

The problems that exist can be solved if we approach them with a rationally planned program based on a thorough understanding of the nature of the nation's health problems and the ramifications of various interventions that may be proposed.

We know that careful consideration will be accorded the several legislative proposals before your Committee. Although we support none of them *in toto*, they each have various strengths that deserve your attention. We are confident that there will emerge from the legislative process a viable and comprehensive health program that will address the very real problems that exist without inflicting the disabilities inherent in some of the more extreme positions currently being espoused.

Mr. Chairman, again, on behalf of the Blue Cross system, I thank you for this opportunity to appear before the Finance Committee. I will be glad to answer any questions that you or other members may have.

The CHAIRMAN. Thank you very much, sir.

The thought has occurred to me that rather than have a number of carriers and intermediaries do this job for us, it might be better to try to get the carriers, or even to require them, to combine in a joint endeavor whereby each would offer the best expertise and the best people they had to the program. We would then have uniform administration rather than have the same programs being administered with policy decisions varying across the country.

How many carriers do we have under the medicare program, for example.

Mr. MCNERNEY. Under medicare, I do not know the answer to that, but there are possibly 100. I think staff can get you that answer. I am sorry I do not know.

The CHAIRMAN. I understand we have 48 carriers and 83 intermediaries.

Now, how would you people feel about it? Maybe you do not know, you might want to go back and ask them, but how would your people feel if we asked them to take a proportionate share of stock in a company which would handle this overall problem so that each company could have its share of holdings in the one parent company which would have a joint venture aspect to it? Would they think it appropriate? What percent of the business do you have for example?

Mr. MCNERNEY. Under medicare, sir?

The CHAIRMAN. Yes.

Mr. MCNERNEY. Under part A approximately 92 percent for the acute general hospitals; for the extended care facilities, it would be approximately 50 to 70 percent; for the home care program something like 50 percent, so that we have a considerable amount of that business.

The CHAIRMAN. Compared to the other intermediaries, if your organization could have its share of the stockholding in the overall association, what would your attitude be toward a joint venture if it were specifically authorized or required by law, in order to eliminate the diversity and the divergence in the different administrations?

Mr. MCNERNEY. Are we talking about the total problem in the country with regard to financing, Mr. Chairman?

The CHAIRMAN. Well, whatever program the Government would require involving use of intermediaries. What would your reaction be to that?

Mr. MCNERNEY. Whatever would be required? I think fewer carriers should be involved, but I would have reservations about coming to one holding company. When I say fewer, I think there is no question that we need some Federal regulation of carriers introducing minimum standards, which the State could supplement. I think if they were well-designed it would result in fewer participants, all of whom would be more publicly accountable. But to move to one superstructure of which the various carriers might be a part, it would seem to me would run the same risk as a monolithic device of another sort. That is to say, it would be less adventuresome, less innovative, than you might want. I think the Government sees this as ability to contrast performance of one contractor against another, assuming that both are accountable. It would be an asset to the Government because all of us are constantly seeking new methods, both as to how to pay, how to audit, how to negotiate, and this comes to the fore when we have the liberty to follow our inclinations and measure up.

The CHAIRMAN. You would favor a smaller number of carriers, however?

Mr. MCNERNEY. I would for the country as a whole and under a Government program. I think some of the participants are weak.

Senator Anderson?

Senator ANDERSON. He has commented on some of the things that happened, and he has done a fine job, and I congratulate him.

Mr. MCNERNEY. Thank you.

The CHAIRMAN. Senator Bennett.

Senator BENNETT. I have some questions which were based on a study made by the Bureau of Health Insurance. I have four questions. One is general.

Is your national association supportive—does your national association support a policy of not utilizing inefficient and uneconomical individual Blue Cross plans? Do you believe that we are obligated to take the poor with the good?

Mr. MCNERNEY. The Board of the Blue Cross Association, which embraces all 74 plans, is on record as saying that performance standards must be set. We have set some, we are setting others. The plans must live up to them to participate under programs. I anticipate as we get into this deeper and deeper that there will be increasing regionalization of a function, Senator Bennett.

It does not necessarily mean that we will revise drastically the number of plans, but where a plan does not perform a function well, for example EDP, or a claims administration function persists in inability, we will regionalize that by having a selected plan assume that function. We do not intend to live with weak performance, but will coordinate activities among the plans until we get to the standards that we set.

Senator BENNETT. You are aware of the study, are you not?

Mr. MCNERNEY. Yes.

Senator BENNETT. You are familiar with it?

Mr. MCNERNEY. Yes.

Senator BENNETT. The study shows that nine Blue Cross plans were rated as substandard or unsatisfactory, and including those nine, 23

were rated as being not as good as "par". Do I understand that you believe that this comparatively high proportion of your total membership should be terminated and subjected to your proposal for regionalization or building a new layer of authority on top of the existing one?

Mr. McNERNEY. I'm sorry. I thought you were referring to a proposal commissioned by the Social Security Administration for the National Academy of Public Administration to study contract relationships. The study you refer to is relative to medicare performance?

Senator BENNETT. Yes.

Mr. McNERNEY. Yes.

First, let me say our performance under medicare is, I think, the best of all alternatives. If you examine our unit cost, if you examine our record versus other carriers, you will find ours is distinguished, so that that should be said first.

The nine plans that might have been below par have been worked on and are continually being worked with, and will be brought up to par. Nine out of 74 obviously are a minority in numbers.

Mr. McNERNEY. Which one is that, sir?

Senator BENNETT. It is not nine, it is 23. Nine are rated as unsatisfactory, 23 are below par.

Mr. McNERNEY. I think, sir, you may be talking about Blue Shield, whereas I am representing Blue Cross.

Senator BENNETT. I am looking at the page which says "when a State or city designation is made, the intermediary referred to is a Blue Cross Plan," so it is not Blue Shield.

Senator BENNETT. We understand one of them is being terminated.

Mr. McNERNEY. We have not had any terminated, and I am not——

Senator BENNETT. We understood that Social Security considered terminating the plan in Buffalo, N.Y., which rates 33 points on a scale of 120.

Mr. McNERNEY. In Buffalo, there was trouble with the data processing. We sent a team in, strengthened it, and have turned it around. I think rather than shooting from the hip on this, Senator Bennett, that I would prefer to supply for the record a statement which indicates what the plans are, what we have done and where they now stand. But I am sure that our overall performance is without peer under the medicare program.

(The following was subsequently received by the committee:)

Subsequent to the hearings, the Blue Cross Association asked for and received from the Social Security Administration a document marked "Administrative Confidential" dated March 19, 1971, and entitled "Evaluation of Part A Intermediary Performance". In the introductory paragraph of this report, it is noted that the six specific functional categories listed covering intermediary performance are quantitative in nature.

The Blue Cross Association, in carrying out its administration of the contracts for the Blue Cross System, has used these quantitative indices of performance among many others, as well as qualitative evaluations for the performance of the respective contract functions. Using both the quantitative and qualitative evaluations available to the Blue Cross Association, we have been able to identify performance deficiencies, report these on a regular basis to all Blue Cross Plans, and to each individual Plan with specific commentary and recommendations for correction. Further, the Blue Cross Association carries on an extensive on-site evaluation program, relating to the specific areas of functional performance where deficiencies have been noted.

In the confidential Bureau of Health Insurance Report, nine Blue Cross Plans are identified as substandard or unsatisfactory. Using the example of the Buffalo,

New York Blue Cross Plan, as cited by Senator Bennett, the following actions to improve performance have been taken by that Plan and the Blue Cross Association staff.

Blue Cross Association routinely provides the Blue Cross Plan Chief Executive with a statistical comparison of its performance with other Blue Cross Plans having similar claims workload, and with the statistical performance averages for all Blue Cross Plans. This report is furnished each quarter and contains approximately 40 individual performance comparisons. It highlights specific areas of operation that need special attention.

Within the last twelve months, the Blue Cross Association staff in Chicago have worked with the Buffalo Blue Cross Plan staff to achieve improved performance and cost reductions in such areas as cost identification and control, electronic data processing leasing arrangements, and re-structuring the medical review process for Medicare claims.

The Blue Cross Association Regional Provider Relations and Fiscal Management staff have been in regular contact with the Buffalo Blue Cross Plan on a routine basis to maintain performance levels in all areas of Intermediary performance, and to effect performance improvement where needed.

In February, 1971, six of the Blue Cross Association staff from Chicago spent a week at the Buffalo Plan working with Plan staff to identify and resolve performance problems. This effort covered claims processing, medical review, provider relations, data accumulation, financial management, provider audit, and provider reimbursement.

A review of our performance data which is prepared on a quarterly basis, indicates for the first quarter of 1971 the Buffalo Blue Cross Plan has reduced its administrative costs per claim by 82 cents and has improved its overall productivity by 391 claims per employee. In the claims processing department this increase in productivity amounts to 765 claims per employee per year. In addition, there has been a reduction of 6 percent in the error rate on bills submitted to SSA and a 30 percent reduction in weeks work on hand. The data also indicates a more effective screening of claims for identification and denial of noncovered care. These improvements have occurred during the first three months of calendar year 1971.

The above activity and results are illustrative of mutual efforts to improve performance, by Blue Cross Association staff and staff of the other eight Plans designated as substandard or unsatisfactory, as well as with respect to the twenty-three Plans identified as below par in the Bureau of Health Insurance Statistical Analysis Assessment.

Senator BENNETT. That rating was made in March for the year ending December 31, 1970, so it is very recent.

Mr. MCNERNEY. Yes.

Senator BENNETT. We understand that Chairman McGee of the Senate Post Office and Civil Service Committee has introduced legislation which would take away from Blue Cross and Aetna, both of them, part of the power to represent the Federal employee health benefits.

Do you know why Chairman McGee feels that this is necessary?

Mr. MCNERNEY. No, I do not. I think the FEP program is a distinguished program. I think that it has, for example, raised good standards for participating carriers. There are some 40 carriers under the program. The Civil Service Commission has very patiently negotiated benefits over the years and has allowed full options to be exercised by the participants. They can select a group practice plan, or a service or indemnity plan. I think a look at it will show that its design is basically sound.

Senator BENNETT. Going back to my question, is it that you do not know why Chairman McGee made that recommendation?

Mr. MCNERNEY. I do not know, Senator Bennett.

Senator BENNETT. Don't you think you had better find out?

Mr. MCNERNEY. I will attempt to find out.

Senator BENNETT. If that bill were passed, you might find yourself without an opportunity to represent them.

Mr. MCNERNEY. We testified recently before a committee on this and had an opportunity to state our case.

Senator BENNETT. What changes do you believe are necessary in order for Blue Cross plans to function on a true-arm's length public interest basis in dealing with hospitals?

Mr. MCNERNEY. I think our relationship with hospitals over the years has benefited the public to a very great extent. Particularly during the 1930's, 1940's, 1950's, when the problem this country faced was an undersupply of beds in many areas, and the need to increase the number and variety of facilities.

More recently, I think, the problem has shifted to a control problem, namely, better use of the facilities that we have. Reflecting that shift, we are now discussing with the American Hospital Association a change in our structure to accomplish greater arms-length bargaining both in terms of board memberships, and in terms of the various programs that we sponsor.

Senator BENNETT. Can you supply the committee with an analysis, or a list, or an explanation of these changes you are discussing?

Mr. MCNERNEY. I would be glad to.

(The following was subsequently received by the committee:)

CHANGES IN THE AMERICAN HOSPITAL ASSOCIATION—BLUE CROSS ASSOCIATION RELATIONSHIP NOW UNDER DISCUSSION

The nature of Blue Cross-hospital relations has been the subject of considerable comment and speculation in recent years. Among hospitals and Blue Cross Plans, there is widespread feeling that the relationship needs examination in light of many changes that have occurred in the medical care system and the entire society. Both hospitals and Blue Cross are non-profit institutions and relationships are structured and validated by the effectiveness of the service they render to the communities they serve.

The challenge to Blue Cross and hospitals is to change their relationship in ways that will improve accountabilities and service. Discussions are underway between the American Hospital Association and the Blue Cross Association to restructure the relationship and a number of elements are being considered. Included are a Joint Board Committee comprised of board members of the two national associations, composition of the Boards, public advisory committees, membership on functioning committees, Blue Cross membership in the American Hospital Association, ownership of the Blue Cross name and mark, programs for management review of hospitals, staff communications, and service contracts between Blue Cross Plans and hospitals. The outcome of these discussions will clarify the responsibilities and authorities and allow the public and constituent members to take better measure of each.

Senator Bennett. That is all, Mr. Chairman.

Senator ANDERSON (presiding). Senator Jordan?

Senator JORDAN. As president of a major carrier in the health insurance industry, how would you explain the fact that health costs have escalated two and three times as much as they have in any other phase of the economy?

Mr. MCNERNEY. I think the two or three basic reasons for it are: First, that the health industry is so labor-intensive, it has so few opportunities to substitute machines for men.

I think, second, that the industry had an extraordinary infusion of money at a given point in time pressing against a set structure. For example, in 1965, the infusion of new funds through titles 18 and 19,

shortly following minimum wage legislation, put upon the system an extraordinary demand which any system would find difficult to accommodate to in a short period of time.

Quite importantly, Senator, I think the third reason is that the field intrinsically is not a model of a classic market. It does not contain much real competition nor consumer choice, If you are ill enough, you must have care and there is not even consensus as to whether or not demand is the paramount virtue.

In a situation like this, if you let it run it ends to become inflationary. So what we are talking about today, I think, is a need to intervene to strengthen what is basically a weak market through controls of one sort or another while, at the same time, putting purchasing power in the hands of the significant minority in this country that cannot by themselves afford good care.

This is a problem which is in the realm of the public utilities, essential services, and, I think, it is a major challenge to those of us who are facing its solution. Those would be the reason I would give.

Senator JORDAN. Would you care to provide for the committee a list of controls that you would recommend as being helpful for the reduction of this escalated cost in health services?

Mr. MCNERNEY. I would be glad to, Senator, and I would stress right now that it will take several in concert. No one in itself has the power to do it. In other words, it will have to be a judicious blend of regulation by Government, a negotiated purchasing, ingenious incentive reimbursements, areawide planning to get at the capital structure of the system, and in the melding of these together that is the key. No one of these controls is enough in itself.

Senator JORDAN. Nearly every witness here has said we do not indict the doctors, we do not indict the hospitals but the system is bad, the system is bad, and this is what we want to correct and if you can help us we would appreciate it. Give us your recommendations.

Mr. MCNERNEY. I would be glad to.

(The following was subsequently received by the committee:)

LIST OF CONTROLS FOR CONTROLLING HEALTH CARE COSTS

With rising costs, controls and incentives for reducing health care costs are receiving increasing attention. In health there are three basic methods of exercising controls:

Legal Methods which are exercised by the public through some level of government. Examples are state licensing of hospitals and the regulation of Blue Cross Plans.

Financing Methods in which the controlling agency grants or withholds funds in order to maintain the limits of action. An example here is the Blue Cross-hospital contract which defines allowable costs.

Professional Methods by which the controlling agency appeals to the professional pride of groups or individuals to regulate their own behavior. Hospital accreditation is an example of this type of control.

No single control is universally effective or can influence the large number of variables affecting costs. Also, costs, quality, and quantity of care are intimately related in a manner that usually prevents influencing only one factor at a time and sometimes can lead to unexpected and unwanted side effects. In essence, while bolder interventions are necessary, there are no easy solutions nor can dramatic results be expected. As we act, we must learn more about the factors that are causing the upward curve in health care costs.

Incentives which reward lower costs also need to be considered and are valuable when used in concert with controls that impact differently. Below is a listing and brief discussion of some controls which have been effective; the need is to structure a blend of controls which lower costs yet do not lead to lower quality or overhead.

Provider Payment Methods.—The methods of paying hospitals, doctors, and other providers influence cost significantly. For example, the contract between Blue Cross and a member hospital defines allowable elements of cost, sets ceilings on maximum limits, and allows audit and investigation of actual costs. A great deal of experimentation by both public and private agencies is underway in this area. Prospective reimbursement is a method that shows great promise. It provides a method for a review and negotiation of expenditures before they are made and puts the hospital or other providers at risk to a greater extent than other methods.

Claims Review.—This is a basic control carried on by all Blue Cross Plans and other third-party agencies. Claims review serves several functions. Claims are screened for completeness and internal consistency. Eligibility of the subscriber for treatment is determined. Physicians are often involved in claims review and admissions judged to be unnecessary are denied. Excessive or inappropriate treatment can lead to partial denial of payment.

Utilization Review.—Utilization review shows great promise as a control, especially when linked to claims review. There is a concerted effort by utilization review committees to shift from case-by-case review to a broader profile review of physician and providers as well as patients and the services they receive. This is accomplished by analyzing statistical reports generated by data systems. This facilitates comparisons with pre-existing norms and standards, and wide deviations from usual patterns can be investigated.

Recertification Programs.—Under recertification programs, attending physicians are required to recertify the necessity for continued hospitalization after a specific time period, usually 14 or 21 days. This is used successfully under Medicare and in Blue Cross private business.

Community Health Planning.—State and areawide health planning can be a useful tool which enables the community to insure an orderly development of the health care delivery system and the appropriate investment of capital. Successful planning can prevent the construction of unnecessary facilities.

Planning also is being increasingly tied to franchising or certification-of-need legislation. Under this approach, a health care institution must have approval by a state regulatory body to be permitted to create new facilities or services.

Progress in the planning area has been slow caused, in part, by the duplication and overlap apparent in several Federal planning programs.

Licensure Laws.—State regulation of health personnel came into existence in the early part of the century and has changed little since. It is an example of an outmoded control mechanism which inhibits innovation and change rather than achieves its purpose of protecting the public. Licensure laws need to be reviewed and rewritten to allow more flexibility and consumer involvement in the process.

Alternative Delivery Systems.—Prepaid group practice and the proposed health maintenance organization concept are examples of useful efforts to control costs. They offer the consumer and the professional an option to the traditional method of providing health care services.

Broadening of Benefits.—Blue Cross and other carriers have traditionally emphasized hospital benefits. This was due largely to consumer desire for protection against the dramatic, high cost incident and led to an overemphasis on the utilization of the expensive hospital bed. Recently, Blue Cross has moved strongly to provide outpatient, home health, extended care and other benefits and decrease the pressure for inappropriate hospitalization.

Visibility.—An underutilized technique to influence cost is the publication of important data that reflect on performance and allows the public to make comparisons. Carrier retention rates and hospital costs are useful examples here.

This is only a partial listing of controls. More important is the determination to use them and the creation of a leadership and management capacity in the Department of Health, Education, and Welfare, and the private sector to implement them.

Senator BENNETT. Mr. Chairman, in view of what Senator Jordan has been saying and just as a little footnote to the record, my experience in 1965–66, I was hospitalized in a room that cost me $35. In 1971, my wife was hospitalized in a room that was not nearly so attractive—they were both crowded rooms—$101. That is multiplied three times in 5 years. Now, there are no economic factors that can justify that kind of an increase.

Mr. McNERNEY. There is no question that this is a situation that has got to be overcome.

Senator ANDERSON. Thank you.

We will recess until 10 a.m. tomorrow morning.

(Whereupon, at 1 p.m. the hearing adjourned to reconvene at 10 a.m. on Wednesday, April 28, 1971.

NATIONAL HEALTH INSURANCE

WEDNESDAY, APRIL 28, 1971

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to recess, at 10 a.m., in room 2221, New Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present: Senators Long, Anderson, Talmadge, Ribicoff, Byrd, Jr., of Virginia, Bennett, Curtis, Miller, Jordan of Idaho, and Hansen.

The CHAIRMAN. This hearing will come to order.

We are pleased to have with us this morning to testify for his bill the Honorable Thomas J. McIntyre, Senator from New Hampshire.

Senator McIntyre, we welcome you before the committee.

We will be pleased to hear your views.

STATEMENT OF HON. THOMAS J. McINTYRE, A U.S. SENATOR FROM THE STATE OF NEW HAMPSHIRE; ACCOMPANIED BY MISS JANIS HUMPHREY, STAFF MEMBER

Senator MCINTYRE. Thank you very much Mr. Chairman and members of the committee.

I am accompanied here this morning by Miss Janis Humphrey of my staff and I am delighted at this opportunity to present a statement in support of my bill, S. 1490, "The United Health Care Act," a measure which seeks to provide a national health care system offering equal access to quality health care for all citizens regardless of income.

Mr. Chairman, I might say this statement will take me about 10 minutes or so to read. At any time if any members of the committee or the chairman desire to interrupt for questions, I would be perfectly happy——

The CHAIRMAN. I would prefer that we hear you through and then we will ask you questions.

Senator MCINTYRE. All right.

Most of us, I am sure, agree that we have a crisis in both the delivery and cost of adequate health care in this country today.

We know that delivery of care is frequently uneven and fragmented; and we know that the cost of that care is rising by the day.

We also know that while our resources are great they are not limited. Were health care our only challenge, perhaps there would be no problem. But we face many other crises as well, and our ability to pay for corrective programs to resolve all of them is therefore circumscribed by reality.

This is why I have said that while we strongly need health care reform, while we are obligated to provide quality care for the poor and the near poor, we cannot afford to squander tax dollars, we cannot afford to impose a crushing burden on the middle-class taxpayer, and we must not promise more than we can deliver.

In the case of health care, I believe that tax dollars should be used to buy such care for those who cannot buy it on their own. I do not believe tax dollars should be used to buy health care for those who can afford it.

Indeed, Mr. Chairman, it makes sense to me that the tax dollars saved by adhering to such a principle could be put to effective use in resolving other crises which have a direct bearing on health—such as pollution problems, for instance, or housing problems, nutrition problems, yes, and even traffic and transportation problems.

There is more to preventive care than vitamin C or the vaccination needs.

I cannot help but wonder how many hospital beds we could make available, how many doctor hours we could suddenly salvage, if we could end the air pollution that triggers respiratory and cardiac attacks, if we could drastically reduce the traffic accidents that kill 50,000 of us and injure millions more each year, if we could get rid of disease-infested, substandard housing and wipe out malnutrition.

So my bill, Mr. Chairman, responds to the need to allocate limited tax dollars to the most appropriate priorities.

It saves tax dollars for that purpose by preserving and building upon a system of private health care insurance which already covers 90 percent of the population under 65—a total of 164 million Americans. More than 70 percent of our people under 65 are covered under employer health insurance programs.

Why should we scrap this system and start all over?

Why—in this era of inflation and unemployment—should we pump billions and billions of Federal tax dollars into a Government directed and financed health care system?

And what would we do with the 350,000 employees of private health insurance companies who would be thrown out of work? Put them all on the Department of Health, Education, and Welfare payroll?

No, Mr. Chairman. What I propose in S. 1490 is a substantial, but at the same time nonradical, reform of our health services, utilizing and improving upon some of our existing systems of adding—whenever needed—the resources of this Government.

Thus the plan that I propose would provide Government financial help to get more students through medical school and into medically deprived areas, Government financial help for medical schools to meet the need for new skills, Government financial help to build more ambulatory care centers to provide quality health care at lower costs.

My proposal would set Federal minimum standards for health care insurance policies and provide tax incentives for meeting those standards. It would require cost control in health care institutions and peer review of doctor care and fees; and it would provide for comprehensive health care planning in order to mobilize our great but nevertheless limited resources to maximum positive effect.

As I see it, Mr. Chairman, there are four primary reasons why the existing system fails to meet our needs and must have Government support in order to meet them:

First of all, there is a bad distribution of health manpower. To begin with, there is an acute shortage of such manpower. We need at least 48,000 more doctors, at least 18,000 more dentists, and at least 50,000 more nurses.

And what limited health manpower we have is poorly distributed geographically and poorly distributed in terms of type of practice. We are all familiar with the inability of rural areas and urban ghettos to get competent medical personnel and the difficulty so many communities have in obtaining certain medical specialists.

Second, we have poor allocation of health facilities and not enough diversification. Hospital bed shortages contribute to the spiraling cost of institutional care. So does a surplus of beds, because of the economic necessity of keeping them filled.

Third, our country needs a rational national health policy.

Fourth, our entire system has been emphasizing treatment and care rather than prevention and rehabilitation.

Up until now we have had little success in checking the rising cost of health care mainly because we have not had effective cost and utilization controls.

Our current problems with medicare and medicaid are caused in part by our having dealt primarily with the means of financing these programs rather than with increasing the personnel and facilities needed to make the programs operate.

Further, while wages and salaries of medical personnel have properly gone up, there has not been a corresponding increase in productivity to offset the higher cost of services. What is to be done?

I believe, Mr. Chairman and members of the committee, we have three choices:

We can preserve the present system, largely operated by private enterprise or we can discard the private sector and opt for a system largely dependent on Government, or we can convert the existing system to one which is a more efficient blending of private enterprise and Government services.

Mr. Chairman, S. 1490 takes the third course and does so through six action programs:

First, taking the problem of distribution of health manpower, my bill would lead to the coordination of all programs of financial aid and improve them to encourage training and placement of personnel where needed. It would provide student loans that would be forgiven for service in medically needy rural or inner-city areas. It would provide grants to schools that train health personnel to provide ambulatory care. The bill would also provide for a 5-year direct grant program temporary in nature, to meet the immediate needs of rural and inner-city areas and to attract health professionals.

Second, my bill proposes a redirection of health services to place less emphasis on costly hospitalization and institutional care and to provide improved health maintenance and disease prevention through ambulatory care. My bill proposes that Federal hospital financing be extended to encourage the construction and equipping of ambulatory care centers in areas of greatest need. The bill would subsidize administrative operating, and maintenance costs during the first 3 years.

If we could cut, Mr. Chairman and members of the committee, just 1 day from the average hospital confinement, we could save close to $2 billion a year—and our people would be happier for it.

Third, my bill proposes a strengthening of comprehensive community health planning. This would avoid unnecessary duplication of facilities and would assist in cost control.

Fourth, my bill seeks to regulate the quality and uniformity of health care. It would require certification of essential need by an appropriate health planning agency before any health facility could qualify for the Federal financing. It would involve the planning agency and health facility in planning capital expenditures, developing of administrative systems, and encouraging combined purchasing and/or cooperative equipment use with other institutions. It would require more effective review of services and charges by health care institutions. It would set guidelines for such services and charges.

Before any institution qualified for payment under any federally supported program it must agree to abide by a controlled charges system, that is, its budget and charges must be reviewed and approved in advance by a State health-care institutions cost commission.

Fifth, my bill creates a National Council of Health Policy Advisers which would function in a manner similar to or somewhat like the Council of Economic Advisers. This advisory board would keep the President and the Nation informed on all matters relating to health and recommend on priorities and needs. The President would also utilize this body in making a mandatory annual health report to the Nation.

Sixth, and finally, my bill provides access to quality health care for all persons regardless of income.

Most Americans, 90 percent of those under 65, are already covered by health insurance. Most of those—60 percent—are covered by employer group health insurance programs. But some are better than others, so I propose the setting of Federal minimum standards for health insurance. If an employer's plan measures up he gets a full tax deduction for his expenses of the plan. If not he only gets half. The minimum standards would apply to both benefits and coverage.

These standards would also apply to individual health plans. Premiums paid by individuals covered by qualified plans would be 100 percent deductible on their Federal income tax return instead of being only partly deductible as under present law.

But what of those who cannot buy insurance themselves because of poor health or lack of money?

The poor, the near poor and those previously uninsurable would be eligible for coverage under a State plan in which all insurers in the State would be required to participate.

The poor would pay nothing; the near poor would pay a partial premium and the solvent but uninsurable would pay a full reasonable premium.

However, Mr. Chairman, and this is important, there would be no second-class care or second-class plan. The State plan would have to meet the same Federal standards as other plans. In fact, the initial benefit standards would be even higher for the State plans.

My bill proposes that these minimum benefit standards be phased in on a three-stage basis. The gradual phase-in seeks to avoid a repetition of the mistake of imposing additional financing before health delivery is improved.

We have a responsibility not to raise expectations beyond our capacity to deliver. By phasing in benefits as our delivery capacity in-

creases, my bill attempts to bridge the gap between promise and performance.

Between now and mid-1975 S. 1490 would authorize nearly $2½ billion for specific improvements in our capability to deliver health care. At the same time the Federal minimum standards for health insurance will be steadily raised over the next decade as our delivery capability increases.

The first stage would be effective by 1973, the second by 1976, and the third by 1979.

Initially, more extensive benefits would be required for those people covered under the State pool plans because they generally have less resources and need more care. In fact, they would get benefits under the bill in 1973 which would not be required for the remainder of the public until phase II went into effect in 1976. In 1976 these individuals would begin receiving benefits not required for the general public until 1979. These benefits would increase again in 1976 at which time group and individual coverage would also advance to the level previously accorded to the pool plan.

By 1979, however, groups, individuals, and pool plans would all share comprehensive coverage that would include ambulatory care, coverage of diagnosis and laboratory exams, surgery and radiation therapy, visits to physicians, well-baby care, dental care for children, prescription drugs, maternity care and family planning, and 300 days in a general or psychiatric hospital, 180 days in a skilled nursing home, and 270 days under an approved home health care program.

Mr. Chairman, S. 1490 meets another deep concern of every thinking American—the fear of financial ruin should he or a member of his family be struck down with a catastrophic illness or injury.

Under the benefits proposed under my bill, catastrophic illness claims of $50,000 or more could be made by those who are covered.

I might point out that this coverage is more than that provided for Federal employees, a plan that may be familiar to the members of this committee. Surely every American citizen deserves protection against a blow, a disastrous blow that could bankrupt the average man.

Let me briefly summarize, then, Mr. Chairman:

The National Health Care Act of 1971 would build upon a private health insurance system which already serves millions and millions of citizens. Because it is primarily based upon the free enterprise system it would encourage healthy competition to make health care more efficient and less costly.

Monopoly, Mr. Chairman, whether it be in private or in public enterprise, stifles dynamic growth. It does not make sense to me, for example, to move the postal service out of Government and move health care into it. At the same time, however, the nature of the health care crisis and its awesome proportions make it naive to believe that the private sector can resolve it without Government help.

The feasible option, I am convinced, is to harness private and public resources into that working partnership which throughout our history has been so effective in resolving crises that defy the individual efforts of either sector.

This is a combination which can indeed offer quality health care to all—at a cost all can afford.

This combination, functioning under the provisions of S. 1490, would bring these benefits to the average American:

Make qualified health insurance costs 100 percent tax deductible.

Cover catastrophic illness claims of $50,000 or more.

Establish Federal minimum standards to make sure his insurance policy measures up and provides the maximum benefits the economy can sustain and the system can deliver.

Help develop lower cost ambulatory care centers to take the place of some higher cost hospital care.

Provide incentives for hospitals to give better care at lower costs.

Insist upon a controlled charge system for all health institutions by withholding Federal support from those which do not comply.

Require cost and quality review of his health care.

Provide more medical personnel for areas that need them by giving financial help and assistance to students who agree to practice there upon graduation.

Encourage development of health care teams to multiply a doctor's productivity and efficiency.

Give financial help to medical schools to develop the new skills needed in the 1970's.

Require planning and coordination to avoid costly duplication of medical facilities, such as cobalt cancer treatment units, such as the open heart surgery team, in one community while another community goes without.

For the poor, my bill would establish a Government-subsidized insurance pool in every State to make quality care insurance available at no cost and to the near poor at a cost they can afford.

For the previously uninsurable, my bill provides that the same State insurance pools would make quality care insurance available at a reasonable cost.

Finally, Mr. Chairman, my proposal will not impose a crushing burden on the average taxpayer.

I estimate that the first year of operation of this program would increase governmental expenditures by some $3.2 billion.

This is not an insignificant amount, I realize. But if we concede that the only way we can protect those who simply cannot afford health insurance is through Government subsidy—if we agree that the only way to develop a health care delivery system that will match performance to promise is to draw upon the resources of Government—and if we contrast that $3.2 billion with the $70 billion in tax dollars that a full Federal health care plan would cost, then I respectfully suggest to this committee that the price of S. 1490 in terms of tax dollars spent is a modest price, indeed.

The problems are difficult but if we can devise a partnership of all Americans we can succeed.

This concludes my statement, Mr. Chairman. I would request that the record of the hearing show at this point a summary chart specifying the amounts authorized by S. 1490 for improvements in the all-important delivery of health care.

(The chart referred to follows:)

AUTHORIZATION—DELIVERY OF HEALTH CARE (S. 1490)

[In millions of dollars]

	1971	1972	1973	1974	1975	Total
Training, scholarships, and waiver of student loans:						
Medical students	50.0	70	100	100	100	420.0
Nurses	25.0	50	75	75	75	300.0
Allied health professionals (grants)	10.0	30	50	50	50	190.0
Allied health professionals (loans)	7.5	15	40	60	75	197.5
Subtotal	92.5	165	265	285	300	1,107.5
Grants to medical and other schools	10.0	25	40	50	50	175.0
Grants for service in deprived areas	10.0	50	50	50	50	210.0
Grants and loans for developing and building ambulatory-care centers		200	200	200	200	800.0
National Council of Health Policy Advisers	1.0	1	1	1	1	5.0
Community health planning	25.0	40	60			125.0
Total	138.5	481	616	586	601	2,422.5

Senator McINTYRE. Thank you, Mr. Chairman.

The CHAIRMAN. Senator, I have some questions suggested by members of our staff to ask you and I am going to submit those and would like for you to simply provide an answer to them before the day is out.

Senator McINTYRE. I will be happy to do it.

(The questions, with answers supplied, follow:)

Question. If your bill were enacted, could health insurance companies use it as a device to cancel present high-risk policyholders and, in effect, leave those high cost people to be covered under the government subsidized insurance pools?

Answer. No. As far as insurance company cancellations are concerned, present policies are either cancellable or non-cancellable by their own terms. If not cancellable, the passage of S. 1490 would not make them cancellable. If cancellable, they can be cancelled whether or not S. 1490 is passed or not. In other words, if an insurance company finds a certain policy to be undesirable in terms of the risk involved, it may cancel the policy at its own will, provided the terms of the policy permit cancellation. S. 1490 does not—and cannot—affect the terms of the policy.

However, I would want to emphasize that under my plan, those whose policies have been cancelled and who are unable to secure insurance protection elsewhere, will be entitled to coverage as part of the state pool.

Question. Your bill provides unlimited tax deductions for the premium cost of private health insurance.

Inasmuch as the majority of taxpayers take the standard deduction—rather than itemize deductions—wouldn't that provision of your bill be valuable only to people with substantial incomes?

Answer. No. In taxable year 1969, 27.6 million taxpayers with adjusted gross income under $15,000 itemized their tax deductions, without having the benefits of my bill.

Furthermore, additional low income persons now taking the standard deduction will be able to switch to itemized deductions to get the benefit of my bill.

I would point out that more and more group coverage for the average worker is fully paid for by the employer, which S. 1490 further encourages. The tax incentive for the individual is needed most for the self-employed individual, who is most likely to be in the position of itemizing.

The CHAIRMAN. I would like to ask you about one other item. I think we all would like to give the taxpayers the best break they can get either as a consumer or taxpayer on medical expenses.

As you well know, I have been concerned about the high cost of drugs. I have cited one example before.

Here is a drug that is not infrequently used to treat against arthritis. The official name for it is prednisone. If you buy that from Merck or from Upjohn, you pay about $2 for 100 tablets.

On the other hand, if you buy it by the brand name from Schering Co., Meticorten, it costs $10.80 for 100.

It would seem to me that if the Schering Co. is unable to establish that their drug is better than the other fellow's, and, after all, both of them have to meet standards of the Food and Drug people to go on the market at all, then it seems to me that we ought to say we will pay $2 a hundred for those tablets and that is all we are going to pay.

Of course, that is wholesale. At retail we would have to pay more.

Do you agree with that concept of what we ought to pay for these drugs, or do you think we ought to pay anywhere from five to ten times——

Senator McIntyre. Mr. Chairman, I am aware of the study which the chairman started in this whole field and which is being carried on so ably by the Senator from Wisconsin, Mr. Nelson; and it does seem if we are going to get this health care, and get it at a cost that can be borne by the consumer, then we certainly have to have some teeth in the law to prevent these trade names from being sold, as you say, under fancy titles at a much higher expense than is required.

The Chairman. Well, when you and I get most drugs that we need, we go to the clinic in the Capitol Building. The doctor might say you need some of this or some of that. Whatever it is, you just go to the clinic and they hand it to you.

Now, these drugs are bought on a bid basis. If you were getting prednisone for arthritis, you wouldn't know whether it was a Schering product or Merck product or Upjohn's. You wouldn't know who was manufacturing it. All you know is that you are pretty well assured because of the testing of the Pure Food and Drug people and also by the military, which is buying most of those drugs, that it meets the quality standards.

When the President goes down to Walter Reed to have treatment, that is the way he gets his drugs.

Is there any reason why the sort of drugs that you and I and the President of the United States take wouldn't be good enough for the ordinary taxpayer?

Senator McIntyre. Well, you are putting me on the other side of what my usual position on this matter is. My own inclination is that despite the industry's position, we must try to bring these medications that are needed; and, as you say, one is just as good, probably even better, than the other, at a much lower price than what they obtain on the open market in various drugstores.

The Chairman. If we do business that way, I will tell you what will happen. Meticorten will be selling for the same price as other prednisones. It is all the same thing anyhow. So Schering will just drop their price down to $2 in order to meet competition. The alternative is to continue to allow the companies to confuse the public with this sort of hocus-pocus by calling something a fancy name and putting it in an attractive package and making the public pay anywhere from two to 10 times as much for something when it is not a bit better than the competing product.

Thank you very much, Senator.

Senator McIntyre. I agree.

The Chairman. Senator Anderson?

Senator ANDERSON. How does your bill differ from the Kennedy bill?

Senator MCINTYRE. Well, the Kennedy bill, as you know, Senator Anderson, calls for a federally administered health insurance program. Private health insurance plans would pretty much be phased out of the picture.

Second, our bills differ in the area of costs. Roughly estimated, the Kennedy plan might run from $40 billion to as high as $70 billion a year. The plan I am proposing would cost initially, the first year, $3.2 billion.

I would want to emphasize, too, that the bill I am presenting for your consideration this morning moves ahead in an attempt to redirect and expand our health care facilities and our health care personnel to meet the demands that will be coming in the whole health field.

To do this, for instance, we are suggesting over $1 billion in the first 2 years of operation. The Kennedy bill is only at $600 million in the first 2 years.

As opposed to our bill, with its gradual phasing-in of various kinds of health care coverage, the Kennedy bill would provide comprehensive coverage immediately. In so doing, it would cause the same problem that we encountered when medicare was enacted. Medicare, you know, greatly increased the demand on our health services—far beyond the capacity to supply. As a result, our health care costs have escalated at a terrific rate. My bill, S. 1490, on the contrary, would provide for a phasing-in—from 1973 to 1976 to 1979—of comprehensive health care coverage and; at the same time, would provide a buildup of health resources to make sure they will be adequate to meet an increased demand. In this way, hopefully, we will avoid a rapid escalation of costs, and the consumer will be protected.

These are three principal ways.

Senator ANDERSON. No other questions.

The CHAIRMAN. Senator Bennett?

Senator BENNETT. Thank you, Mr. Chairman.

Senator, on page 2 you say:

> My proposal would set federal minimum standards for health care insurance policies and provide tax incentives for meeting those standards.

I like your idea of mandatory minimum standards for health care insurance policies. I think that is probably essential if we are going to preserve the right of the insurance industry to participate in the program.

If we are going to use private insurance, shouldn't we also go the next step which the President does and require employers to cover their employees under a mandatory insurance program with these mandatory insurance standards?

Senator MCINTYRE. Well, I think one of the things that attracted me to this plan here that I am offering in S. 1490 today has been the voluntary character of it.

Now, the President's plan is not as clear to me as it might be, but there is always something that is a little bit abhorrent to the American people of saying here is a policy; you have got to have it, you have got to take it.

Now, the President's plan, too, if I remember correctly, departs from my thinking a little bit when it offers two types of coverages; specifically, a lower level of insurance protection for the poor and the near-poor. But, in answer to your question, I would simply say that on balance I prefer the voluntary characteristic that my plan has.

Senator BENNETT. Well, what happens to the employees of a company that decides not to have a health care policy?

Senator MCINTYRE. Well, in the first place, the employer would be very foolish not to provide such coverage. Already you have seen the great success of group plans and it is under the group plan where the individual gets the best return, the best price for his policy. And I am not aware of whether or not in a group plan—there may be certain religious objections, for instance, and some individuals may want no part of this, and therefore it would give them an opportunity to back out. But I would think that on all fours there would be very few people that would not go down the line and want to be part of an employee group, health policy protection. It is the best health protection at the best price available.

Senator BENNETT. Agreeing with that, at least it is the most effective and the most economical type of insurance protection that has been devised thus far by the private industry, this concept of a group plan with no obligation for examinations, and so on. Don't you think the Government should, if it is going to rely on the insurance companies, just go that extra step and make sure that every employee is covered by an insurance program with mandatory minimum standards?

Senator MCINTYRE. I would just have to say on balance I would differ with you and prefer the voluntary character of this plan, and I say in answer to that, too, that if what you are fearing is that there would be many, many individuals who would opt out of it, wouldn't want to be part of it, I think it would be a very small amount.

Senator BENNETT. I am not thinking of the individual. I am thinking of the employer. He may be struggling just to keep alive. He may decide that the difference between the insurance on that plan and not having to pay it may be the difference to keep him in business for another year and he just says to his employees, "I am very sorry, under the circumstances I cannot provide health insurance for you." Then what do they do under your proposal?

Senator MCINTYRE. Well, of course, the employer today is in business and all around him are companies that are offering this sort of plan. He has got to be competitive if he intends his employees to stay with him and the fact of the matter is that even the individual would have a tax deductibility under this plan in addition to the employer. So this is something he can provide either through collective bargaining with his union or on his own as an additional attraction to employees.

Senator BENNETT. I can understand he can provide it and I think he should provide it. I think the Government should require him to provide it.

As for the tax incentive, if he pays out no money to support a plan, of course, there is no tax incentive because he is not out of pocket on any money.

I don't want to pursue this. I have developed the difference between our points of view. I would suggest you think that one over a little

further with the idea that if we are going to have a plan that is supposed to protect, to use your figure, 90 percent of the people below 65, that it would not be too great an invasion of individual liberty to say as we now say to employers, "You have got to protect these people under social security. You have no choice." Now, shouldn't we say you have also got to protect them under the health program?

That is all, Mr. Chairman.

Senator McINTYRE. Well, I think, just to respond to that, that these hearings are going to set forth various plans.

Senator BENNETT. That is right.

Senator McINTYRE. Then in its wisdom this committee is going to take these plans, look at them, and come up with what seems to be the best or the best composite.

Senator BENNETT. I think you have given us some ideas today that may well end up in the final package that the committee might put forth. I am glad you are basically building on the concept of the maintenance of the private insurance system rather than to destroy it. Maybe what I am suggesting is nit-picking, but I think it is worth considering.

Senator McINTYRE. Thank you.

The CHAIRMAN. Senator Talmadge?

Senator TALMADGE. Senator McIntyre, I want to congratulate you on your statement.

How would your $3.2 billion be financed the first year?

Senator McINTYRE. The first year the cost of this plan, $3.2 billion, would come out of general revenues. Of it, about $2.6 is figured to be that portion of money that Uncle Sam would have to put up to provide coverage for the State pools, the poor. Then, about roughly $600 million in the first year would start the work toward developing our ambulatory care centers, toward beefing up the student and scholarship loan programs, toward directing our medical personnel into areas of need like a ghetto or rural area through loan forgiveness programs.

Senator TALMADGE. Would that figure include the deductions that the Treasury would lose by making that deductible on the tax returns?

Senator McINTYRE. No; it does not.

Senator TALMADGE. Are there any estimates as to what that figure would be?

Senator McINTYRE. We have asked the Internal Revenue Service to provide some well-based, intelligent estimate but we have none at the present time. It has been estimated that in the first year, which would be the most serious year, would run about $300 million loss in revenue to Uncle Sam, to the Government.

Senator TALMADGE. We are providing medical services for the poor under medicaid. We are providing for medical services for the aged under medicare. What percentage of the group which is not eligible for either medicare or medicaid have private insurance policies now?

Senator McINTYRE. We are talking about 65 or under?

Senator TALMADGE. Yes; I am talking about persons under 65 who do not fall in the medicaid category. I am talking about that category that is not now provided for the so-called average American.

Senator McINTYRE. I am not sure I am going to answer your question, but, No. 1, 90 percent of the population under 65 now have or are a part or parcel of some sort of private health insurance plan.

Senator TALMADGE. Yes; that is what I am trying to get at.

Senator MCINTYRE. Ninety percent.

Senator TALMADGE. I am trying to find out what percentage of the population is covered by private health insurance policies.

Senator MCINTYRE. Ninety percent, and of that, 60 percent would be found to be in group employe/employee types of policies.

Senator TALMADGE. I agree with your theory. I see no need for Government to saddle the cost of health coverage on the taxpayers of this country if an individual can afford to pay for his own medical care and pay his own private insurance premiums. That is the general thrust of your bill, is it not?

Senator MCINTYRE. Right. As far as the bearing of costs is concerned, we see no need to buy a policy for one who can afford it but we do see a strong need to move into that area where they can't because they are the poor, the poor or the near poor. Then, of course, this bill is very strong in its emphasis on preventive medicine, rehabilitation, and efforts to reduce the need for cost by hospital care.

Senator TALMADGE. Private coverage may not be totally adequate. I know some of these private health plans are limited in scope. Perhaps we may need some legislation to provide minimum standards of coverage.

Does your bill provide for that?

Senator MCINTYRE. Yes; it does, Senator Talmadge, it sets a minimum standard for health insurance policies and it gives every company 1 year to meet that standard and then it begins to penalize those companies which continue a policy not up to standard by reducing the tax deductibility which would be 100 percent if it is up to the standard set in this bill. So there is an incentive to bring these plans—as you say, some of them are not what they should be—up to standards.

Senator TALMADGE. As you know, we have more problems with medicaid and medicare than we have been able to resolve. Therefore, it seems that it would be a mistake for the Government to rush pellmell into a cradle-to-grave proposition before we resolve some of the medicare and medicaid problems which already exist.

Would you agree with that?

Senator MCINTYRE. I do, and I would want to say, too, that that S. 1490 bill would eventually take the Government out of the medicaid business entirely; although I am not familiar with every State. I know New York and California would be two States where it would take longer because of State laws, but medicaid as we know it would be taken out of the picture with the enactment of this bill.

Senator TALMADGE. Thank you, Mr. Chairman, I have no further questions.

The CHAIRMAN. Senator Curtis?

Senator CURTIS. Mr. McIntyre, there are many facets of your proposal that I like very much, that I think should be considered by this committee. I would like to ask what does your proposal provide so far as catastrophic illnesses are concerned? Or, more particularly, how do you define catastrophic illness?

Senator MCINTYRE. Well, I don't know that there is a standard definition of catastrophic illness. I think we all have a feeling for the very dramatic incident that occurs unfortunately every now and then to people across this country where the medical bills after hospitalization and continued care run to such an extent that if a man is earning

$5,000 or $7,000 a year it absolutely bankrupts him. He is hopelessly lost as the medical bills pile up.

Senator CURTIS. In your paper you mentioned $50,000. Is that the overall total or is that the qualifying point?

Senator MCINTYRE. As I understand it, the bill would move through its three phases so that by phase 3, a person stricken by a serious malady or illness to the extent that it became a catastrophic coverage would not only get $50,000 worth of coverage, but might be covered for an even greater amount.

This bill, I would make the point, would handle catastrophic illnesses in a fashion better than some of the plans available to our Federal employees under the high-option policies with which you may be familiar.

So it is and does cover the catastrophic illnesses. But as I understand it, it does not move that quickly to take care of it in the first two phases.

Senator CURTIS. At what point does an illness become catastrophic?

Senator MCINTYRE. Illness becomes catastrophic when it inundates the person's ability to try to pay for the services rendered, where his income is such that he cannot handle it.

I want to say one thing, too, and I appreciate your interest, Senator Curtis, as I know this committee does, and we were right on the verge last year in December of coming to grips with this catastrophic illness which has been of great concern to this committee, that while this is dramatic and while it is important and we do want to cover it and this bill speaks to it, the fact remains that the real nitty-gritty of health care is right there when a family is hit with a $300 medical expense here, and another $200 there for another member of the family. When these kinds of expenses are repeated again and again during the year, they mount up, and can become a serious drain on family income.

That is not catastrophic, perhaps, but that certainly puts a family behind the economic eight ball. So in our desire to help catastrophic illness we don't want to forget the main thrust of the bill.

Senator CURTIS. I think the term catastrophic needs some attention. When I was home a few weeks ago I was called on by a family who were going to have a medical expense to save the life of a son. It was going to cost in excess of $60,000. They raised approximately one-third of that. Other people raised some, and so on. That was truly catastrophic.

This morning I received a letter concerning an individual who has to have an artificial kidney, and he is 200 miles from the nearest artificial kidney machine. And I believe the treatment calls for twice a week.

My idea of catastrophic is just something that is so enormous and probably has no end in sight, and I think that if there is a responsibility on the Government for people's health probably that would be the starting place.

Senator MCINTYRE. If I understand correctly, in the bill that was brought out of this committee last year, that dealt with catastrophic illness, it had a deductible, if my memory is right, of $2,000 for doctor care and a figure of about 60 days for hospitalization. That is about right, Mr. Chairman?

The CHAIRMAN. Sixty days and $2,000.

Senator MCINTYRE. The figure I quoted represents $2,000 worth of physician expenses and $4,200 worth of hospital expenses, figuring the average per diem hospital rate at $70.

Senator CURTIS. I don't think that is catastrophic for somebody who is making $30,000, $100,000 a year.

Senator MCINTYRE. I think you are right; it is related to income.

Senator CURTIS. Maybe it should be a year's income of the family group, but if we put a figure of a couple of thousand dollars, all the providers would have to do is get the figure up over that. I don't say that would be done; but it also is an invitation for the Congress to just keep on lowering it and lowering it. And as we do that, we will spread the benefits so thin that it won't do much good tothe individual or the family who just faces one of these situations that there is no answer to unless government comes to his rescue.

I thank you.

The CHAIRMAN. Senator Byrd.

Senator BYRD. Thank you, Mr. Chairman.

Senator McIntyre, I think this is a most interesting proposal. You gave to Senator Anderson the difference between your plan and Senator Kennedy's, particularly so far as cost is concerned.

In your reply to Senator Bennett do I judge that the basic difference between your plan and the administration's plan is that yours is a voluntary approach and the administration's plan is mandatory?

Senator MCINTYRE. That is certainly one of the differences. I would want to point out, too, that under my bill, we would have no second-class citizens when it comes to health care.

I think that the administration's bill, and as I say I am not overly familiar with it, does have a double standard; the poor who are receiving AFDC aid for families with dependent children have a lower level of benefits and a lesser coverage than does the rest of the population.

Senator BYRD. The administration's plan that was testified to a couple of days ago would cost $3.9 billion. You use in your statement $3.2 billion but you said as I recall a little while ago in response to a question that Uncle Sam puts up $2.6 billion?

Senator MCINTYRE. The figures I have work this way: The cost of operating the insurance policies and the State pool and the planning agencies to be fitted in runs about $5.4 billion. Subtract from that $2.8 billion that would come out of the medicaid and you come down to a figure of about $2.6 billion. But then I think very importantly this bill then looks to the future, starts taking a look at our health personnel, our health services facilities, and in the first year or so would put about $600 million into students' loans and scholarships, for medical students for allied health specialists; for construction of ambulatory centers.

So it has about $600 million on top of that net cost of $2.6 billion, giving a figure of 3.2 that would come out of general revenues to finance this plan's first year.

Senator BYRD. For health insurance itself it would be——

Senator MCINTYRE. 2.6.

Senator BYRD (continuing). 2.6 as compared to the administration's 3.9. I guess that would be the more comparable figure to the administration's rather than the 3.2.

Senator McINTYRE. That is correct.

Senator BYRD. Overall your plan would appear to be a little more conservative, shall we say, than the administration's plan?

Senator McINTYRE. Well, I think it goes back to the question that was asked by Senator Talmadge, and that is that this plan says that if a man can afford to buy himself a health policy, he should buy it. When a person can't, when a person is uninsurable, when a person only has an income of, say, $3,000 to $4,000, near-poor, he should be assisted in buying a premium, but all policies will come up to a minimum standard of good health care.

Senator BYRD. And under your plan, medicaid would be eliminated entirely?

Senator McINTYRE. Eventually, but because of the lack of knowledge of the 50 States, we do know offhand that California and New York would probably not be reached until phase 3.

Senator BYRD. But as a practical, a general matter, speaking generally——

Senator McINTYRE. You will be moving out of the medicaid business.

Senator BYRD. Only one other question.

You state that you make qualified health insurance costs 100 percent tax deductible. Is that tax deductible to the individual as well as to the business?

Senator McINTYRE. Yes.

Senator BYRD. And I assume under your plan that it would be paid 50 percent or—what percentage would the business pay as compared to the individual?

Senator McINTYRE. Let's take the group policies, for instance. The employer and employees, through arbitration and agreement, would agree on the ratio, whether 50–50, 65 employer, 35 employee. It would vary depending on the agreement worked out between employer and employees.

Senator BYRD. But your legislation does not set a specific percentage for the employer.

Senator McINTYRE. No, it does not. It allows that to flow in the free enterprise system.

As you know, today an employee can take, outright, up to $150 maximum, and then the balance he may be paying for his health policy will go down into the 3 percent of his gross adjusted income formula. Under this bill, the single individual who buys a policy would be able to deduct this 100 percent.

Senator BYRD. I think you have given the committee a very interesting plan and one that will be of immense help.

Thank you, Senator.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator, for a very fine presentation here today.

Senator McINTYRE. Thank you, Mr. Chairman.

The CHAIRMAN. The next witness will be Senator Percy, the senior Senator from Illinois.

Senator, we are happy to welcome you back before the committee to discuss a subject that always has been close to your heart.

STATEMENT OF HON. CHARLES H. PERCY, A U.S. SENATOR FROM THE STATE OF ILLINOIS; ACCOMPANIED BY MRS. McCORNACK AND MRS. JULIA C. BLOCH, STAFF MEMBERS

Senator PERCY. Thank you, Mr. Chairman. I have been testifying before this committee about 15 years, I guess. It is a great honor and privilege for me to be appearing before you today.

I would like Mrs. Hannah McCornack and Mrs. Julia Bloch to join me here. I hope I won't need any technical assistance, but I think it would be a fitting tribute to their work to recognize their dedication to this issue. Mrs. McCornack, who is on Senator Scott's staff, has worked about 6 months on this bill. And Mrs. Bloch, who is on my staff, has worked with her.

I think it is fine that we have such bipartisan interest in the bills being presented by members of the Senate. The fact that these hearings have standing room only for these last 3 days, I think, is testimony to the fact that the subject is of deep interest to the American public.

I would like to begin by saying that although we all recognize, to a certain extent, that we have to wait for House initiative in this area of health legislation, this committee is doing right in beginning to collect a body of knowledge as to what is the right thing for our Government to do at this stage in our national history. We recognize, I think, that the effect of health legislation on every individual and every family is so profound that consequences would be catastrophic if we made a mistake. I think, to hold hearings this early, to hear from every segment of American life, including legislators, is a fine thing.

I have been very honored, indeed, in working with Senator Scott. I am really appearing on his behalf as well as my own. I want to point out that Senator Scott has carried the major portion of the creative work of this bill that we are presenting for your consideration. At the same time we have also drawn very heavily on the advice and counsel of others in the field.

I am honored this morning to have 40 members of the Illinois State Medical Society, including the members of their families, here in the audience to represent our State.

I sent a questionnaire to 10,000 physicians and doctors throughout Illinois. I had 2,500 responses back in time to take into account their suggestions and ideas before we dotted the final "i" and crossed the final "t" in this bill. Yet, we submit it to this committee with the recognition that it is not perfect, that it is subject to modification and review. We only hope that there will be portions of it that you will consider important enough to finally put into an overall omnibus piece of legislation that will come from this committee.

I would also like to commend the administration for its leadership in signaling 1971 as a year of health reform. I think they feel and we feel that this Congress can make a marked impact on the future of American society by writing legislation in this field.

I would also like to point out the dedicated work that Walter Reuther did in this field. I spent many hours with Mr. Reuther in my office and in his office, talking about health insurance, mainly to educate me, as he was way ahead of some of us in the Senate in understanding the need for health care reform. Leonard Woodcock has very finely carried on this work. I have also consulted with the AFL–CIO

and pay tribute to them for their efforts in bringing the complex and serious problems of health care reform to national attention.

Other Senators have contributed greatly in this field. You have heard from one of them today, and the others earlier in the week.

Senator Scott and I recently introduced S. 1598, which we call the Health Rights Act. We feel, as President Nixon does, that the national health crisis is massive and that it has deepened, and I am convinced that we must respond to this before it somehow engulfs us.

The cost of care for a growing number of Americans has become prohibitive. In the decade of the 1960's, medical costs went up twice as fast as the cost of living, and hospital costs rose five times as fast as other prices. By the end of fiscal 1970, the Nation's health bill equaled 7 percent of our gross national product—$67.2 billion.

I am unhappy to say that the quality of medical services being offered is going down. The delivery system simply isn't adequate to meet the demand that we have in the country today. I know the medical profession is alarmed at this.

In the last 6 months I probably visited a dozen hospitals, including veterans' hospitals and suburban hospitals. I have been to Cook County Hospital four times in the last 9 months. And I have been to nursing homes for the elderly, all the time trying to understand what is happening right out at the grassroots level.

The emphasis on hospital-surgical protection by private insurance today has placed inordinate pressure on patients and doctors alike to use expensive inpatient care when ordinary diagnostic procedures and day-to-day medical care would suffice.

This is why I pleaded years ago for a greater emphasis to be placed on neighborhood health centers. I was gratified that we moved ahead with this, and a part of what I had suggested with some degree of timidity and humility has since become law. Now, the States have the option of building more neighborhood health facilities to provide patients with adequate day-to-day care to maintain good health and anticipate serious illnesses.

Although 80 percent of the population under 65 own hospital insurance coverage, and 79 percent have some surgical insurance, only 65 percent are covered for out-of-hospital X-ray and lab work, 43 percent for physicians' home and office visits and 48 percent for out-of-hospital drugs. So a majority of the Americans are not covered in these important areas.

Fully 20 percent of the population do not have insurance of any kind. Only 36 percent of those in families with incomes under $3,000 and 57 percent in families with incomes between $3,000 and $5,000 have any insurance.

An astounding 77 percent of the children in families with incomes under $3,000 have no insurance coverage whatsoever.

Medicaid, designed to provide benefits to low-income people, served only one-third of the poverty population by 1970.

Senator Scott and I have proposed the Health Rights Act to make good health care readily available to every citizen, whatever his economic status. Our plan establishes a single, unified health care delivery system—for both the rich and the poor. It will provide protection for all against the financial calamity of catastrophic illnesses, supplemented by comprehensive outpatient coverage.

As Senator Scott pointed out in his statement, the catastrophic health insurance—or inpatient—plan will provide coverage for hospital inpatient services, secondary care inpatient services and home health services following inpatient status in either a hospital or a secondary care facility.

And inpatient mental health services are also covered, with a lifetime limit of 180 inpatient days for each individual.

Our inpatient plan differs from traditional catastrophic health insurance plans by covering all costs above each family's "health cost ceiling." This cost ceiling is determined by a family-by-family basis, by use of a formula taking into account both family income and family size. The family must spend an amount equal to one-half of its cost ceiling on covered expenses before there is any Federal contribution.

Covered expenses between one-half the cost ceiling and the cost ceiling will be matched on a 50–50 coinsurance basis until the family reaches its ceiling. So these are the answers to the very pertinent questions that Senator Curtis asked before.

For example, a family of four with a $4,000 per year income would have a health cost ceiling of $145 per year. A similar family with a $10,000 per year income would have a $545 per year cost ceiling.

The CHAIRMAN. Senator, might I interrupt you to ask how you arrive at the family health cost ceiling? I know the first figure is roughly about 3 percent of income. The second figure is about 5.5 percent.

Senator PERCY. That is right. The health cost ceiling is computed on a sliding scale, based on the ability to pay.

I might add, I would respectfully disagree with Senator Curtis in his definition of a catastrophe. I think it is catastrophic for a family if their life savings is wiped out. I don't think they should have to lose their home and move out before it becomes a catastrophe. If a family cannot educate its children when it wants to because of a serious illness in the family, I think that's a catastrophe.

Of course, different families have different catastrophic levels. That is why Senator Scott and I graduated each family's health cost ceiling. While a family of four earning $4,000 per year has a cost ceiling of $145, a similar family earning $20,000 per year has a ceiling of $1,090.

Senator BENNETT. Mr. Chairman, may I ask a question?

I know the arithmetic would indicate that the cost ceiling is the same percentage for a $10,000 income as a $20,000 income. Is that then the ceiling of your cost ceiling?

Senator PERCY. It's really based on a more complicated mathematical formula based both on family income and size. Also, in our outpatient plan, we have a deductible provision to bring the cost down. For example, for a family of four with an income of $2,000 per year, there is a $10 deductible. Whereas, for a family of four with an income of $20,000 per year, there is a $50 deductible. So, our deductible provisions are also scaled according to both family income and size.

While everyone is eligible for the benefits under this plan, no premiums are involved. Those who do not require hospitalization pay nothing. High-income families may purchase personal insurance to cover costs which fall under their health cost ceiling, although this plan almost completely supplements the outpatient program for low-income families.

The outpatient plan would provide outpaient physicians' services, including diagnostic services, limited checkup examinations, well-child care for children under the age of 5, dental care for children under the age of 12 and outpatient mental health services, with a lifetime limit of 104 visits for each individual.

Senator Scott and I are putting the emphasis on doing a great deal for young children because so many health problems develop during infancy. As a former employer of tens of thousands of people, I have seen adults come in year after year with no teeth or with a few teeth. You look back in their records and find that had they had dental care in early childhood or had they had some instruction on dental care, they could have saved their teeth. When someone has reached 17 or 18 years of age, there is often nothing you can do for them.

Our outpatient plan would pay all covered costs above the individual deductible figure of from $10 to $50, adjusted according to income. There is an additional individual deductible amount of $25 for covered dental services, with lower deductibles for low-income individuals.

The outpatient plan would be administered by private insurance carriers who have contracted with the newly created Office of Health Care under HEW. It would be financed through individual premium payments which would be supplemental in whole or in part with Federal payments for low-income families.

Existing employer-employee health insurance contracts would remain in force, or employers could contract with the regional insurance carriers to provide this outpatient package on a group basis to their employees.

To insure that an increase in demand would not adversely affect the quality of care, the Health Rights Act would authorize Federal grants and loans for planning and development programs—including construction—of prepaid health maintenance organizations, with incentive to locate in scarcity areas. And here, Mr. Chairman, I might add that the over 2,500 doctors in Illinois are overwhelmingly in favor of establisihng some incentives to encourage doctors to practice in areas where there is a scarcity of medical services. We have provided those incentives in this plan as a direct result of these physicians saying that this is absolutely necessary.

It also would provide an immediate incentive for an increase in health manpower training by improving the medical and nursing student loan programs under the Public Health Service Act. In addition, it would establish a special program of yearly grants to new and existing medical schools for an initial period of 5 years.

We put great emphasis on this because I cannot imagine anything more cruel or more chaotic than creating a health care delivery system that gives hope and promise of quality care without providing, at the same time, adequate measures to insure that the providers and facilities for that system would be sufficient to meet the demand.

At the same time, our bill is careful to preserve some element of cost consciousness within our health care system by having everyone pay something, however small, based on his income. It would further moderate the costs of health care through the use of Utilization Review Boards and through emphasis on an inexpensive and extensive outpatient plan that would enable families to visit doctors regularly to maintain good health and prevent serious illnesses.

I hope this committee will agree with the generous provisions of our bill's catastrophic health insurance plan. No family in America should have to face financial ruin due to illness.

Although our bill requires strong Federal participation, it also draws heavily on the private enterprise system. I have always believed that a pluralistic system will serve the public much better than a monolithic one. I vigorously oppose any plan that would abandon or throw away the years of experience we have developed in the private sector. For the most part the private sector operates effectively. Where it simply cannot underwrite the cost of serving low-income people, the Federal Government ought to supplement it. We ought not throw away everything we have built up through the years to start all over again. That would be a waste.

Neither Senator Scott nor I have exact cost estimates for this bill, since some of the data are not yet available. We have urgently requested an estimate from HEW although I realize HEW has a number of other plans that they are now costing out.

We recognize our obligation to provide this committee with such information, however, and we will do so as soon as it is practicable. If our analysis suggests that the cost of the Health Rights Act would be exorbitant, we fully intend to amend the legislation to bring the expenditures within reasonable limits. That is the only fiscally right and responsible thing to do.

In conclusion, let me summarize the major strengths, as I see them, of this bill that these dedicated young women working with their Senators have put together in the Health Rights Act. I point these out as most important:

First, the catastrophic plan differs from traditional plans by covering all costs above each family's health cost ceiling.

Second, inexpensive and extensive outpatient coverage would enable families to visit doctors regularly to maintain good health and prevent major illnesses. I think an ounce of prevention is worth a great deal, and we need to put strong emphasis on trying to prevent illness.

Third, the plan would be totally voluntary, but it would protect—through Federal financing—those who are financially unable to meet their health care costs.

Fourth, to preserve some element of cost consciousness within the health care system everyone would pay something, however small, based on his income.

Fifth, the plan would require strong Federal participation, but it would also draw heavily on the private enterprise system, insuring a pluralistic system.

Sixth, to insure that increases in demand would not adversely affect the quality of care, the plan would authorize grants and loans for prepaid health maintenance organizations.

I think all of us recognize—I know it is a common denominator here—that health maintenance organizations are necessary, and we ought to provide the incentives for developing them.

The plan would also provide immediate incentives for an increase in health manpower training.

Here, I want to again indicate my great appreciation to the 2,500 physicians who answered my questionnaire. They have helped me immeasurably. I also want to compliment the American Hospital Asso-

ciation, the various health organizations, Blue Shield, Blue Cross, and others that have an open mind and are trying to work with this committee and the House toward what we think can be one of the single most important steps taken in helping to insure human rights in this country—the right to good health.

Thank you very much.

The CHAIRMAN. Thank you very much, Senator. You made a very fine statement.

There is one thing that I am considerably in doubt about and maybe you can help enlighten us.

So far we have been unable to come up with any cost estimate on your suggestions. They are very persuasive. However, we would like to be able to have a better idea than we have at this time on what the cost of this might be.

Our staff has struggled with it and tried to get some help from the Department. So far they are not able to give us any estimate that they are willing to say could be relied upon as anything more than just a ballpark estimate.

Can you give me some idea as to what you think this program will cost?

Senator PERCY. Senator Scott and I have urgently asked HEW to price this out, and as I have said—I think when you were out of the room—if the cost comes up too high, we have a list of areas where we can pare and cut and amend to bring the costs down to what we think is reasonable. I know that if we are at all unreasonable in this area we are going to get nothing. It is better to get started on the principle.

If I were just to guess, and I would like my two able staff assistants to correct me if they think I am wrong. On a scale of 1 to 10, if the administration cost would be, say, 1 to 1½ and, say, the Kennedy bill would be 10, I would just roughly estimate we would be 4½. Now, is that about right? [Laughter.]

Senator PERCY. So, if the committee is looking between these two forces—the administration and Kennedy—for the middle road, which many think may be the mainstream of American thought, the Health Rights Act fits just right in the middle.

The CHAIRMAN. So in trying to estimate what it would cost for one of these health programs, you have to compute as do engineers in computing the cost of demolishing a bridge. They take out their slide rules and think about the tamping effect, the maximum action from their explosive, how much explosive, the circumference of the pilings and the kind of material that the bridge is built of, and then having taken all these things into account they add 25 percent for contingencies.

Then just to be sure the bridge comes down, they increase that by 100 percent.

That is about the way it has worked out on medicare so far. They undertook to estimate what all this would cost and then they put 20 percent on the estimate for contingencies.

Well, the short-term cost estimate for 1975 has exceeded that by 100 percent. Just like the engineers blowing the bridge up.

The long-term cost estimate for 1990 shows a 400-percent increase.

Senator Wallace Bennett showed up with the courage to suggest a method to hold these costs down that would place primary responsi-

bility on the doctors. We finally managed to make them understand that Senator Bennett is serving the national interest in trying to hold the costs in line; and those of us on this committee have bitten the bullet to try to hold these costs down. So we want the best advice we can get on the cost of these proposals as we go along.

Senator PERCY. Just as soon as we get an analysis from HEW we will submit it to the committee. I understand their difficulty in coming up with an estimate because we don't know what human beings are going to do. It is very hard to predict what 205 million or 206 million people are going to do.

We thought we could estimate what the cost of welfare would be. If I ever thought 5 years ago that welfare would be one-third of our State budget today—$1,100 million in Illinnois—I would say the man who gave that estimate was out of his mind. But that is what it is today.

And now we have a welfare system that is bankrupting the cities and the States. Public officials are in despair because all they can do is cut back the benefits. They are caught in between.

My hope is that this committee would add a large enough factor for contingencies so that we don't end up finding that whatever plan we do adopt costs 50 to 60 percent more, necessitating benefit cuts. Then, we would end up with the kind of condition we now have in welfare.

So, I would prefer to be a little more conservative in the promises we offer. But let us get the principle established.

The CHAIRMAN. If you look at the Kennedy bill, based on prior experience with medicare, after it was in effect for about 5 years, it might cost us about $200 billion which is what all the government put together costs right now. We would provide so much health for people that we wouldn't have anything but health insurance. That is all we would have.

I am not saying it costs that much, but prior experience with these programs would indicate that it might. We have yet, Senator, to have the first person show up with a low estimate on any health cost plan. Every estimate, even those by the opponents, has been on the low side so far.

Senator Anderson?

Senator ANDERSON. Thank you, Mr. Chairman. I appreciate very much this fine statement. I think you have done a good job and I appreciate your testimony.

Senator PERCY. Thank you, Senator Anderson, very much.

Senator BENNETT. Thank you, Mr. Chairman. I just have one question to clear up my understanding.

You talked about the cost ceiling and then you also talked about deductibles. In a family of four will each member of the family be required to pay each deductible if they use the services?

Senator PERCY. Yes, that is right.

Senator BENNETT. So the cost of the deductibles is approximately equal to the health care ceiling?

Senator PERCY. That is right.

Senator BENNETT. And a family of four with a $4,000 income, the ceiling is $145 and the deductibles including dental care for all four adds up to $160?

Senator PERCY. That is right, and I think we can save billions of dollars by this. This is the experience we have drawn from the in-

surance companies. It doesn't matter whether it is health insurance or automobile insurance. The principle is the same. If we are going to avoid those low costs, we have to charge a deductible—something that every family can somehow bear. We are not trying to insure every cost.

Senator BENNETT. I just wondered whether it was deductible per family, deductible per individual in the family?

Senator PERCY. Per individual.

Senator BENNETT. No further questions.

The CHAIRMAN. Mr. Jordan?

Senator JORDAN. I yield.

I didn't hear his testimony.

The CHAIRMAN. Senator Byrd?

Senator BYRD. Thank you, Mr. Chairman.

May I ask the Senator from Illinois just if he would comment briefly on two sentences?

While everyone is eligible for benefits under this plan, no premiums are involved.

And the next sentence:

Those who do not require hospitalization pay nothing.

No premiums involved in that plan?

Senator PERCY. No premiums are involved in the inpatient plan.

Senator BYRD. In the inpatient?

Senator PERCY. That is correct. No premiums are involved in the inpatient plan. In the outpatient plan, there would be—there are two separate plans. We have separated the two to give each plan as much emphasis as possible. The inpatient plan would be financed through the health insurance portion of the Social Security payroll tax and part of the general revenues.

Senator BYRD. Thank you, Senator. Thank you, Mr. Chairman.

The CHAIRMAN. Senator, I want to thank you for adding more constructive thought to what has already been brought before the committee. I really think that if we can develop a program that seizes upon the very best that each sponsor and each group has to offer, and also keeps in mind the cost in a responsible way, we should be able to develop something that the Nation would be very happy to have. You have made a very fine contribution here today.

Senator PERCY. Mr. Chairman, I thank you very much. I think that the months we have put into this puts us in a position at least to appreciate the magnitude of the task that this committee has undertaken. I don't think anyone can really appreciate what is involved in trying to put a plan together until they have tried to put one together themselves. You really get down to the tough decisions that have to be made when you look at all the options, at all the problems, and weigh the benefits against the costs. We sympathize with this committee. If there is any way that our own staff members who have worked for months in this area can help, Senator Scott and I would be happy to have them work with your staff. We respect you a great deal.

The CHAIRMAN. Don't be surprised if you find some of your thinking coming to us in a House-passed bill. I am happy to see that our friends on the House side carefully reviewed the ideas that have been suggested in studies and hearings before this committee. They have the right to initiate revenue bills and I don't envy them at all in that.

I am happy to go along with that. We have the opportunity to second guess and we certainly are pleased to see that they like some of our ideas. We are always glad to see a bill come over to us that incorporates ideas we have advocated in the Senate. So you may very well find some of this is in the House bill that comes before us. Anyone who works on this committee has to adjust to the fact that after he has worked for something for 10 or 20 years and it finally becomes law it will be part of the Mills bill because all of those revenue bills are Mills bills.

[Laughter.]

Senator PERCY. In the homeownership area, Senator Bennett and I worked on that and I found it very helpful to start working with Bill Widnall, the ranking Republican over there, and Lenore Sullivan, both of them experts in that field, and I intended to find comparable people like Bill Springer who has worked on health bills over there for years, an Illinois Congressman, and I will with Senator Scott send a few of these ideas over to the House and maybe they can trickle into the House bill.

Senator BENNETT. Off the record.

(Discussion off the record.)

The CHAIRMAN. Thank you, Senator.

Our next witness will be Dr. Russell Roth, Speaker of the House of Delegates of the American Medical Association.

Doctor, please have a seat. We will ask you to wait just a moment or two before you begin your statement while the staff distributes copies of your statement, and while the Illinois delegation yields some of their seats to some others who want to hear what you will present here today.

Dr. Roth, this committee is aware of the fact that your group has been studying the programs for health insurance for several years now and that you have a very keen interest in this matter for many different reasons, all of which are admirable, and I would now urge you to proceed with your testimony.

STATEMENT OF RUSSELL B. ROTH, M.D., SPEAKER, HOUSE OF DELEGATES, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY HARRY N. PETERSON, DIRECTOR OF THE AMA LEGISLATIVE DEPARTMENT

Dr. ROTH. Thank you, Mr. Chairman.

I have had a strong temptation, since seeing Senator Percy here just a moment ago, to remind him—I am sorry he has left the room—that the basic thinking in medicredit was first submitted to him by my late great partner, Dr. Elmer Hess, when we worked together when Senator Percy was working on the Republican platform committee during the Eisenhower administration.

I am Dr. Russell B. Roth, a practicing physician in Erie Pa., and speaker of the house of delegates of the American Medical Association. With me is Mr. Harry N. Peterson, director of the AMA legislative department.

We are pleased to respond to the invitation of the committee to present briefly at these exploratory hearings our views on national health insurance, particularly with respect to medicredit.

Mr. Chairman, I believe that at this time it is probably unnecessary to review with this committee the full details of the medicredit proposal which has the endorsement of the American Medical Association. But I should like to take a few minutes, however, to present a few of its features.

Medicredit is a program to give every person in America under the age of 65 equal access to high quality medical and health care regardless of ability to pay.

Without disturbing the present medicare program for the elderly, while covering services now provided under medicaid for the poor and near poor, it makes available to everyone under 65 a private program of comprehensive medical and health care protection, covering both the ordinary and the catastrophic expenses of illness or accident.

Payment for the private programs of health care protection would come wholly or partly from the Federal Government, depending on the financial condition of the family or individual.

For persons of low income who are unable to buy protection for themselves and their dependents, the Federal Government will pay the total cost of the premium or membership. For persons whose income is higher, the Federal contribution is reduced along a specified sliding scale; as income rises, the Federal contribution diminishes. Every family, however, is eligible for at least a small amount of Federal contribution to provide an incentive for them to protect themselves with an approved policy or plan.

I would point out that in one very important respect the bill, S. 987, which is currently a matter of consideration by this committee, has been altered from the form which it had in the 91st Congress. This is through incorporation of extended coverage. It has long impressed us, as practicing physicians, that the serious end of the risk in respect to health matters is not so much the financing of the first few dollars, or even the first few hundred dollars of medical expenses. It is coping with long, continued or especially severe illness which leads to expenses which simply cannot be met by the average individual and which may be ruinous even to the affluent. Under S. 987 extended coverage provided would be paid for by the Federal Government for everyone.

It is recognized, moreover, that there are many persons who lack the financial resources to purchase insurance or to meet any significant part of the cost of medical care. For them we suggest that health services be paid from tax sources, and we feel that general Federal revenues are best utilized for their purpose. Thus the Government pays for all or a part of basic coverage depending on the financial condition of the family or individual, measured by Federal income tax liability.

We have become persuaded that a 100-percent Federal subsidy be granted at some level of income and that a fair level of entitlement to such full subsidy is the economic level at and below which one owes no Federal income tax. Those who owe some income tax almost by definition have some disposable dollars. As tax liability rises, this is evidence of more and more disposable dollars which could be used for the purchase of adequate insurance.

In consequence, we suggest that every person or family should be given the opportunity to secure a policy of health insurance for a sum

which is within reasonable financial reach. To accomplish this, we propose that the element of Federal subsidy from general revenues should decrease as personal disposable income increases. When resources as judged by income tax liability have become adequate, the individual or family would be expected to pay as much as 90 percent of the premium cost for adequate basic coverage. We have suggested that this upper limit be defined as that economic level generating a Federal income tax liability of $891 or more, at which income the Federal contribution would be 10 percent of the premium. And, the extended coverage premium would be paid by the Government for all persons.

Thus, a smooth gradient of tax credits has been created between 100 percent Federal contribution and 10 percent tax credit, decreasing as income tax liability rises. The result is that any individual or head of the family may secure a contract of insurance or entitlement to medical services from any agency doing business in his State which has been approved for the provisions of such coverage. Such agency, may be a private insurance company, a voluntary pre-payment plan, a pre-paid group practice plan, health maintenance organization or other approved provider.

The contract would provide two types of benefits: basic and extended. It is suggested that basic coverage should embrace the following: Hospital services up to 60 days, with a $50 deductible; outpatient services with no deductible but with 20 percent coinsurance for the first $500 of charges; and physician services, again without deductible, but with a 20 percent coinsurance on the first $500 of charges. Two days in an extended care facility could be substituted for one general hospital day.

The extended insurance would provide full pay for additional hospital days, plus an additional 30 days of extended care and the costs of prescribed prosthetic appliances after basic coverage for hospitalization has been exhausted, and after the individual had incurred a certain expense, dependent upon his income. This corridor or deductible would equal 10 percent of the first $4,000 of net taxable income, 15 percent of the next $3,000 and 20 percent of net taxable income beyond this.

The result is to insure that no individual or family would be required to pay out of its reserves so much as 20 percent of net taxable income of any one year. Amounts paid out as deductibles or coinsurance under the basic coverage would count toward the deductible in the catastrophic coverage, so that low-income families would come under its protective provisions at a very low level of out-of-pocket expenditures.

The deductible and coinsurance provisions are designed to encourage the use of ambulatory outpatient facilities to encourage the use of ambulatory outpatient facilities rather than in-hospital care.

Aside from these changes the general character of the proposal is not significantly different from that which has previously been reviewed by this committee. We have appended to this statement a brochure describing the current proposal in more detail.*

Our association represents the preponderance of practicing physicians who would be called upon to provide the care in question under any system of national health insurance which may be devised. We

* See p. 219.

identify in a very realistic and practical way the complexities of the problems to be solved. We know the educational gaps, the manpower deficiencies and maldistributions, the special problems of inner-cities and rural services, the forces for overutilization and for underutilization, the potentials for the physician to function more effectively as a conservator of expenditures for his patients, and the contributions to be made and the responsibilities to be accepted by consumers of medical care. Most importantly, we know a great deal about the motivations of physicians to pursue medical practice as a career and the counteracting forces which lead to avoidance of clinical practice or a retreat from it into research, teaching, administration or premature retirement.

We have developed some very firm concepts as to what may be accomplished by legislation, what may be helped by legislation, and what stands in serious jeopardy of being set back by legislation.

Among the many barriers standing between people needing medical care and those able to provide it, the financial barrier is perhaps the easiest to knock down because Government can provide tax dollars when private dollars are not available.

Medicare to the extent that it has been helpful to older people has assisted in this way. Medicaid because of inadequate financing has failed to do its job as well.

Insofar as people under 65 require help in achieving medical service without formidable dollar barriers, we present our medicredit approach as a well-designed, equitable, easily administered and practical solution. Here legislation could clearly achieve a desirable mix of public and private resources to meet a need.

On the other hand, we are concerned by the overpromise which seems inherent in a wide variety of legislative proposals placing strong reliance on a restructuring of the delivery system. It is alleged that if our providers of medical service were regrouped into a health maintenance organization or form of prepaid group practice, much of our problem would be solved.

Many of our physician members who work within such prepaid groups or kindred forms of comprehensive care delivery believe that this is not so. This point of view has been well expressed by Dr. Sidney Garfield, the founder of the Kaiser-Permanente program, and one of its most respected and active promoters. He has said: "As for group practice, though it is flattering to have part of our program proposed as a model for this Nation's future delivery system, it is a mistake to believe that it will automatically solve very much. There is nothing inherent in prepaid group practice that guarantees ready availability of services. In fact, this has been as serious a problem with us as in practice in general."

Those of us who are in group practice, and there are over 40,000 of us, have our own concepts of its advantages to our patients and to us. But few of us look upon group practice as a panacea.

The notion has been advanced that the American Medical Association opposes salaries for physicians and champions direct fee-for-service alone. This would come as news to our large number of member physicians who derive their income in whole or in part from salary. It is a false premise. Upon it is based the allegation that fee-for-service favors overtreatment and prepayment does not. One might as

logically assert that prepayment favors undertreatment. Actually, a good and conscientious physician responds with consistency to the needs of his patients as he sees them.

One hears over and over the statistical studies to show reduced utilization rates under prepayment. But less prominence is given to other studies such as that by the Russell Sage Foundation which concluded that nearly half of all members of the Health Insurance Plan of Greater New York and also of the Labor-Health Institute go outside of the plan for some medical service.

It is not our aim to downgrade prepaid practice. Many physicians, as well as many patients, like it. Under the Kaiser plan only some 15 percent of beneficiaries who have opted into prepayment coverage opt out of it later on. But mark you, they do have an option.

I would also say that we have included as a potential provider any health maintenance organization or prepaid plan under the medicredit proposal.

It is implicit in our defense of a pluralistic flexible system that prepaid group practice and such modifications of it as may be devised under the title of health maintenance organizations should have their opportunity to demonstrate their capacities to provide effective, efficient, and economical care. Any freeze into a single mold would deprive our Nation of the benefits of competition and comparison. Here legislative mandate could do more harm than good.

In a somewhat similar vein of caution we would note that there is danger in expecting too much of professional services review or peer review. To attmept to legislate it into effective being may be a frustrating experience. The frustration stems from the fact that when the question concerns the appropriateness of technical, medical care and the equity of charges for it, only another physician can pass the judgment.

This is a fact which is forcing upon physicians the obligation to evaluate the practices of their colleagues. Large segments of the medical profession take substantial pride in their accomplishments in this respect. In applying the principles of peer review the reviewing group seeks to uphold quality, to promote efficiency and to eliminate departments from accepted practices and equitable charges. By and large practicing physicians accept the necessity for checks and balances in the paying out of public funds and private funds as well. On the other hand, they have no appetite for the job to be done by nonmedical persons or agencies ill-equipped to judge.

This is why they are willing to redouble their efforts within their professional organizations to do the job well. We know of no successful efforts to legislate ethics or morals which must be at the heart of any system of competent, conscientious delivery of medical care. On the other hand, we know of no profession which has shown a better motivation or performance through its collective professional organizations to rule out abuses and lack of competence. It is a paramount importance to support the progress which has been made, not to cast it aside.

We would also caution against uncritical acceptance of the statement that it is somehow possible to legislate American medicine into a system of health care as opposed to sickness care.

The great advances in adding to life expectancy have been achieved in world medicine by controlling epidemics and plagues, draining

swamps, purifying water, and devising immunizations. Smaller gains have been made in individual physician-patient encounters, removing diseased organs, supporting failing hearts, controlling diabetes, and the like. Few gains, indeed, have been made or can be made through changing the role of the physician in respect to well patients. Not that there is any shortage in things to be done, especially in the realm of public education.

Nutrition can be vastly improved, cigarette smoking can be curbed, drug addiction and alcoholism somehow must be abated, proper exercise may be promoted, accident prevention is essential, environmental deterioration must be reversed. But how many of these things can be done by the individual physician, besieged as he is by those who are, or think they are, already sick?

The things that are to be done are the province of our public health organizations, voluntary health agencies, communications media, government, and our professional educational associations such as the AMA.

All physicians practice come degree of preventive medicine. Many could do more. But to believe that some sort of basic restructuring of medical practices could yield great dividends in this respect is wishful, impractical thinking.

For example, accidental death is one of the great tragedies of our industrialized, motorized generation. It is the leading cause of death for those under 37. Each instance is somehow avoidable. But can the orthopedist neglect the fractures while he counsels junior to drive carefully or grandpa to negotiate icy sidewalks circumspectly. In the long run is not much of this call for health maintenance in the realm of professionals other than those trained in the intricacies of diagnosing and treating disease? The call for physicians to concentrate on this is a curious reversal of the commonly expressed desire to relieve the physician of those tasks which do not require his special expertise. Let us instead develop the allied health personnel necessary to do the job.

In short, we commend to you our specific proposal for attacking financial barriers. We also solicit your support in ongoing efforts to augment manpower, to improve practice patterns, to apply effective measures to moderate and contain costs, to meet the challenges of the inner-city and the rural scene, and in general to meet the goal that no one shall be deprived of the best that is within our power to provide. We caution against the attractive but totally impractical notion that one legislative act can solve the problems of a profoundly troubled society.

Mr. Chairman, I should like to close with a favorite quotation, one which Robert Burton, that wonderful old Anglican monk in his Anatomy of Melancholy attributes to Plato:

> Where they be generally riotous and contentious, where there be many discords, many laws, many lawsuits, many lawyers, and many physicians, it is a manifest sign of a distempered melancholy state.

Mr. Chairman, I believe we have been diagnosed. May we collectively and cooperatively work to find a cure.

Thank you.

The CHAIRMAN. Thank you very much, Doctor Roth, for a very fine statement on behalf of your group.

I want to suggest one thing to you.

Your very fine organization by its very structure is really immobile. It takes a while for it to arrive at a position and this is a changing world.

When the crucial decisions were made with regard to medicare, your organization was advocating something that was not going to become law, and you were not sufficiently flexible to be in a position to advise us if it could support something different, or if it could live better with one variation than another of what was going to become law.

Now, the result of this was that the influence of your group was not really felt very much in the drafting of the medicare bill. I think you would have been more effective if your group had been sufficiently flexible to take a stand as between variations of a bill that was going to become law.

Now, in the event that your suggestion here is not to become law, would your group be in a position to advise us with regard to whatever might develop in this committee?

Dr. ROTH. Mr. Chairman, I hope it has become apparent already that the American Medical Association is indeed anxious to work cooperatively with you, with this committee, your staff, with all people in government who are concerned with looking over these many innovative ideas, several of which have been presented to your committee.

We stand with no pride of authorship in our own bill. The fact that we recognize that it may be improved is perhaps manifested by the fact that it has changed a little bit from last year.

The CHAIRMAN. I am satisfied that the overwhelming majority of your members feel that individuals on some basis ought to be insured against catastrophic illnesses, for example.

There is a debate as to the definition of catastrophic illness but the overwhelming majority of doctors who are members of your association seem to feel that in some fashion, individuals should be insured against it. Is that not correct?

Dr. ROTH. That is correct, sir.

The CHAIRMAN. Now, I want to congratulate you, upon a very fine job that your organization has done. They presented me with a copy, which I assume it is for the benefit of the entire committee, of your publication: "AMA Drug Evaluations," first edition, 1971.

It seems to me that this is a perfect example of the responsible educational activity which professional societies should perform. I very much want to commend the AMA for doing this job.

Dr. ROTH. We thank you, Mr. Chairman. A lot of time, a lot of effort, has gone into the preparation of this volume. It is primarily for the use of practicing physicians. I have already in the short months that I have had it available to me found many occasions to consult it.

The CHAIRMAN. I was looking at page 184 on mixtures containing codeine, and here—is a combination, Edrisal with codeine, and the text under that says:

Irrational mixtures containing aspirin, phenacetin, amphetamine and codeine; see individual evaluation on Edrisal and introduction to this section. Adverse reactions are those of ingredients; usual dosage, not recommended. Preparations: Edrisal with codeine, Smith, Kline and French, codeine sulfate, aspirin, phenacetin, amphetamine sulphate.

And then there are some others that follow. They have this same note under usual dosage: "Not recommended."

Dr. ROTH. Yes, sir.

The CHAIRMAN. Then we go over to some other drugs that are rather commonly sold. Here are some Darvon compounds: "Usual Dosage, not recommended."

Would you mind explaining to me what that means?

These are drugs that are commonly sold on the market and yet you say they are not recommended.

Dr. ROTH. First, let me plead some lack of expertise. I am not a pharmacologist, and these recommendations were put together by men with substantial expertise.

However, as I understand it, in a drug such as Edrisal, the first one which you mentioned, where there was phenacetin, codeine, aspirin, and amphetamines, the position of the committee, and this applies pretty well across the board, is that each one of these items can be given independently with its dosage varied to suit the particular indications of that individual patient. Therefore, they feel that it is more rational for the physician to adjust the amount of each drug given, if indeed he wants to give all four, to the particular requirements of the patient.

The end result is not necessarily irrational therapy, as you and I may conceive the word "irrational." It is just irrational to feel that that one combination of dosages in that one pill is the ideal thing for every patient.

The CHAIRMAN. In other words, this, involves a situation where there is a combination of drugs mixed up into one tablet and it is not logical to assume that the patient needs that particular mixture?

Dr. ROTH. I think you used a word that might make a lot of doctors very much happier, had it been proposed. It is perhaps an illogical combination. To say it is irrational rubs a lot of people the wrong way.

The CHAIRMAN. I see. Then you are not saying this drug should not be taken. You are only saying that this would not be a drug that is necessarily indicated for an illness because the mixture would depend on the patient's own particular illness and the degree of it?

Dr. ROTH. This is absolutely correct, sir. Long ago it was my personal feeling that when using powerful antibiotic medications in combating infections, I would rather give the antibiotic and then any other pain relievers or something independently rather than take fixed combinations which might not give the amount of each ingredient that I wanted to give to my patient.

The CHAIRMAN. Well, I was trying to understand it because in terms of self-medication I suppose I run into the same problem. You have a headache and you feel an aspirin tablet might help, but then again something else might help, so you start to take one thing and then another and you just wonder what the mixture is going to be by the time you get it all down.

Now, I was just wondering if that is parallel to the situation that you are talking about with some of these compounds.

Dr. ROTH. Yes, sir; I believe it is, very accurately.

The CHAIRMAN. Thank you very much, Doctor. Senator Anderson?

Senator ANDERSON. Thank you, Mr. Chairman.

I am very appreciative of your statement on deductibles.

Dr. ROTH. Thank you.

Senator ANDERSON. I have a strong feeling on deductibles also. I know there are certain organizations which want to abandon them completely, but at the time Medicare was adopted there was strong emphasis on deductibles.

I am extremely grateful for your support of deductibles. I hope you hold that position for a while.

Dr. ROTH. Thank you, Senator Anderson.

The CHAIRMAN. Senator Bennett?

Senator BENNETT. Mr. Chairman—obviously you were here and heard the kind things the chairman said about peer review, so of course I have looked carefully at that part of your statement which refers to peer review and I realize I have you in a little bit of a trap because the Pennsylvania House of Delegates not only approved peer review but are working very hard to implement it, according to my information.

You say, "To attempt to legislate it into effective being may be a frustrating experience." We can legislate it without being frustrated.

Dr. ROTH. It may be very frustrating to the physician, sir.

Senator BENNETT. So you are saying to implement it might be a frustrating experience rather than legislate it?

Dr. ROTH. I think that is correct; yes, sir.

Senator BENNETT. But you very carefully do not come out categorically and say that the AMA is against peer review, that the AMA doesn't want peer review in this legislation. Are you saying to us that the AMA being a national pluralistic organization has some of its constituent members who are in favor and some who are against, and in the end maybe we had better use our own judgment?

Dr. ROTH. What I hope I am saying, Senator Bennett, is we are aware of your personal belief in the soundness of the principle of professional peer review and Professional Standards Review Organizations. At least I think it has been manifested in some of the work which was done in the last session of Congress and I assume it will be in evidence again. We share this same conviction with you, that this is the way, the most hopeful way, of bringing into a highly technical and complex business, the practice of medicine, the proper kind of checks and balances, regulations and controls.

I think we have an identity of respect for the mechanism. We have been proud of the fact that our profession has undertaken this obligation which sometimes entails some unwelcome duties on the part of physicians, to sit in judgment upon their colleagues, but they have done this, and my own State of Pennsylvania, to which you refer, was one of the pioneers in the Alleghany County, Pittsburgh, area. Nassau, Suffolk, very many other places in this country have done it well. Variations of it have been devised in the California foundations, in the Washington medical bureaus, and in many other areas.

We wish to foster this kind of development because we think it holds the most promise. We think that the role of the physician himself as a conservator of the pocketbook of his patient to the extent that he acts as a purchasing agent for his patient of expensive hospital services, tests, X-rays, drugs, and so forth, has been relatively undeveloped. Physicians have not been educated to this role.

We believe that these peer review organizations, the things that our county medical societies and State medical societies are beginning to do and can do hold the most promising mechanism to develop real cost

controls, the kind of control that I think all of us want, without a sacrifice of quality.

Now, if there were alternatives, if this could be done by someone other than the medical profession, I think we would have many people advocating that it be done by outsiders, simply on personal grounds, but I think we all recognize that we are stuck with the job and we need understanding and we need help.

We want to insure, and the last sentence of my statement tries to say it, that if things have been well developed in the Pittsburgh area, in the Nassau, Suffolk areas. in the California, San Joaquin Valley, and so forth, let's potentiate those and try to continue toward perfection and let us assure we don't do anything that puts these at a disadvantage or makes it impossible to continue to make progress with them. I think this is the intent.

Senator BENNETT. So it is not the concept to which you object? It is the dangers you see that it might upset organizations that are now performing this function and you think performing it well?

Dr. ROTH. I would like to make it perfectly clear that the concept we strongly support. I feel that we have a tender shoot that is coming up well and indeed I want to protect it.

Senator BENNETT. Fine. I have two or three questions.

On Monday Secretary Richardson testifying before this committee said these things:

> Medicredit would encourage the growth of costly, individually sold private health insurance in contrast to group insurance. The type of insurance which would be available under Medicredit does not fit present group arrangements and could well upset employer/employee arrangements. Part of the insurance costs are now met and legitimately met by employers. In sum, a federal subsidy is called for with little public policy direction over the amount spent for the effect of the health system.

Do you want to comment on the Secretary's statement?

Dr. ROTH. Only to the extent, Senator Bennett, that we have conferred with Secretary Richardson and his staff on a number of occasions, particularly as we have contemplated the changes in our bill from the 91st Congress to the 92d; and if indeed this is a true criticism, I wish we had gotten it from him at the time we were constructing the newer version or suggesting the newer version because if this is true, this is precisely what we do not want to have happen.

We have consulted with actuaries, with people in the insurance industry at great length, and our desire is to disturb not at all the provision of group insurance which we recognize as the most effectively and most economically administered and in general that which has provided the best benefits for the dollar. We have attempted to set our income credit scales in such a way that it would at no time lead the consumer to say, all right, let me drop my group insurance because I can buy subsidized Federal insurance.

We have tried to point out that we, too, as in some other bills that will be before you or are before you have suggested, provide that if the employer provides acceptable basic minimal insurance, he gets his full tax credit but for less than this there is a disincentive in that he does not get full income tax credit.

If there are ways in which we may improve our bill to avoid this criticism of Secretary Richardson, if it is indeed a valid criticism, we certainly would want to know it and we could suggest amendments to the bill.

Senator BENNETT. Well, I would think in view of the Secretary's statement you would want to renew contact with the Department and see if you can work that out between your organization and the Department because undoubtedly we will have to face that as we study the various proposals before us.

Mr. PETERSON. Senator Bennett, I might just mention the Secretary did not make any mention concerning the incentives that are in the bill to promote and foster and continue the group coverage.

Senator BENNETT. He made this categorical statement, so I think if I were in your place I would try to make sure you—at least a mutual understanding and if possible eliminate the criticism.

Dr. ROTH. This is correct, sir, and we appreciate the suggestion because we indeed want to do this.

One of our problems at this particular moment in time is that we are still seeing published comments which refer back to the prior version of the medicredit bill, cost estimates and things of this sort. Also some provisions. And there may still be some confusion between the old bill and the new.

Senator BENNETT. Are you saying that the Secretary was referring to the old bill?

Dr. ROTH. Not in this respect.

Senator BENNETT. That is what I mean.

Dr. ROTH. Not in this respect.

Senator BENNETT. Mr. Chairman, I recognize that it is 5 minutes after 12. I have two or three more questions. I will submit them to Dr. Roth and ask him to submit his answers for the record.

Dr. ROTH. Happily.

(The questions, with answers supplied, follow:)

Question. How would doctors be paid for their services under your bill?

Answer. Doctors would be paid in the same manner as they currently are paid under contracts of insurance, group plan, etc.

Question. How would hospitals be paid under Medicredit? Is that more generous than Medicare's reasonable cost method?

Answer. Similarly, hospitals would be paid in the same manner as they are currently under various types of insurance, or other contractural arrangements. Generally speaking, the hospital's usual charge has a direct relationship to its costs, and it is not likely that an insurance carrier would recognize charges to any extent in excess of corresponding Medicare charges. In converse, reimbursement on a reasonable cost basis which does not reflect its full share of the hospital's program costs would require subsidization of the Medicare program by other patients.

Question. Do you think your proposal might be inflationary?

Answer. All national health insurance proposals, particularly insofar as they stimulate increased demand of our health delivery system before its components are strengthened (such as manpower), would have an inflationary effect.

The CHAIRMAN. Senator Jordan?

Senator JORDAN. Thank you, Mr. Chairman.

Dr. Roth, several other witnesses have called the attention of this committee to the fact that the escalation in the cost of health services has far exceeded the general rate of inflation throughout the economy that affects the costs of goods and services in every other area. Would you tell us why the costs of the healing arts and hospitalization have followed that pattern?

Dr. ROTH. Well, Senator Jordan. I think everyone is becoming well aware of the fact that the hospital component of the medical care cost index has been really the runaway one and I would honestly prefer that representatives of the hospital industry account for this fully.

It is my impression that it is a compounding of several elements such as a catching up of wages which were traditionally low, the demand for the provision of evermore expensive services.

It so happens that just about the time medicare became the law of the land it also became demonstrated that any good general hospital should have an acute coronary care unit and also some of the other expensive equipment came along, so that there was tremendous pressure on hospitals to provide them.

I think there have been a multiplicity of factors that have accounted for this and I would not wish to put myself in the position of trying to justify them.

In respect to the physicians' components of the medical care dollar, the escalation has not been so abrupt, although it has outrun the general cost of living index. However, if it is compared to other personal services, it doesn't look so bad.

My understanding is that in the past decade, the increase in physicians' fees has not been so great as the increase in the costs of remodeling a house, papering a room, reshingling a roof, attending the movies, hiring domestic household help, and a number of other things. We are more visible, I guess, then they are.

However, it would seem that it is difficult in a profession which has been subjected to some arbitrary cost controls in the Federal programs, initially the freeze in the medicare program at payment at the 83d percentile of 1969 prices, more recently changed to payment at the 75th percentile of 1970 prices, that at least in that segment it does not seem to me that there can have been any uncontrolled escalation.

Senator JORDAN. It is your testimony, then, that it hasn't been out of line as far as doctors' fees themselves are concerned and that the physicians' component has not been unreasonable if you go back 10 years and apply it against other services throughout the economy?

Dr. ROTH. I think I would endeavor to defend fundamentally that position. We have been in the interesting position of having had mandated upon us a fee structure or the necessity to devise a fee structure, which most of us never worked with before the advent of medicare because we did have a tendency to set our fees for individuals, foregoing many, reducing many, and in some justifiable instances charging more. This simply wouldn't go under a program like medicare or medicaid, so we have had to establish this concept of usual fees. Each individual physician has his usual charges and they are judged in their equity by what is customary for other physicians of the same competence in the same general area, and then the whole batch is judged by criteria as to overall reasonableness. These are the fees to which we would hope to adhere, and when there are departures from them or presumed departures from them, a jury of peers is given the charge to look this over and see whether these were justifiable or not. We feel that this can be the basic control.

If this is provided, there is no reason to say that because demand is high and supply is low, that prices are going to necessarily behave like they do in the widgit market because the medical care market does

not respond in precisely the same way to the same economic forces as the open market for commodities.

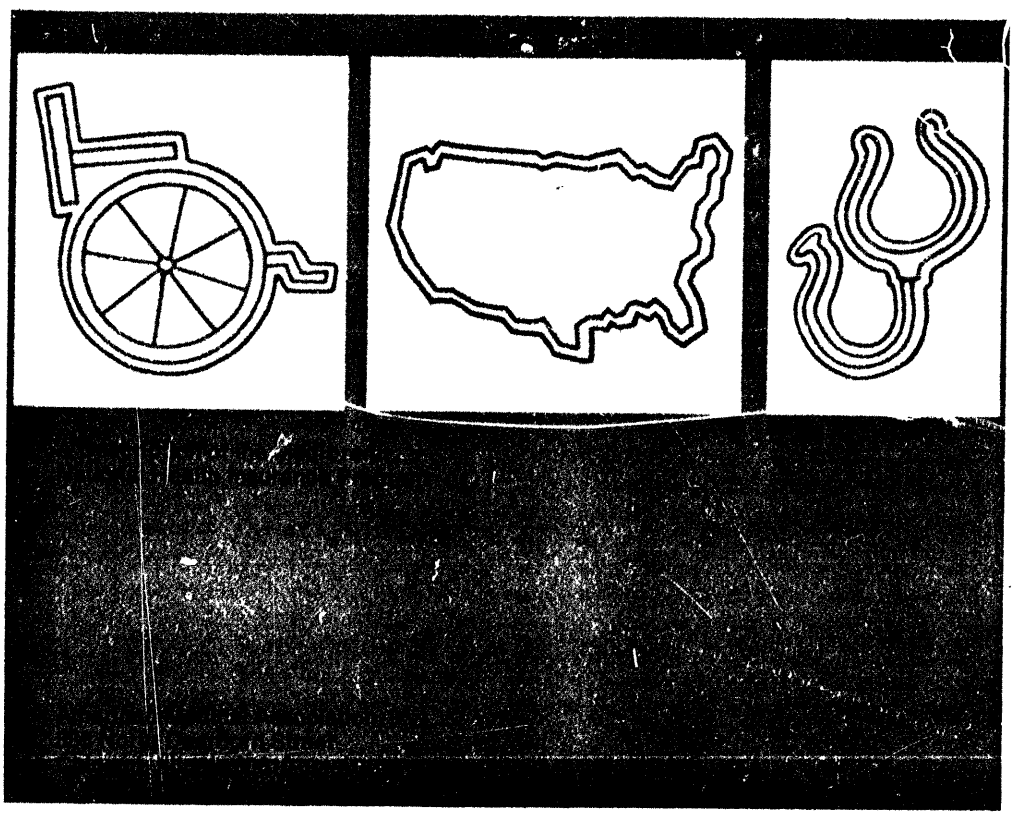
Senator JORDAN. Thank you.

Senator ANDERSON (now presiding). Thank you, doctor, for an excellent presentation.

Dr. ROTH. Thank you.

(An attachment to Mr. Roth's statement follows. Hearing continues on p. 229.)

MEDICAL & HEALTH CARE FOR ALL



It is a basic right of every citizen to have available to him adequate health care; it is a basic right of every citizen to have a free choice of physician and institution . . .; the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person . . .
Health care for the poor should not be disassociated from, but rather should be a vital part of, the over-all health care system.

Policy adopted by the
House of Delegates
American Medical Association
December, 1969

WHY NATIONAL HEALTH INSURANCE?

The policy statement on the opposite page affirms the American Medical Association's long-standing conviction that no citizen of this nation should lack adequate medical and health care because of economic, social or any other reasons.

The AMA clearly recognizes that a significant segment of our population does not share in the over-all national affluence and the impressive advances made in business and industry, science, education, social welfare and most other elements of American life.

But it does not want a special, separate program just for the poor and disadvantaged. The AMA knows they are not the only ones with problems. It recognizes that advances in science and in medical and health care techniques, along with inflation throughout our economy, have driven up the cost of care to the point that even a person of moderate to good income can be left economically drained or seriously in debt after a long or severe illness.

The answer is to make sure that high quality medical and health care are available to every person by removing economic barriers that already exist for the poor, and that can quickly be erected against others by just one catastrophic illness.

The barriers can be removed (and prevented) by passage of a national health insurance program titled the "Health Care Insurance Act of 1971" and commonly called "Medicredit."

SUMMARY OF MEDICREDIT

Medicredit is a program to give every person in America under the age of 65 equal access to high quality medical and health care regardless of ability to pay.

Without disturbing the present Medicare program for the elderly, but replacing Medicaid for the poor and near-poor, it makes available to everyone under 65 a private program of comprehensive medical and health care protection, covering both the ordinary and the catastrophic expenses of illness or accident.

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The protection may be in the form of a health insurance policy from a company; membership in a prepayment plan such as Blue Cross-Blue Shield; or membership in a prepaid group practice plan (in which the patient pays a fixed fee per month or year and receives medical and health care as needed from physicians practicing in that group). Choice of the kind of protection desired is made by the family or individual. All programs offered under Medicredit will be approved by the respective states to assure that benefits meet the national standards.

For persons of low income who are unable to buy protection for themselves and their dependents, the federal government will pay the total cost of the premium or membership.

For persons whose income is higher, the federal contribution is reduced along a specified sliding scale. As income rises, the federal contribution diminishes.

Some things Medicredit does not do:

It does not require restructuring the entire health care system, which provides care very well for the vast majority of Americans. Some of the other programs before Congress would dismantle what now exists and rebuild it along untried lines.

It does not hold up group practice—or any other form of medical practice—as the best or only effective system of patient care. Medicredit permits flexibility and innovation in developing new, more efficient ways to take care of people. It permits free choice of physician by every patient, and free choice by every physician as to how he will conduct his practice.

Finally, Medicredit does not obligate the government—the nation's taxpayers—to pay for care of people who can afford to handle most of their medical problems themselves. The cost of Medicredit has been estimated at $14.5 billion for the first year—considerably lower than nearly all other national health proposals. This estimate does not take into account savings from reduced Medicaid expenditures. Nor does it consider savings to the federal government because of reduced income tax deductions for individual medical expenses.

DETAILS OF MEDICREDIT

PROTECTION OFFERED

Basic Coverage: The approved protection (whether insurance policy or membership plan) must provide payment of expenses for these services:

Inpatient care: In a hospital or extended care facility for 60 days during a 12-month policy period, in a semi-private room. Within the 60-day limit, two days in an extended care facility count as only one day.

Inpatient hospital services cover all care customarily provided in a hospital, including bed, board and nursing services; drugs and oxygen; blood and plasma (after the first three pints); biologicals and supplies; appliances and equipment furnished by the hospital; surgery or delivery room; recovery room; intensive care or coronary care unit; rehabilitation unit; care for pregnancy or any of its complications and psychiatric care.

Inpatient extended care facility services cover all care customarily provided in an extended care facility, including bed, board and nursing services; physical, occupational or speech therapy; and drugs, biologicals, supplies, appliances and equipment furnished by the extended care facility.

Outpatient or emergency care: The policy or plan covers all care customarily provided as outpatient or emergency care, including diagnostic services—X-rays, electrocardiograms, laboratory tests and other diagnostic tests; use of operating, cystoscopic and cast rooms and their supplies; and use of the emergency room and supplies.

Medical care: The policy or plan covers expenses of all medical services—preventive, diagnostic or therapeutic—provided or ordered by a Doctor of Medicine or Doctor of Osteopathy, whether in a hospital, an extended care facility, the physician's office, the patient's home or elsewhere.

Those services include diagnosis or treatment of illness or injury; psychiatric care; well-baby care; inoculations and immunizations of infants and adults; physical examinations; diagnostic X-ray and laboratory services; radiation therapy; consultation; services for pregnancy and its complications; and anesthesiology.

Also included are dental or oral surgery related to the jaw or any facial bone; and ambulance service.

Cosmetic surgery (plastic surgery) is excluded except when related to birth defects or burns or scars caused by injury or illness.

Catastrophic Coverage: The policy or plan pays all expenses for services described under Basic Coverage in a hospital or extended care facility during days in excess of the 60-day basic limit. Only 30 days are covered in an extended care facility under catastrophic coverage, however.

In addition, the catastrophic coverage includes blood and plasma in connection with outpatient medical services (after the first three pints) and prosthetic aids ordered by a physician.

Medical care services are not included under catastrophic coverage because they continue without limit under basic coverage.

WHO PAYS FOR WHAT?

Medicredit is designed to give maximum help to those who need it most, and minimum help to those who are best able to pay their own way. Financial condition is determined solely by the amount of federal income tax a person or family pays whether by withholding or direct payment by the individual when he files his tax return.

Low-Income Families
If a person or family owes no federal income tax for the year—whether because of no income, low income or number of dependents—the total cost of the basic and catastrophic coverage is paid by the federal government. The family would receive a "certificate of entitlement" which would cover the entire premium or membership cost for an approved program from whatever insurance company or plan the family chooses.

All Others: For families or individuals who pay federal income tax, the formula is a little complicated. The cost of the approved policy or plan is divided into two parts. Most of it is for the basic coverage; a smaller portion is for catastrophic coverage. The insurance company or plan will determine how much is for each.

The federal government pays for the catastrophic coverage for everyone.

It pays a percentage of the cost of basic coverage according to the amount of income tax the family or person owes, as follows:

An example shows how the sliding scale would work. A man with a wife and two children who makes $6,100 a year, taking standard deductions, would owe $452 in income taxes. That would put him in the 54% Medicredit category.
(see table).

Income Tax Owed	% Govt Pays	Tax	%	Tax	%	Tax	%
$ 1-10	99%	231-240	76	461-470	53	691-700	30
11-20	98	241-250	75	471-480	52		
21-30	97	251-260	74	481-490	51	701-710	29
31-40	96	261-270	73	491-500	50	711-720	28
41-50	95	271-280	72			721-730	27
51-60	94	281-290	71	501-510	49	731-740	26
61-70	93	291-300	70	511-520	48	741-750	25
71-80	92			521-530	47	751-760	24
81-90	91	301-310	69	531-540	46	761-770	23
91-100	90	311-320	68	541-550	45	771-780	22
		321-330	67	551-560	44	781-790	21
101-110	89	331-340	66	561-570	43	791-800	20
111-120	88	341-350	65	571-580	42		
121-130	87	351-360	64	581-590	41	801-810	19
131-140	86	361-370	63	590-600	40	811-820	18
141-150	85	371-380	62			821-830	17
151-160	84	381-390	61	601-610	39	831-840	16
161-170	83	391-400	60	611-620	38	841-850	15
171-180	82			621-630	37	851-860	14
181-190	81	401-410	59	631-640	36	861-870	13
191-200	80	411-420	58	641-650	35	871-880	12
		421-430	57	651-660	34	881-890	11
201-210	79	431-440	56	661-670	33	891	
211-220	78	441-450	55	671-680	32	and	
221-230	77	451-460	54	681-690	31	Over	10

Assume that an approved program for his family cost $650 and that $600 was for basic coverage and $50 for catastrophic. His Medicredit benefit would be 100% of the catastrophic premium (which everyone gets) plus 54% of the basic premium (which he is entitled to because of the amount of his income tax).

Consequently:	100%	of $ 50	$ 50
	54%	of $600	$324
		Total	$374

Of the $650 for his basic and catastrophic coverage, the government would pay $374. He would pay only $276. He could choose a "certificate of entitlement" for the $374 or could subtract it from the income tax he owed. (In figuring his Medicredit benefit, he also is allowed to count a portion of the money his employer spends to buy his approved program.)

To summarize, here is how to figure the Medicredit benefit:

1. Take 100% of the cost for catastrophic coverage.
2. Find the amount of income tax owed in the table to see what per cent of the basic coverage will be paid by Medicredit.
3. Multiply that per cent by the cost for basic coverage.
4. Add the answers to items 1 and 3.

DEDUCTIBLES

Any insurance policy, prepayment plan or membership group offering as many benefits as those offered by Medicredit's approved programs must have financial safeguards built in. The safeguards are almost always in the form of deductibles (or "co-insurance")—amounts the patient pays before the program itself begins to meet expenses.

The Medicredit deductibles are small, compared with the benefits, but they serve very important purposes.

Primarily, they keep the total cost of the program lower. Because most citizens will share that cost with the government, economy is an important consideration. If a program paid every dollar of medical and health care expense, the cost would be higher.

Secondly, deductibles—even though small—prevent abuse or over-use of the program by patients or physicians. The policyholder or plan member knows—and so does his physician—that the Medicredit program will give him a great deal of help. But both also know that he must pay a certain amount before receiving its benefits. So he will not unnecessarily go to a physician "just because it's paid for." Or enter a hospital "just because it's more convenient."

There are deductibles (or co-insurance) in both the basic and catastrophic coverage, but it is important to note that those paid under basic coverage apply to the one required under catastrophic coverage.

Basic Coverage
Under the basic coverage portion of Medicredit's approved programs, there are three deductibles:

1. The patient pays $50 per stay in the hospital as an inpatient.
2. The patient pays 20% of the first $500 of expenses for outpatient or emergency care (maximum of $100) in a 12-month period.
3. The patient pays 20% of the first $500 of expenses for medical care services (maximum of $100) in a 12-month period.

For example, a mother takes her child to the eye doctor. The charge for the office call is $10. Basic coverage pays $8 and the mother is billed for only $2. If a visit to a hospital emergency room cost $27, basic coverage would pay $21.60 and the patient would be billed for $5.40.

All money spent by the patient on any or all of the basic coverage deductibles then applies to satisfying the deductible "corridor" explained in the next section.

Catastrophic Coverage: Persons who need the additional help of catastrophic hospital or extended care facility coverage are required to satisfy a deductible "corri or" of expenses after basic coverage runs out before the catastrophic coverage begins.

(Deductibles under basic coverage are for each person; the catastrophic "corridor" applies to the entire family.)

The size of the corridor depends on the financial condition of the family. The corridor is based on taxable income—the amount left over on the income tax form after all deductions and personal exemptions have been taken. The corridor is computed as follows:

1. 10% of the first $4,000 of taxable income.
2. Plus 15% of the next $3,000 of taxable income.
3. Plus 20% of any additional amount of taxable income.
4. Minus any amounts spent on deductibles under basic coverage.

A low-income family would have no taxable income, so it would have no corridor. As a family's taxable income rose, the corridor also would rise. The family of four in the earlier example, making $6,100 a year and taking standard deductions, would have taxable income of about $2,900. That is within the first $4,000, so the corridor would be 10% of $2,900, or $290.

If the patient had spent the $50 deductible for an inpatient hospital stay, the corridor would be reduced to $240 before catastrophic coverage would begin paying additional expenses. If another $75 deductible for medical service had also been paid under basic coverage, the corridor would be only $165 (the $290 minus $50 for one deductible and minus $75 for the other).

CONCLUSION: SOME COMPANION PROGRAMS

Medicredit was designed to solve the most immediate and most obvious problem relating to medical and health care: making it possible for everyone to seek the attention he needs without regard to his ability to pay.

The program was deliberately limited to that function so it would not become bogged down in details.

However, through the AMA and many others with whom it is consulting, a package of companion programs is now in preparation to help the medical profession, its allies, the government and the people of the nation solve jointly many of the other health-oriented problems facing our nation.

Those programs will deal with such longer-range problems as the quality of medical and health care, the most efficient utilization of medical and health personnel, the need for additional manpower, the distribution of manpower, the cost of providing care and the need for custodial and home care for the elderly and disabled.

Senator ANDERSON. Mr. Cohelan. Nice to see you again.

STATEMENT OF JEFFERY COHELAN, EXECUTIVE DIRECTOR, GROUP HEALTH ASSOCIATION OF AMERICA, INC., ACCOMPANIED BY H. FRANK NEWMAN, M.D., DIRECTOR AND CHIEF ADMINISTRATOR, GROUP HEALTH COOPERATIVE, PUGET SOUND, WASH., AND FIRST VICE-PRESIDENT, GHAA; W. PALMER DEARING, M.D., MEDICAL CONSULTANT, GHAA; AND JAMES DOHERTY, ESQ., LEGISLATIVE REPRESENTATION, GHAA

Mr. COHELAN. Mr. Chairman, members of the committee, my name is Jeffery Cohelan. I am Executive Director of the Group Health Association of America, Inc., a non-profit organization dedicated to improving the quality, availability and efficiency of health care.

To achieve this, GHAA works especially for the expansion and creation of group practice pre-payment plans. These plans are organizations of medical groups and consumers which provide comprehensive health services directly to the individual member pursuant to a pre-paid arrangement.

GHAA represents all the community-wide, consumer oriented prepaid group health plans now existing in the Nation. In addition its membership includes about 100 labor-sponsored prepaid group practice health plans. These affiliates of GHAA provide comprehensive health care and maintenance for almost 8 million Americans. While the method of delivery of health care and health maintenance can vary from plan to plan, GHAA affiliates have a common characteristic: we furnish a comprehensive set of medical services to our subscribers based on a premium determined in advance.

Our thrust is to furnish services and—unlike insurance plans—not merely the payment of expenses for health care.

We of GHAA take the responsibility of not only providing this wide range of health services to our subscribers, running the gamut of prevention, diagnosis, treatment and rehabilitation, but also providing those services in the most efficient and economically sound manner, that is, through a group of physicians and allied health personnel working as a team to assure the member that he will receive as fully as possible one-stop service.

With me here today, Mr. Chairman and Senators, is H. Frank Newman, M.D., director and chief administrator of the Group Health Cooperative of Puget Sound, one of our affiliates, and among the Nation's most successful and growing prepaid group practice delivery systems in the Nation. Dr. Newman is also first vice president of GHAA. I am sure that whatever Dr. Newman is called upon to contribute to these committee proceedings will be of great interest and value to you.

Also, sir, with me is my colleague and medical consultant, the distinguished Dr. Palmer Dearing, former Deputy Surgeon General.

Mr. Chairman, the present crisis in this Nation's health care system already has been well documented, so I will not seek to amplify that point at this time.

As stated, these hearings are concerned with "the broad considerations involved" in the various national health insurance proposals sub-

mitted for congressional consideration, leaving the specific details and technical aspects of these proposals for later hearings. Examination of these broad considerations is, we believe, a most important beginning.

Health maintenance organizations: It is noteworthy that the majority of the national health insurance proposals submitted to the Congress so far embrace, in one form or another, the concept of health maintenance organizations. As a result of this new found and warm embrace, the concept of health maintenance organizations, while not new, has become highly popular in discussions of solutions to our health care problems.

This concept, as most Senators here know, is not new. In large part the idea grew out of the successful experience of plans which are now affiliated with the Group Health Association of America. While the HMO concept encompasses a variety of plans with a variety of specific delivery systems different from ours, we believe that our record solidly demonstrates their advantages not only over traditional modes of health care delivery, but also over other HMO systems.

The Harvard Law Review, in its February 1971 issue, contains an article titled, "The Role of Prepaid Group Practice in Relieving the Medical Care Crisis." This article declares that "The data are fairly consistent in indicating that prepaid group practice plans have been able to supply care for substantially less dollar outlay than the predominant fee-for-service system." It cites the example of the Group Health Cooperative of Puget Sound as delivering "a fairly comprehensive package of services for approximately two-thirds of the cost of a similar package in this Nation." This is not an exceptional phenomenon among prepaid group practice plans.

In the area of hospitalization—perhaps the most steeply rising and the most costly element of health care bills for Americans—the Harvard Law Review notes that savings through prepaid group practice plans are "particularly evident." Measuring annual hospital days per 1,000 persons covered, those under prepaid group practice plans in six major areas of the country were hospitalized about half as much as those covered by other forms of insurance.

In addition, savings from hospitalization were accompanied by a lower rate of surgery in prepaid group practice plans: in 1966, among Federal employees, "those in prepaid group practice plans had half as many appendectomies as those in the fee-for-service system; they had one-fourth as many tonsillectomies and adenoidectomies—and even more important, they had half as many female surgeries."

Undoubtedly, these fine figures, Mr. Chairman, are attributed, in part at least, to the successful operation of the peer review program inherent in prepaid group practice plans (HMO's). Parenthetically, we would hope that where such peer review mechanisms are effective they will be preserved in a fashion where unsympathetic groups will not be in a position to review efficiency. In short, we should guard against placing "the fox in charge of the hen house."

Therefore, based on our rather broad experience in the field of prepaid group practice plans, we feel it important and helpful to this committee to express our views on what constitutes an HMO. This is in the interest of expanding medical care in a way which will contribute to resolving the health care problems of this Nation.

Health maintenance organizations can have a variety of forms, names, and sponsors. The concept, and this is one of its strengths, has

great flexibility. To be true health maintenance organizations, in our view, they should be based on the following four principles: (1) A health maintenance organization is an organized system of health care which accepts the responsibility to assure the delivery of; (2) an agreed set of comprehensive health maintenance and treatment services for; (3) a voluntarily enrolled group of persons in a geographic area; and (4) is reimbursed through a prenegotiated and fixed periodic payment made by or on behalf of each person or family unit enrolled in the plan.

In short, there is much more to the establishment and operation of a health maintenance organization than just setting up shop and calling yourself an HMO.

If we are to reap the benefits which the HMO concept offers to combating the health care crisis, we must be careful that we do not let our enthusiasm run ahead of what steps and what precautions must be taken to assure the sound and successful establishment of such organizations.

There are dangers, Mr. Chairman and members of the committee. They must be recognized and understood. There are limitations on what an HMO can accomplish. There are qualifications that an HMO must meet. They again should be recognized and understood.

A more careful definition of the foundations on which an HMO must rest provides some key to the elements which must be incorporated in such a system. The system must be organized so that it is capable of bringing together directly, or arranging for, the services of physicians and other health personnel with the services of inpatient and outpatient facilities for prevention, acute, and other care, along with other health services that a defined population would reasonably require. Organization of the system must be such that it affords the enrollee the most efficient and effective entry into the health care system. It must also provide for the continuity of care for the enrolled population without regard to race, creed, age, or income level.

The HMO must be capable of arranging for the provision of the health services that a defined population might require, including primary care, emergency care, acute inpatient and outpatient care, and rehabilitation for the chronic and disabling conditions. A cornerstone of the HMO is primary care, which emphasizes those services aimed at preventing the onset of illness or disability, the maintenance of good health, and the continuing evaluation and management of early complaints, symptoms, problems, and the chronic intractable aspects of disease.

The set of services offered by the HMO should come out of the agreement between the organization and the consumer as to which services will be provided by the HMO in return for the prepayment figure.

The enrolled group includes those individuals or group of people who voluntarily, and I emphasize that, join the HMO through a contract arrangement in which the enrollee agrees to pay a fixed monthly or periodic payment to the HMO. The enrollee will use the HMO as his principal source of health care.

ESTABLISHING AN HMO

Inherent in this description of the basic features of the HMO are the steps which must be taken to establish such a system on a solid and

successful footing. For example: Before it can be determined what services can and should be supplied, studies of the particular area must be taken. Where will the members come from? What are their needs? What are the resources available which can be used to fulfill those needs? What resources must be provided?

Initial capital to set up the HMO must be raised. Undercapitalization is also a serious pitfall. Recent efforts toward establishing and expanding existing HMO's sadly demonstrate that a lack of seed money and initial capital is a primary barrier.

Members must be enrolled. These can be individuals, union groups, employers and other defined groups; there must be money to pay adequate premiums to pay for comprehensive services.

The doctors who will comprise the medical group which will provide the services to be offered by the HMO must be recruited.

The facilities necessary for the delivery of health care services must be obtained. Hospital participation and staffing must be arranged. Outpatient facilities must be arranged. If the HMO contemplates construction of its own hospital or other facilities, there is then the problem of land acquisition and construction.

These are some of the elements that must be considered in the establishment of a viable health maintenance organization. These are elements that attest to the fact that HMO's cannot become, nor are they intended to become, overnight realities.

Because of its success, the health maintenance organization concept can—in whatever form it assumes—seem deceptively simple. To draw this conclusion, and launch a full-steam program designed to proliferate HMO's as the cure-all for America's health care crisis as a result would be a most dangerous course. It must be kept in mind that the basic principles of the HMO concept came out of the experience over many years of operation by existing HMO's. The concept, the principles, and the requirements came through time—consuming trial and sometimes error. Foreseen and unforeseen barriers were confronted and overcome. What services could be offered to meet the needs of the HMO enrollees are constantly being studied, evaluated, expanded and revised.

HMO GUIDELINES

Out of the sum total of experience of the HMO's now successfully operating has come the recognition that not only must certain basic principles be adhered to, but there are certain guidelines that must be followed.

We believe that the establishment of guidelines is a prime necessity in any program seeking to foster the creation of new and the expansion of existing health maintenance organizations. These guidelines must seek to bring order out of the present fragmented system of health care delivery by providing protection against such abuses as over-hospitalization, unnecessary surgery; by assuring the health care recipient that he will receive the fullest possible value in services received for his health care dollar; by reducing the duplication of services and treatment which adds to the declining value of the health dollar under the present chaotic system.

If the term guidelines has a connotation of a repressive authority issuing "thou shalt" and "thou shalt not" ultimata to the organizers

of HMO systems, it would be well for these organizers to regard them as safeguards designed to assure the successful operation of the HMO, the protection of the doctors involved in the operation of the HMO, and the protection of the members enrolled in the HMO.

Some of the safeguards worthy of close consideration in setting the framework for the establishment of HMO's are:

The system should provide all those health services which a defined population might reasonably require to be maintained in good health, including emergency care, inpatient hospital and physician care, ambulatory physician care, and outpatient preventive medical services. The full range of these services should be available to the HMO enrollee; he should not be passed from doctor to doctor, from office to office, for X-rays, for surgery, for therapy and the like. His payment to the HMO assures the enrollee that these and other needed medical services will be readily available in a single place in most cases.

Health care services provided by the HMO must be responsive to the health needs of the members. Examination of the range of services provided should be continuous with an eye to expanding the availability of these services. Greater sophistication on the part of the enrollees as to the use of services available can lead to a greater utilization of some services, necessitating increased capabilities by the HMO in adjusting to these demands.

Enrollment in the HMO must be available to all members of the community, that is, the defined population. Community rating, as opposed to experience rating systems traditional in the insurance industry, must be practiced. Such broader based rating prevents fragmentation of the community into good and poor health risks, resulting in higher premiums for the poor risk.

The minimum size and thus final stability of the HMO ought to be carefully considered. Present assessments of minimum size necessary to support such systems range from an enrollment of 10,000 to 50,000. Characteristics of geography, size of the facilities, and population should be examined to determine this minimum size.

Beneficiaries of HMO services must have full information as to what these services are and how to use them. Lack of the proper information could lead to underutilization of the HMO's full capabilities with the risk of lowering the quality of health care received by the enrollee.

Emergency services must be provided on a complete and continuous basis, not on a 9-to-5 clinical basis. Some HMO's will find this emergency service a most important point of entry to the system until the enrollees become fully educated as to how they can best utilize the system to insure proper health care for themselves and their families.

The availability of services must be continuous for the HMO enrollee. The organization is responsible, as long as the person is in the plan, for the health care of that individual. There can be no shirking of that responsibility on the basis of income, age, or deprivation of benefits through devices such as scheduling appointments at inconvenient times or delaying unduly the scheduling of elective surgery or other treatment.

Incentives for the full utilization of HMO services and facilities must be offered not only for the enrollees seeking more complete and efficient health care but also for the doctors and other personnel involved in the delivery of high-quality health care.

A major incentive for the enrollee would be the assurance that the savings realized by the HMO would, in substantial part, be translated into increased benefits or some other endeavor designed to enhance the efficiency of the organization and its capabilities of health care delivery. Incentives for the doctors and other health personnel to devote most, if not all of their efforts to the delivery of health care through the HMO system would include stability of income and hours, relief from administrative and managerial burdens which accompany solo practice, protection from the constant threat of malpractice suits, more complete use of specialties and talents, and regular opportunities for study in their specialties.

Use of part-time physicians by the HMO's should be carefully assessed, as overuse of this practice can substantially affect the quality of services offered. As part-time doctors divide their practices, they tend to divide their loyalties. There is the danger that when they can add significantly to their income by spending more time with their private patients than with group patients, a decline in the quality of care for the group practice enrollees is likely.

HMO's must be responsive to the demands and needs of their members. This responsiveness can be in a direct manner, such as allowing for consumer participation in the management of the HMO, or a closely related manner such as constant evaluation of complaints, or surveys of enrollees to determine whether the HMO is adequately fulfilling their needs.

Mr. Chairman and distinguished members of this committee, the precautions regarding the establishment of health maintenance organizations which we have brought to your attention today may seem to many to be an effort to make the task far more complicated than it should be. I have no doubt that we may even be accused of seeking to corner the HMO market for ourselves.

But, of course, we want to see the increase of prepaid group practice health plans across the Nation. We are advocates. But HMO's, no matter what form they may take, will assume an increasing importance in the health delivery systems of the future.

The experience of the prepaid group practice plans will be of invaluable assistance as we deal with new and everchanging challenges. What we say is that if we will treat the HMO concept with the proper understanding and carry it forward with proper caution and the proper safeguards, we can fully realize the tremendous potential health maintenance organizations offer the American public.

Thank you, Mr. Chairman.

The CHAIRMAN (now presiding). Thank you very much.

Senator Anderson?

Senator ANDERSON. No questions.

The CHAIRMAN. Senator Jordan?

Senator JORDAN. Just one question.

Under HMO's you are able to get by with about half the hospitalization and one-half or one-fourth the number of operations, and so on. Do you have a group that is chosen selectively in better health than the average person? If you do not you are neglecting some of them or else the people are getting over-serviced under the fee system? Which would you say is right?

Mr. COHELAN. Well, Senator Jordan, Dr. Newman is here and as medical director of one of our operating plans, and I would like to have him respond to that point.

Dr. NEWMAN. Senator Jordan, our program is almost a cross-section, very typical cross-section of the Seattle community. Our age distribution, sex distribution is almost identical to the King County community in general. And I think what we are doing here is we are actually providing more outpatient services than the average patient in the United States receives. But we are providing fewer hospital days. We are only putting patients in the hospital and utilizing the hospital when it is really necessary for the patient to go to the hospital.

We are not putting him in the hospital simply because that is where he gets the best coverage. Actually the coverage under our plan, although it is very comprehensive, provides 180 days of hospitalization for each illness or condition. Under the outpatient coverage, there are no limits whatsoever. So if it is possible to do diagnostic work, work up some tests on an outpatient basis, no reason to hospitalize the patient, that is where the testing is done. Yet if the patient really needs to go into the hospital, we are going to put him there.

Now, I think there are in certain instances abuses in conventional practice, particularly in the area of surgery. The only real solution to an acute attack of appendicitis is removal of the appendix. It is possible to treat it with antibiotics, but the best way to treat an acute appendicitis is to remove the appendix.

Now, we have approximately the same incidence of acute appendicitis in our plan that you have in the city of Seattle in general. So we remove the appendix when there is actually acute appendicitis. We have no reason to remove it for any other reason.

I think in areas of female surgery, this is even more graphic. Removal of the uterus is many times done unfortunately in the community when it isn't necessary to remove the uterus. We don't have any incentive to do that in our plan. If the doctor is getting no more pay because he removes a uterus than if he doesn't remove the uterus, he does what he feels is medically indicated.

Now, the big saving in the plan is in the hospital utilization per se because our costs are very similar. I have a chart here which I brought along with me and I will be glad to send copies of this to the committee.

Mr. COHELAN. Mr. Chairman, I would ask consent that we supply this for the record.

The CHAIRMAN. Without objection.

(The material referred to follows:)

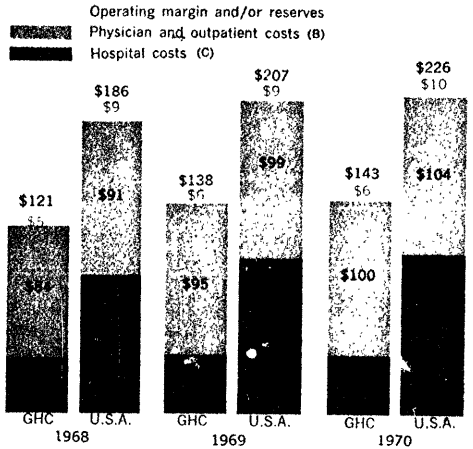
Cost and Utilization Statistics

Hospital admissions during 1970 totaled 11,122 (85.5 per 1,000 enrollees), up from 1969 total of 10,156.

Hospitalization days per thousand enrollees were 420 days in 1970; total hospital days 54,589.

ANNUAL PER CAPITA COSTS OF SELECTED HEALTH SERVICES

Group Health Cooperative compared to U.S. average, 1968-1970 (A)

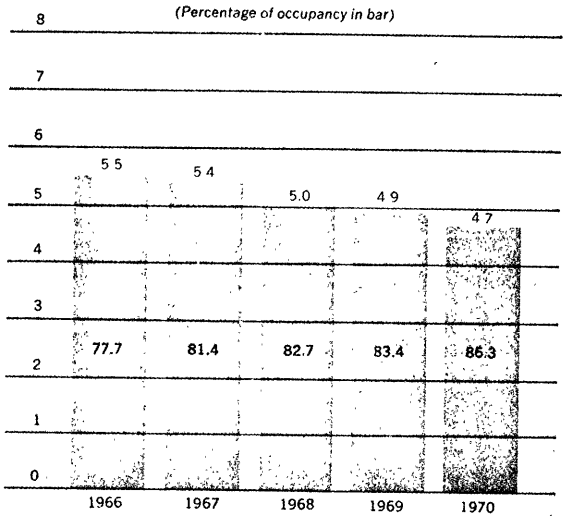


(A) Excludes dental, nursing home, eyeglasses, construction, research and public health costs.
(B) Includes visiting nurses, physicians-office expenses and outpatient lab, X-ray and drug costs.
(C) U.S. data excludes operational costs of psychiatric, tuberculosis and other long term hospitals.

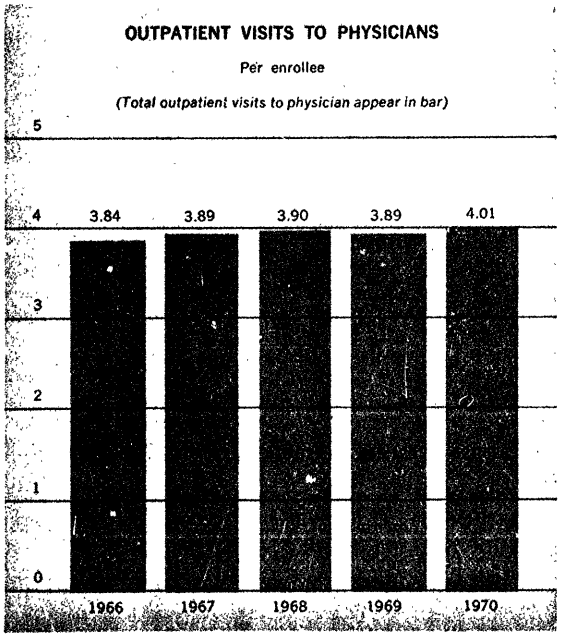
Annual per capita costs of GHC Health care delivery are significantly lower than U. S. average.

HOSPITALIZATION

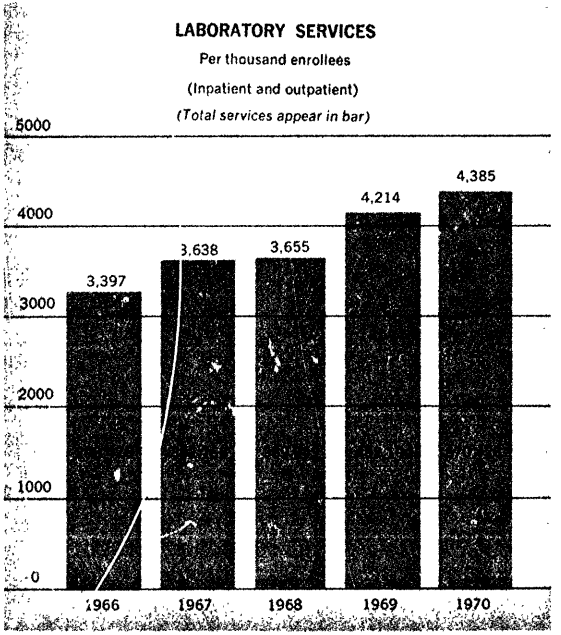
Length of stay
Per discharge
(Percentage of occupancy in bar)



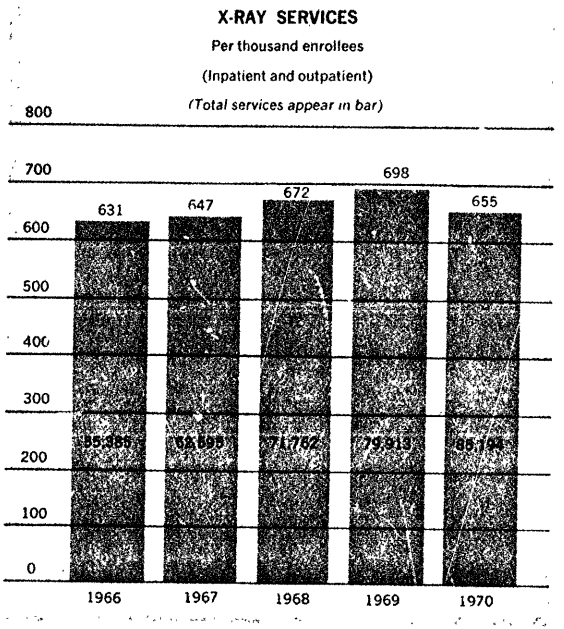
GHC Hospital during 1970 operated at 86.3% capacity occupancy rate. Patients treated and discharged averaged 4.7 days in hospital.



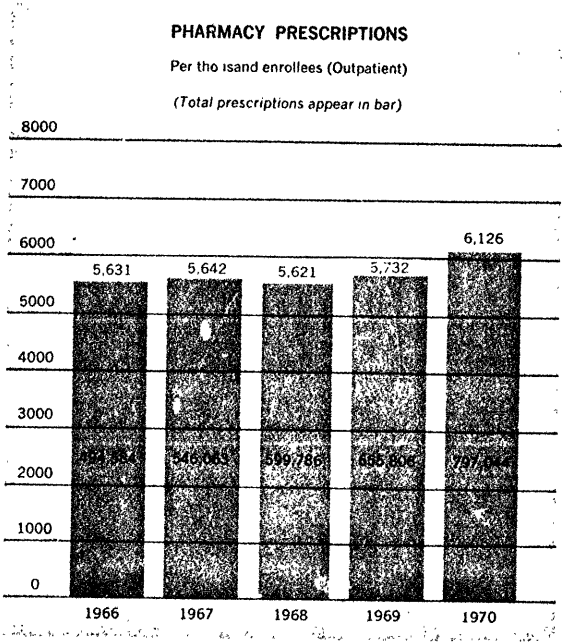
There were 521,626 visits to physicians by GHC enrollees; rate per enrollee 4.01.



GHC laboratory services totaled 570,428 during 1970, that amounts to 4,385 lab services per thousand enrollees.



Enrollees during 1970 received 85,194 X-ray services, at rate of 655 per thousand.



GHC pharmacies handled 797,044 prescriptions during 1970; 6,126 per thousand enrollees.

Dr. NEWMAN. This shows some costs which we have abstracted from the best data we can get from the Federal Government on the average cost of medical care in the United States. We found in the year 1970 that it cost the average patient in the United States, the average citizen in the United States, about $226 for his medical care. We have tried to exclude the types of services and benefits that we do not provide from that figure, so it is a figure that has had to be refined somewhat.

In our program it costs our average individual $143 for his medical care. Now, it costs us $100 to provide outpatient services in our plan.

It cost $104 in the United States as a whole. So there is little saving in our plan as far as outpatient services are concerned. In fact, our patients would probably go to the doctor more than the average patient in the United States. But the tremendous saving is in hospital costs. Whereas it costs the average consumer in the United States $112, it costs the consumer under our plan $37, and we are in a high cost area. Labor costs in the Seattle area are quite high.

Senator JORDAN. Thank you.

Senator BENNETT. I have a question, Mr. Chairman, suggested by the staff, and for the record, do you provide an annual physical to every member of your HMO?

Dr. NEWMAN. We have full coverage for physical examinations. We don't necessarily advocate an annual physical on every member of our organization because in some individuals this would be just a considerable waste of the patient's and the doctor's time. But if the patient comes in and wants a physical examination, we provide it without any cost whatsoever.

Senator BENNETT. What would happen to your fees if your program required an annual physical of every member of your group?

Dr. NEWMAN. They would have to go up. The average citizen of the United States is not getting an annual physical either.

Senator BENNETT. Have you made an estimate by how much you would have to raise your fee (premium) schedule if you added that to your service?

Dr. NEWMAN. Yes. I think that it probably would go up at least 25 percent, Senator Bennett. What we would like to do and what we have under study at the present time is certain methods of health screening that are productive in certain age groups, in respective sexes, males versus females, and certain people with certain occupations or certain habit patterns.

For example, an individual that smokes three or four packs of cigarettes a day has certainly things that need to be checked more often such as chest X-rays and things like that, than an individual who is a nonsmoker. People involved in the mining industry have certain occupational hazards. You should try to analyze your patients and try to adapt some form of health screening which meets his particular needs. Then we will get a productive health evaluation or health screening, if you want to call it that.

Just doing a routine physical which is routine and really isn't oriented to the specific patient's needs is not the proper way to go. So we think a lot can be done through adapting a screening program and studying a screening program and we have that under analysis now.

Many of our members do receive quite a comprehensive health evaluation at the time they join the plan. That is included in the plan for our so-called co-op member.

(The following was received by the committee relative to the preceding testimony:)

COOPERATIVE OF PUGET SOUND,
CENTRAL MEDICAL CENTER,
Seattle, Wash., May 3, 1971.

Senator WALLACE BENNETT,
Senate Office Building,
Washington, D.C.

DEAR SENATOR BENNETT: At the hearing on National Health Insurance on April 28, you indicated an interest in getting more information for the record on annual physical examinations.

First of all, may I say it was a real privilege and pleasure to testify before your committee with Mr. Jeff Cohalen of our national organization, Group Health Association of America, Inc. I hope you and your committee will find the information we provided valuable in your very important tasks.

The specific question that was asked was—"how much would it cost you, doctor, to have everyone in your plan get an annual physical examination?" I stated I did not have a definite figure in mind and I do not have an exact figure here in Seattle. It would be necessary to go through quite a few complicated calculations to arrive at such a figure. However, this could mean an extra 140,000 visits per year. A physical examination of any real value probably takes at least forty minutes of the doctor's time plus laboratory tests and x-ray examinations as indicated in the particular individual's case. 140,000 visits compared with 520,000 total visits for the year 1970 represents more than 25% of all of our physician visits in a year. Of course, such an examination might reduce the number of examinations otherwise requested by our membership thus I gave the figure of 25% as the increase in cost to the organization. This may be a little high since you don't have hospital costs involved in an annual physical examination, however, the real point that I wanted to make was the real burden it would place on the medical staff already burdened with care of sick people. That staff would have to be increased considerably and certainly facilities would have to be increased to accommodate that significant an increase in load.

The point I also tried to make during the committee hearing was that approaches to getting a better medical history, perhaps a medical history that can be self administered for the most part, and certain types of screening examinations oriented to the patient's age, sex, occupation and habits would be much more productive. A number of experiments are being done to determine which types of examinations and screening tests are best in various populations.

The value of the annual physical as a preventive measure is much overstated if the annual physical is performed on otherwise healthy individuals. Certainly important medical problems can be discovered, however, studies have shown that the discovery of "new disease" (disease not already known) is very low and certainly not significant enough to justify the tremendous expenses of the examination. I believe this statement has been borne out in the studies that were done for a number of years in Framingham, Massachusetts and refer you to those studies.

I hope this additional information will be of value to you and if you wish it may be included in the record along with my statement before the committee.

Sincerely,

HAROLD F. NEWMAN, M.D.
Director.

Senator BENNETT. I am sure you are not in a position to answer this next question and we mustn't take your time or the committee's time. But I am intrigued by the basis for Senator Jordan's question, and apparently your statement quotes from the Harvard Law Review article in which it says: "1966, among Federal employees, those in prepaid group practice plans had half as many appendectomies as those in fee-for-service systems," and then it goes on and lists other operations.

I don't know what is behind the Harvard Law Review data and it would be interesting if you could supply for this committee an answer to this question. Is it due to the fact that this is a limited area, Federal employees? Is it due to the fact that there are many Federal employees who either live in areas or selectively choose not to become members of HMO's? In other words, is there a statistical phenomenon in here other than the incidence of the disease which might throw these figures out of balance?

Dr. NEWMAN. Well, maybe Dr. Dearing and I both can attempt to answer that. But one of the reasons I think the Law Review might have selected that Federal experience is to try to get around any type of favorable selection that organizations such as our own might have.

In the city of Seattle, for example, the Federal employee has five health care plans to choose from. Ours is one of them. And we get the people as they come in and they have enrollment periods, limited enrollment periods, during which to enroll. This is all specified by Federal law, and we cannot believe that our selection is that much different than any of the other programs. If anything, because our program is the most comprehensive one offered, it might be an adverse selection against us, so we think for that reason——

Senator BENNETT. But there may be areas where there are no HMO's?

Dr. NEWMAN. Yes.

Senator BENNETT. Federal employees have to get medical attention. So I don't think you can take the city of Seattle alone and say this is typical. I am trying to figure out whether there is any additional statistical factor to create what to me is an amazing statement. I cannot believe that in general members of HMO's have half as much the need for appendectomies just because they are members of HMO's.

Mr. COHELAN. Dr. Dearing, would you like to respond?

Dr. DEARNG. Senator, these Harvard Law Review data are based on the studies that we have made periodically of the Federal employee experience nationwide, and one of the reasons we think is because this is the largest and most comprehensive body of data available. And we are just as intrigued and desirous of finding out precisely why these differences occur, and are continuing to work on this question.

We have inquired with regard to geographic differences—is there a bias because of the very large Kaiser population in the West? Is it different in the East?

Well, in analyzing the geographic areas around GHA, Washington, D.C., HIP in New York, Community Health in Detroit, Puget Sound, and California, we find in each case the difference between the HMO, the group practice plan, and the other population, persists. We looked at the age, and taking annuitants, the employee himself, and his dependents, it gives you three different age groups, and we find the differences in the hospitalization use persist consistently.

We are checking it every way we can with the methods available. There is right now in process, funded by the Department of HEW, a joint study by the Blue Cross and Group Health Association of Washington, D.C., taking a matched population that have had hospitalization and also taking some individuals with a selected series of diagnoses that are enrolled in Blue Cross and enrolled in Group Health, and to study what happened to them and why.

So we are pursuing this as systematically as possible and are well aware of the possibilities of underutilization, people not getting what they need, in one or the other.

The only thing that we can say in addition to the fact that these things hold up in every way that we have been able to test them so far, is that the trend of the population in the Federal program has been gradually toward the HMO's. Group practice plans have grown rather slowly but steadily in the proportion of the Federal employees that elect these plans.

Now, as you say, there are many places in the country where they are not available, but where they are available they have tended to grow and this is some indication at least, a measure that the consumer believes he is getting satisfactory care there. He doesn't believe he is getting skimped or he wouldn't persuade his friends to move across from their other coverage into the group practice plan.

And we will be glad to submit these data on 1966 and also some later studies of this nature if the committee should wish it for the record of this morning.

Senator BENNETT. Well, if you extrapolate that the other way, this would indicate that those who are providing services outside of HMO's are providing twice as many services as are necessary.

(The supplemental information follows. Oral testimony continues on p. 249.)

Analysis of the Federal Employees Health Benefits Program experience in the United States reveals these economies and suggests some basis for them. The Federal Employees Program is the largest employee sponsored voluntary health benefits program in the World (7,816,965 persons on June 30, 1968). The program is administered by the United States Civil Service Commission, the personnel management organization o fthe U.S. Government. The Commission sets standards of benefits and administration, periodically reviews rates and benefits experience, and approves carriers for participation.

The Program, established by act of Congress, started in 1959, and offers Federal employees, retirees (annuitants) and their dependents a choice among a number of insurance and group practice health benefits coverages. The law required that two options be available government-wide—a so called service benefit plan offered by the Blue Cross/Blue Shield, and an indemnity benefit plan offered by Aetna Life and Casualty Company as agent for a consortium of insurance companies. The Act provided also for group practice plans and Federal Employee Organization plans (which had been created by various Federal employee organizations to serve their membership before the Government program was created) to participate.

Employees have three months after entering government employment in which to elect type of coverage (self, or self and family; high or low option benefits) and carrier-group practice, indemnity, employee benefit plan, etc. Thereafter, they may change coverage and carrier only in "open seasons" declared by the Commission at intervals varying from one up to three years.

For the calendar year 1970, there were thirteen approved for participation in the Government program, counting the six Kaiser Regions as individual plans. Individuals enrolled in group practice plans under the Federal program numbered approximately 300,000 in 1968, or 4.6 percent of the total. Analysis of the use of services and costs reported periodically to the Civil Service Commission, supplemented by some additional information supplied by Blue Cross/BlueShield permits comparisons of group practice services with those provided under the reimbursement system.

George S. Perrott, Consultant to Group Health Association of America, has made these analyses periodically since the Federal program began in 1959, and first reported the results at the American Public Health Association meeting in 1964 (APHA Journal Reference, January, 1966). His analyses of subsequent terms have confirmed and refined the conclusions from the early experience, and are the principal body of data which has sparked today's

widespread interest in prepaid group practice as a health services delivery system.

The report by Perrott and Chase on FEHB Sixth Term Coverage and Utilization,* highlights the differences between health service benefits provided by prepaid group practice plans and those received under the indemnity reimbursement system.

Table I shows that both numbers of persons using hospitalization and days of hospitalization used per 1,000 covered persons were half or less for group practice plans than for the Blue Cross/Blue Shield, Aetna, and the Employee Organization plans. Of the 298,000 group practice plan enrollees, 46 per 1,000 were hospitalized, compared with the two government-wide indemnity reimbursement plans.

TABLE I.—HEALTH BENEFITS REPORT FOR CONTRACT TERM JAN. 1–DEC. 31, 1966, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM—SELECTED DATA AND CALCULATED UTILIZATION RATES

[I. Non-maternity in-patient hospitalization, a. Total, both options]

	Average number covered (thousands)	Number		Annual rate per 1,000		Days per utilizer
		Utilizers (thousands)	Days (thousands)	Utilizers	Days	
All plans	7,149.0	654.7	6,006.5	92	840	9.2
Blue Cross-Blue Shield	4,068.0	397.7	3,565.7	98	876	9.0
Indemnity benefit plan	1,464.8	124.0	1,294.3	85	884	10.4
Employees organization plan	1,185.9	109.9	958.9	93	808	8.7
Individual practice plans	132.5	9.4	66.1	71	499	7.0
Group practice plans	297.8	13.7	121.5	46	408	8.9

The consistency of the trends in three separate years Figure 1 is striking; actually the hospital days per 1,000 covered persons in group practice plans dropped from 460 in 1962 to 394 in 1967, while the Blue Cross/Blue Shield and indemnity hospital days climbed respectively from 882 to 914 and 760 to 945.

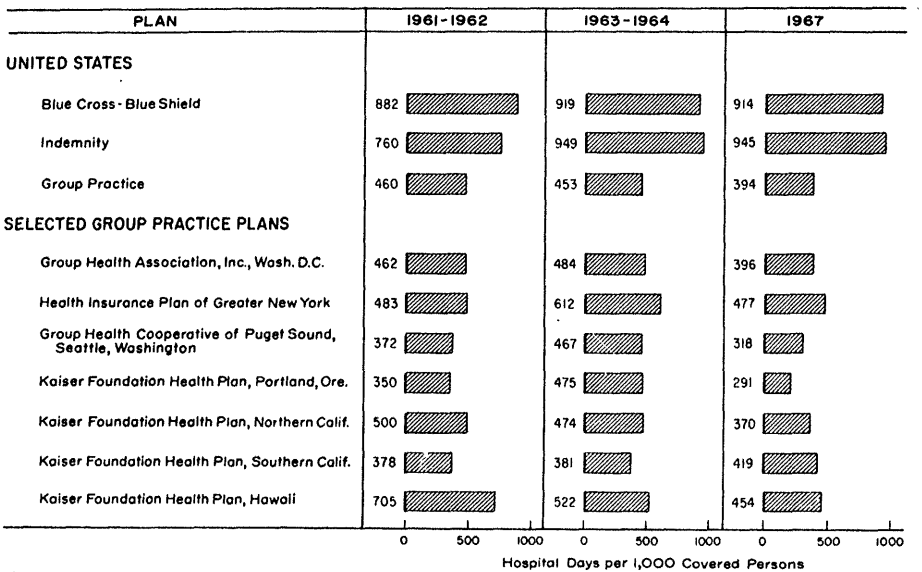
* Group Health & Welfare News, Special Supplement, Vol. IX, No. 10, October, 1968.

HOSPITAL - Three Specimen Years

Figure 1.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Experience for Three Contract Years - Comparing Individual Group Practice Plans
Non-maternity In-hospital Services, High Option



1/ Plans omitted with 200 or fewer persons receiving in-hospital benefits.
2/ Virginia and Maryland residents in the Washington Metropolitan area constitute nearly one-half of the membership of GHA

Figure 2

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM
Sixth Contract Year – January-December 1966
Comparing Hospital Utilization among Several States for Blue Cross, Individual, and Group Practice Plans
Non-maternity In-hospital Services, High Option

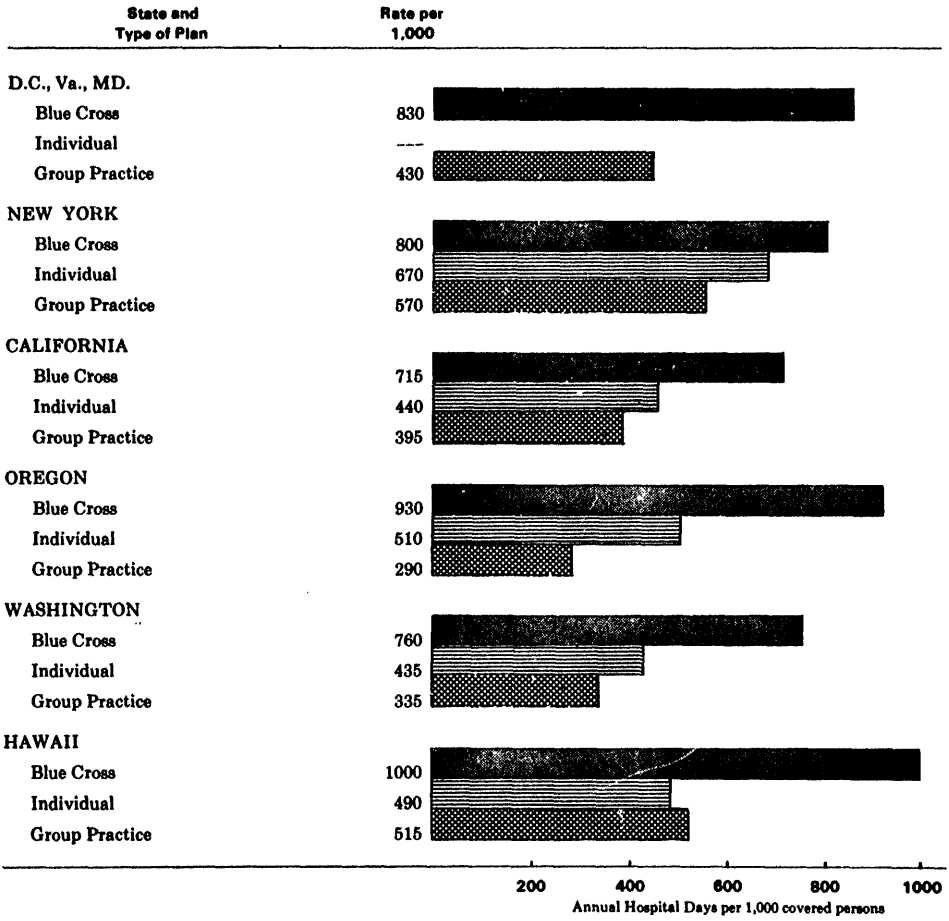
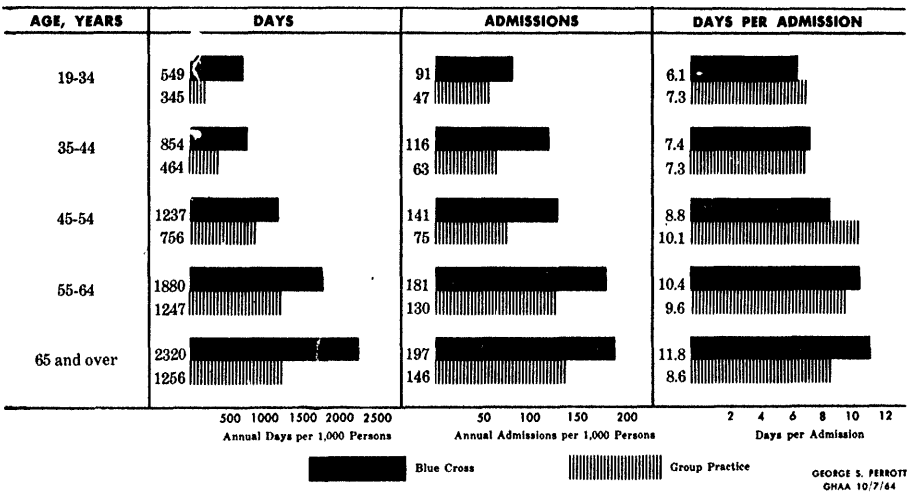


Figure 3

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

2nd Contract Year – November 1, 1961 – October 31, 1962

Comparing Hospital Utilization between Group Practice Prepayment and Blue Cross Plans Non-Maternity In-Hospital Services, Both Options Employees and Annuitants



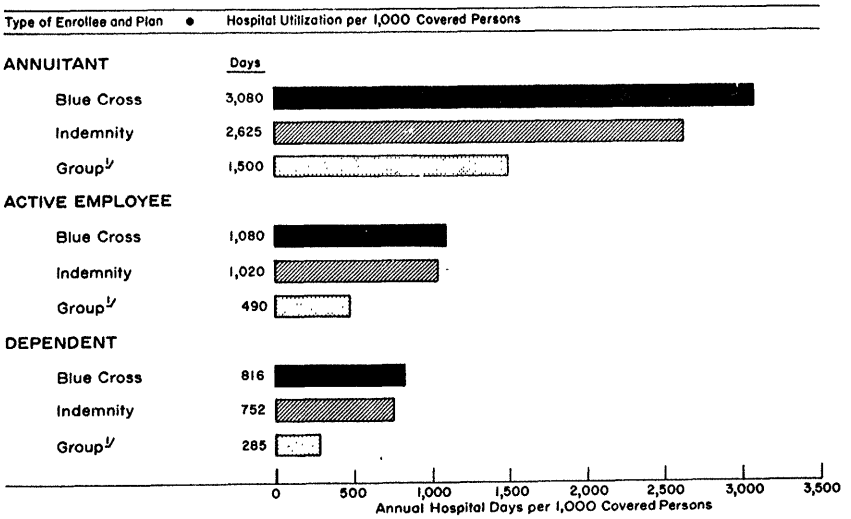
HOSPITAL by Enrollee Class

Figure 4.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Seventh Contract Year - January-December 1967

Comparing Hospitalization for Annuitants, Employees, and Dependents; Blue Cross, Indemnity, and Group Practice Plans Non-maternity In-hospital Services, High Option

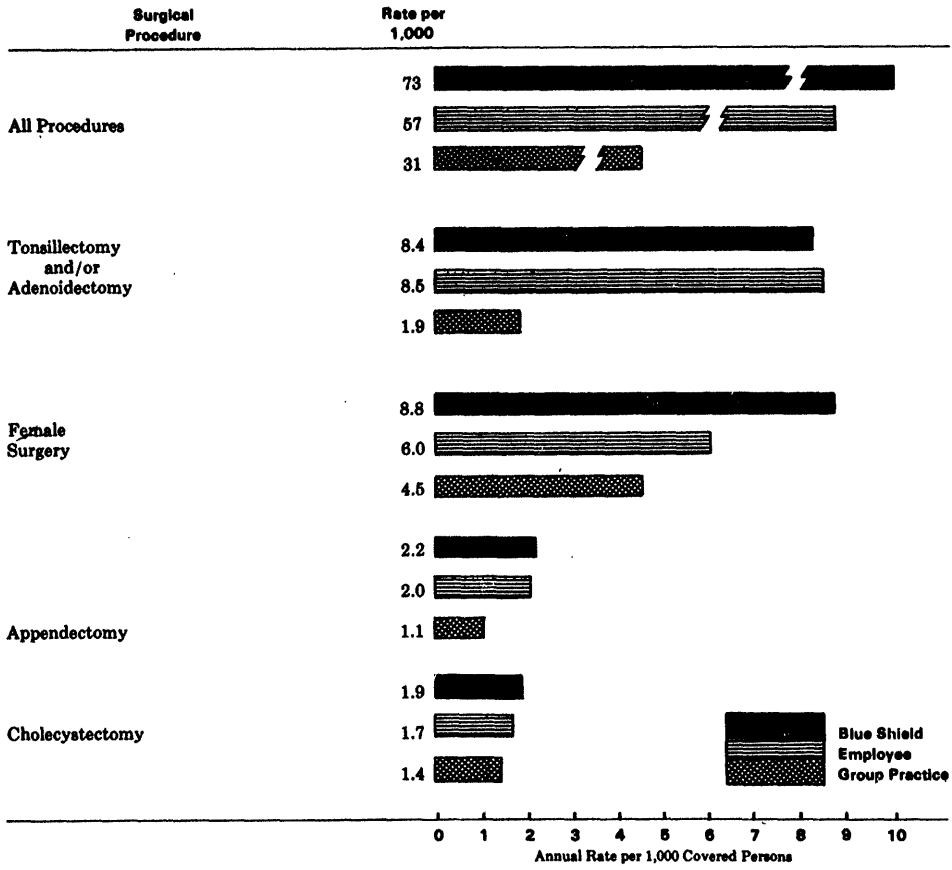


1/ Includes over 85 percent of group practice enrollment - The four Kaiser Foundation Health Plans in Northern and Southern California, Oregon and Hawaii; Group Health Cooperative, Puget Sound; Group Health Association, Inc., Washington, D.C.

SURGERY

Figure 5

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM
Sixth Contract Year—January-December 1966
Comparing Rate of Surgical Procedures for Blue Shield, Employee and Group Practice Plans
Non-Maternity In-Hospital Services, High Option



The statistical principal of consistency has also been repeatedly observed in testing the hypotheses that differences in population constitution or in medical practice customs in various parts of the country might account for these great differences in hospital use. Figure 2 shows that the difference is observed in each of six geographical regions of the U.S. ranging from New York to California. With respect to age constitution, Figure 3 shows that the difference appears at all ages, Figure 4 shows that the difference appears when the various types of persons covered in the Federal program—active employee, dependent, and annuitant—are segregated.

Perrott and Chase also present some analyses which shed additional light on the differences between group practice plans and insurance carriers. One of these is the striking differences between the large proportion of eligibles (over 80%) who received at least one covered service from the group practice and individual practice carriers, and the comparatively small portion (less than 30%) who received any covered service under the insurance plans (Table II).

TABLE II

Plan	Average number covered	Percent of covered persons receiving nonmaternity benefits, both options		Benefits per person receiving benefits	Annual benefits per covered person
		Any benefit	Inpatient hospital		
All Plans	7,149,000	28.9	9.2	$224	$65
Blue Cross-Blue Shield	4,068,000	25.3	9.8	252	64
Indemnity	1,464,800	22.5	8.5	301	68
Employee organization	1,185,900	29.8	9.3	214	63
Individual practice	132,500	81.4	7.1	74	60
Group practice	297,800	84.6	4.6	84	71

The fact that more than four-fifths of the group practice plan enrollees used covered services during the year, would help to explain the low hospitalization rate of only 4.6% for group practice plan enrollees, compared with an 8.5 to 9.8% hospitalization rate for the insurance enrollees, less than one-third of whom received any covered service. The higher use of services in the group practice plans could reduce the need for hospitalization.

The most dramatic feature of the analysis, however, is the reduced use of surgery in the group practice plans compared with Blue Shield and the Federal Employee Organization plans. The surgical rate for the 300,000 persons covered by group practice plans was less than half the rate for the 4 million Blue Shield enrollees—31 per thousand versus 73 per thousand, respectively (Chart 5). Perrott first reported this phenomenon in his second term (1961–62) analysis (reference above) but the spread is even greater for the sixth term.

Among specific procedures, tonsillectomy shows the greatest differences—the group practice plan rate was 1.9 per thousand, less than one-fourth the rates of 8.4 and 8.5 per thousand for Blue Shield and Employee plans. The appendectomy rate for group practice plans was one-half that of the insurance plan—1.1 per thousand compared with 2.2 and 2.0 for Blue Shield and Employee plans. For female surgery, the group practice rate was 4.5 per thousand, just over one-half of Blue Shield's 8.8 and three-quarters of Employee 6.0

This consistently lower use of surgery in group practice plans must be considered a major element in their reduced hospitalization requirements.

Mr. COHELAN. Well, there——

Senator BENNETT. Either that or there is bias in the sample.

Dr. DEARING. As Dr. Newman mentioned, how much is necessary is not really absolute. This matter of elective surgery, whether to operate or not, is judgmental and there is absolute standard—you can talk about preventive appendectomies, talk about taking an appendix out when a sailor is going out to sea; this is considered by some physicians to be justifiable, by others not to be. There is considerable left up to judgment—how long shall a patient stay in the hospital.

Senator BENNETT. I will close because we have still got two more witnesses and suggest to you an advertising slogan. Join the HMO's and cut your risk of having appendicitis.

Dr. NEWMAN. One problem with that, we don't advertise, Senator.

Senator JORDAN. One more question.

Do you reserve the right to reject any applicant who in your judgment would likely become a catastrophic case?

Mr. COHELAN. There are many different methods of admission but, of course, if a person comes in, in a group, the Kaiser organization, for example, the Kaiser Foundation health plan, Senator, has over 1,000 groups. They are usually negotiated through collective bargaining agreements and there, of course, is a choice because they insist they have a choice. Now, if they elect for the plan and they happen to have a predisposition for some sort of illness or some profile of illness, it is just too bad. They are in the group.

Now, Dr. Newman has a more specific example that I am sure he can cite with relation to his own loss.

Dr. NEWMAN. Well, as far as group participation or participation in group contracts, there is no screening of qualifications of whether you can join the plan or not. We take the same risk as all the other carriers take. We do have an individual program that is available to any family in the city of Seattle. For that program we do screen, because in our plan, for example, fully covers all outpatients' drugs. There is somewhat of an adverse selection as far as we are concerned by the people who apply, and so we do have to do a screening there.

However, if we could enroll the whole city of Seattle all at the same time and took just our risk along with every other carrier in the area, we could take the entire community and would take the entire community with its bad risks as a group at the moment.

Dr. DEARING. And the Federal program requires you take everybody who comes at the open season.

Dr. NEWMAN. That is correct.

Senator BENNETT. Thank you.

The CHAIRMAN. We will resume at 3 o'clock here.

(Whereupon, at 12:55 the hearing was adjourned, to reconvene at 3 p.m. this date.)

AFTERNOON SESSION

The CHAIRMAN. The hearing will come to order.

The next witness is Mr. John Horty, accompanied by Mr. Kenneth Williamson in behalf of the American Hospital Association.

STATEMENT OF JOHN HORTY, MEMBER, SPECIAL COMMITTEE ON THE PROVISION OF HEALTH SERVICES, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY KENNETH WILLIAMSON, DEPUTY DIRECTOR, AHA

Mr. HORTY. Mr. Chairman, I am John F. Horty, an attorney and president of Aspen Systems Corp. in Pittsburgh. I was a member of the American Hospital Association's special committee on the provision of health services. The association asked me to serve on that committee as a result of my background and experience in health law and because of my interest in the delivery of health services.

I appear here today in behalf of the association to discuss Ameriplan—the special committee's report—a report which proposes a radical reorganization of the Nation's health resources. With me is Kenneth Williamson, deputy director of the association and director of its Washington service bureau.

Every Member of the Congress has received a copy of Ameriplan. Therefore, we would like to comment on the essentials and on those aspects that differentiate it from other proposals that would affect the delivery of health care in the United States. We are presently well into the process of drafting a bill which will embody the recommendations of Ameriplan and which we hope to have for submission in the near future.

Ameriplan was proposed by a 15-member committee which included hospital administrators, three practicing physicians, hospital trustees, and attorneys, a committee whose members were extremely diverse in their philosophy as to the future direction of health care as well as diverse in background and experience. The committee met extensively for 14 months, studied numerous documents, and interviewed many leaders in the health field.

The resulting report is truly pragmatic. Describe the diversity of the committee's initial views and philosophy, the committee believes strongly that only through a radical restructuring of the health care delivery system is it possible to retain its best features and still accomplish the large task that faces us.

I believe that the unanimous adoption of the report by the committee, and the adoption of the principles by the association only 3 months after the committee's report was submitted, reflects the urgency which we feel this restructuring requires.

The basic recommendation in Ameriplan is that the delivery of health care be accomplished through a system of new organizations, called health care corporations. About 4,000 of these corporations would span the entire United States, providing comprehensive health care for all of the people who desire it.

Ameriplan is founded on a basic, irreducible principle: that health care is an inherent right of each individual and of all of the people of the United States.

The corollaries of this basic principle are that health services must be so organized and so located that they are readily accessible to all; that they be available without regard to race, creed, color, sex, age, or to any person's ability to pay; that they enhance the dignity of the individual and promote better community life; and that it is a function of government to assure that this occurs.

A system of health care corporations providing local control on the operating level, State supervision and uniform national standards is the best way to implement this basic principle and its corollaries attractively and equitably for all. Health care is extremely personal and local control is essential. At the same time there must be uniform controls and rate setting, and we have selected State government to accomplish this. And there must be national standards to secure care for all. In short, we propose a new system, not a bandaid to cover some specific ills of the present system.

Some may believe that our proposal is complicated, but the health field itself is inordinately complicated, and easy solutions do not exist

for providing health care. I should state strongly that Ameriplan is not a "hospital" proposal, and that health care corporations are not superhospitals.

Now, let me explain more carefully the organization we propose in Ameriplan.

The outline of Ameriplan shows how Ameriplan would restructure the health care delivery systems through health care corporations.

The basic thing to remember with respect to them, is that they are the method of delivering care at the local level. They would have to be sufficiently large in their resources to provide all five components of what we have considered to be comprehensive care. You may say there are six, or there are four, components. We have selected five.

These are health maintenance or preventive care, primary care, specialty care, restorative care, and health-related custodial care.

The network of health care corporations will cover all the geographic areas of each State. The chief point about them is that the entire State would be covered by such health care corporations and every person would have an opportunity to join such corporations, as a registrant, and he would have a choice of such corporations in the urban areas where more than one health care corporation might exist, and that the consumer, the registrant, would have a say in the management of the health care corporations.

The health care corporations would, in short, be corporations of providers of care, either providing that care directly or through contract with other agencies, or groups of physicians, or individual physicians.

On the State level there would be new agencies called State health commissions which would control quality, supervise the operations of these health care corporations, and set rates. They would be responsible for approving—you might call it franchising but we call is approving—health care corporations and for authorizing their operation. They would be responsible for seeing that all geographic areas are covered and that all people are served who desire to be served.

They would be responsible for assuring the quality and adequacy of service and, as I said before, they would be responsible for rate setting.

The National Health Board, which we propose as a new Federal agency would set national uniform standards of quality of care. It would establish the scope of benefits through regulations, and would establish standards of comprehensiveness of care and services. Finally, it would establish benefit packages.

I would like to spend a few minutes on how we feel Ameriplan, if put into operation, would benefit the public.

First, it would assure access to care for all.

Second, as many as the other proposals have stated, we would create continuity of care through ambulatory care centers and physicians' offices, interrelated health care institutions providing acute inpatient care, extended care, nursing home care, home-health care, and health-related custodial care.

We would assure an identical range of services of uniform quality for all and through the national standards, establish continuing programs of health maintenance.

We would assure continual availability of physicians' services.

We would also, through the health care corporations, require that one continuous personal health record for each health care corporation registrant be kept. We would assure round-the-clock emergency services and adequate emergency transportation.

We would maximize the effective use of components of care through transfer of patients from one facility to another within the Health Care Corporation as their need would be required from an acute hospital to an extended care facility, and so on.

We would provide counseling for the individual and the family on health and health-related programs.

We would provide educational programs in health for patients and the public and all of these would be within the ambit of responsibilities of the Health Care Corporation.

How would this kind of system affect physicians and other providers?

The first point is that our proposal quite clearly requires that a role be created for physicians in the management of Health Care Corporations, that they would have to assume, and we would hope would gladly assume, responsibility for the quality of care, the amount of service which is being provided, the kinds of services and costs as an integral component in the management of the Corporation and as a part of the management of the Board of Trustees.

We would encourage group and multispecialty practice of medicine, but that would not be essential. There would be some physicians who could contract with the Health Care Corporation to deliver services as individuals.

We would assure varied forms of service, varied forms of payment for services. Of course, no proposal such as what we envision can increase by itself the supply of health care personnel, but one of the purposes of the Health Care Corporation would be to provide inservice training and other training programs. It would be the responsibility of that agency to do so, recognizing that the educational system has a burden to bear in this area and all groups must work together.

Especially we are concerned with providing a system for continuing education and to create career ladders within Health Care Corporations so that people could progress from job to job as their qualifications increased and as their experience increased, and we hope without some of the impediments of licensure that now prevent people from moving from one role to another as their experience dictates.

We would afford an opportunity to all physicians in the community to participate in the Health Care Corporation, and, finally, we would create coordinated peer review extending to the physician's office.

I might add one other point that we would like to make with respect to the effects of Ameriplan on the public, and that is, that part of the requirements for health care corporations would be that in order to service the registrants they would have to create facilities in rural areas, and in urban ghettos as well, in order to bring care to people rather than standing, as some of our facilities do today, waiting for people to come to them.

How would we finance this? I would say at the outset that at present, pending the draft of the bill which we are costing out, we face the obvious problems with respect to the financing of any new proposal,

so that I do not have financing information at this time. This information will be submitted when the bill is submitted.

I would like to go over the general structure as we see it. We would provide health maintenance benefits for all and do this through general Federal revenues for the poor, and in part by general Federal revenues to the near poor, through a specific tax under the social security mechanism for all other persons, including the aged.

We would provide what we call a standard benefits package which will be basically what we consider as Blue Cross, Blue Shield and ordinary insurance at the present time.

Funding through general Federal revenues for the poor and again, in part, for the near poor, a specific tax collected through social security for the aged, and direct private payments to prepayment plans and private health insurance companies for those for whom the Government is not required to pay. In other words, basically, from the philosophical standpoint what we are saying is that we feel we have got to keep all of the money in the health care system in the system; that we cannot see at this time going to a total Federal program with the amount of the moneys that we feel it would cost.

So the idea is to trap, in effect, as much of the money as is present in the system and keep it there but to augment this for certain benefits by a new tax, and that would be a health maintenance benefit, and then a catastrophic illness benefit and, again, we would fund the catastrophic illness benefits through general Federal revenues for the poor and near poor and through the specific tax for all other persons, including the aged.

In effect, what we are proposing in new Federal benefits would be on two ends of the scale, health maintenance benefits and catastrophic benefits. The catastrophic benefits would take effect on a sliding income scale so the people who could afford to pay would have to pay up to the point where they became eligible for the Federal benefits.

Again, we do not have figures and I am not prepared to give them but what we are saying again philosophically is that those of us who can pay must pay, but at some point all of us should be relieved from the burden of catastrophic illness. That at least is the philosophy.

I should also indicate how Ameriplan is being presently implemented. We have, obviously, a considerable job of education to do within the hospital field itself and within the health field and we are moving to that task immediately. Meetings are being held with allied health organization and interested groups. We are having seminars with State hospital associations, discussions with regional advisory boards of the American Hospital Association.

The Committee of the American Hospital Association Board of Trustees is reviewing Ameriplan and, as we said, we are in fact moving forward to create research and developing programs for model Health Care Corporations.

I now note parenthetically that some of Health Care Corporations presently exist and I am not referring solely to the ones Kaiser has developed, but in other areas of the country directly within the structure of the American Hospital Association are now what we would consider to be in whole or in part operational Health Care Corporations. And, finally, Ameriplan is moving toward a program of public education and information in the planning stage.

I think that most of the other proposals for providing health care deal primarily with financing rather than tackling the major problems of how you deliver care. They seem only to emphasize the infusion of new money. Our committee believes that we cannot deliver better care merely by putting large sums of new dollars into the delivery system. More important than additional funding is a better organization of the system and greater incentives for the efficient provision of care of higher quality.

The committee felt that federalizing health care was no solution. Likewise, it came to agree that the system could not be left the way it is, with fragmented units of health care institutions and with physicians largely uninvolved in the responsibility for how health services are delivered, how effective they are, and for their cost. The committee concluded that its task was to propose a system in which the totality of health services could be provided more effectively for the entire population—a system that would grow, and mature, and serve the next 50 years.

The result is Ameriplan.

It is our hope that there will be hearings in depth before this committee on all specific proposals for changing the system for delivery of health care and that the bill embodying the Ameriplan proposal will be given due consideration.

Thank you.

The CHAIRMAN. Thank you very much.

I have prepared a number of questions for you.

Are there a substantial number of hospitals which are not enthusiastic about Ameriplan? If so, why?

Mr. HORTY. We have been very pleased at the acceptance of the Ameriplan concept by the hospital field. Since the Committee's report was made public in November there have been numerous meetings and program sessions to discuss Ameriplan and the reception has been favorable. As I stated, Ameriplan has been adopted in principle by the House of Delegates of the American Hospital Association, the representative body of the Association, after extensive discussion and debate of the plan at each of the Regional Advisory Board meetings. I can state personally that I have discussed Ameriplan before hospital groups in Pennsylvania, Massachusetts, Iowa, and West Virginia as well as at three sessions of the College of Hospital Administrators since November, and the reception has been uniformly enthusiastic. Of course, some hospitals have reservations about some aspects of Ameriplan as well as confusion about it. This is only natural with so far-reaching a proposal. And, as I detailed earlier, the Association is currently engaged in an organized effect to inform and educate its membership about Ameriplan (as well as invite hospitals and Regional Advisory Boards to help shape the details of the proposal). I do not believe a substantial number of hospitals are unenthusiastic.

The CHAIRMAN. Has there been organized support of Ameriplan outside the hospital field? If so, by whom?

Mr. HORTY. As I stated earlier in my testimony, a substantial effort directed toward informing other areas of the health field and beyond is currently taking place by the Association. We are actively seeking advice, understanding, and discussion with a wide variety of organizations both within and outside the health field. We have not so-

licited endorsement of Ameriplan by any organized group although we would welcome such support. The entire concept has been public only since November 1970 and education, discussion, and acceptance must precede support. We believe that Ameriplan is a concept that many organizations will find attractive and we have had many unofficial expressions of agreement. We believe that it will be more feasible to judge organized support for Ameriplan once we have it in bill form.

The CHAIRMAN. Do you have any estimates of the overall cost of your Ameriplan?

Mr. HORTY. As I stated in my response to a question from Senator Bennett, we hope to have a cost estimate when the bill is ready for submission.

The CHAIRMAN. How does the Ameriplan concept of comprehensive care differ from the HMO concept?

Mr. HORTY. One of the central points of Ameriplan is that Health Care Corporations must be so located that they can assume the responsibility of providing comprehensive care for all the people. Each State's entire geographic territory will be covered by HCC's and all people be given an opportunity to become registrants. Because the establishment of HMO's is strictly voluntary they are likely to be established precisely where they are not needed, where care is already good. There is no guarantee that all people will get care or that all of a State will be serviced by HMO's.

The CHAIRMAN. Senator Bennett?

Senator BENNETT. I was delayed. The only question that occurs to me in what I heard is approximately how long will it be before we will have the actual text of a bill to study?

Mr. HORTY. Well, as you can understand, Senator, this is a more complicated proposal than it would be if you had nothing but a federalized system, so we have to consider setting up the necessary State agencies and the difficulties of that.

I would say that we are talking in the neighborhood of 2, 2½ months, 3 months, before a final bill will be finished. Then, of course, it must go through the process within the organization before it is made public. But I think we are talking in that area.

Senator BENNETT. I only hope the routine of getting it worked out won't delay it so long that we will have made our decision without it.

Mr. HORTY. We certainly hope not.

The CHAIRMAN. Senator Bennett asked one of my questions.

Senator BENNETT. I apologize.

The CHAIRMAN. Senator Miller?

Mr. HORTY. I might add that drafting the bill is complicated by another thing and, that I alluded to in the last part of my statement, and that is that we are looking toward a system which is a direction not a solution. This means that we must as best we can take into consideration not only the situation today but the situation as we can foresee it 5 years, 10 years, from now, and move in a direction that will allow the freedom to change as change must be implemented, which is slowly.

I don't think any of us believe that we can turn the health system inside out by any legislation of this Congress or even by any act of will of the Members who prepared it. It is going to take time, and our

hope is that our bill stands the test of the kind of time that it would take.

The CHAIRMAN. Since Senator Bennett asked that very important question, I think I ought to compliment you for the fact that you are trying to get your people together. They are a nationwide group and you are trying to get them to agree on something. Each of them has something to contribute.

Mr. HORTY. Yes.

The CHAIRMAN. We congratulate you. It is a very democratic organization that you have.

Mr. HORTY. Thank you. I would like to say with respect to this that this is a rather radical proposal from what is essentially one of the more conservative groups in this country, and as such I think, if nothing more, it recognizes the urgency with which the field feels something must be done and that our members intend to participate in doing it.

The CHAIRMAN. The fact that you are proposing this plan pretty well demonstrates that you are not dictated to or dominated by any particular group. You are trying to do what you feel is right and that is about all we can expect.

Mr. HORTY. Exactly.

The CHAIRMAN. Senator Miller?

Senator MILLER. Mr. Horty, one of the corolaries to the basic principle you outlined in your statement is that these services be available without regard to any person's ability to pay.

Mr. HORTY. Yes.

Senator MILLER. And yet when you detailed the three general categories of coverage, you indicated that the poor and near-poor will be taken care of out of Federal revenues, but with respect to the standard benefits package and with respect to those who are going to be covered by catastrophic illness who are not the poor or near-poor, they are going to have to pay tax money or they are going to——

Mr. HORTY. That is correct.

Senator MILLER (continuing). Use the premium rate road. So I think—maybe I misread your statement but I think that that "without regard to any person's ability to pay" is not quite correct.

Mr. HORTY. It is correct in the sense that the inability to pay should not be an impediment to care in any way, shape or form.

Mr. MILLER. That I would agree with. I think "without regard to ability to pay" might be misinterpreted.

Mr. HORTY. Yes. We are not intending that all should be on the Federal tax roles.

Senator MILLER. Now, on page 6 you refer to assuring continual availability of physicians' services.

Mr. HORTY. Yes.

Senator MILER. What do you envision in that assurance, a contractual arrangement with the typical traditional fee-for-services base to be continued? Would there be salaried doctors? What is the format of that assurance?

Mr. HORTY. Well, let me speak to the assurance first and then I will deal with the other questions. I think the only way you can assure the availability of physicians and the availability of physicians' services is to give somebody the job of seeing to it that it be done, and this is not

a pleasant job as any administrative job is not. It requires negotiation, contracting. It requires a give and take on both sides.

What we have done is to say at least that the Health Care Corporation must be given the job of seeing to it that physicians' services are available to all, everywhere, and that if a Health Care Corporation has the responsibility for rural areas, that it must see to it as part of the franchise which it receives from the State that physicians' services are in fact available.

But how they go about doing it will be a matter of difference in different parts of the country. In some places, I am sure salaried physicians, as they are now, will be used. In other places there will be, in fact, fee-for-services. In most cases, there probably will be fee-for-service type contracts. In other areas or even in the same health care corporation there may be group practice. Ameriplan does not mandate the exact direction that this must take.

What we are saying is that somebody must have responsibility for doing the job. The health care corporation for that territory will be a corporation composed of community residents with providers and consumers on it, then we are going to have to see that they take care of the people that they are supposed to serve and the State will see to it that they do it through their control mechanism.

It is a lot easier to say that, I heartily agree, than it is to see in all instances how it is going to be done, but I think the first step in getting something done is to put the bee on someone to do it and that is what we have done.

Senator MILLER. What do you do if the corporation is mandated to make sure that services are going to be available in a certain area and the medical doctors who work in the general area that may be 40, 50, 60 miles away, don't like the arrangements that the corporation proposes and they are just not going to provide that service? Are you going to mandate the corporation to compel the doctors to render that service?

Mr. HORTY. Under this country's system, I don't see how one can compel physicians to render any services, and this is obviously a problem in any system that would be proposed, nationalized medicine or not. You can only coerce so far. You can persuade so far. You can give incentives to physicians. You can point out to them the benefits of associating themselves with the health care corporations.

You can, of course, by our mechanism move slightly in that direction because of the two Federal benefits. The two benefits are, one, catastrophic care and two health maintenance care, which would be available only to registrants of health care corporations and only to those people who had bought the standard package or been provided the standard package. Therefore, physicians who wish to practice outside of that system—would have to at least not receive recompense for those services if they were given, but I think it is impossible for any plan to coerce physicians and, obviously, you are going to have pretty poor health care if you do.

Our moves in the direction of providing incentives and reasons for them to move within the framework of the health care corporation.

Senator MILLER. Well, I think——

Mr. HORTY. Which they would control in part, at least. In other words, having a say in management which often physicians do not have today.

Senator MILLER. Well, I like your philosophy. Of course, how much say in the management could be a very critical question.

Mr. HORTY. Yes.

Senator MILLER. And I have the uneasy feeling that to just suggest that these local corporations will work out the problem on their own may lead us into some difficulties and it is a delicate area of draftsmanship, but I hope when you do get around to doing it, that you might take into account the views of some of the people in the medical profession who, I am sure, would share your philosophy but would be concerned about the legislative language that might be used.

Mr. HORTY. We are very concerned with that, too, because we do not wish to forfeit support of medicine.

Senator MILLER. Well, it is a problem that is going to have to be faced head-on, and we may have to face it in the Federal law that we would promulgate.

Now, finally, I don't need to tell representatives of the American Hospital Association that we have got quite a long way to go in this country before we have the health manpower and health facilities that we need to sustain any substantial increase in services. We have already found out what happened when medicare went on the books, and we are still going through the pangs of trying to match the entitlements under that program with the resources that are available.

Do you have any phasing-in plan for implementing this program so that we can look down the road and see that as our health manpower resources grow and our facilities resources grow, that there would be a phasing in of additional entitlements and additional coverage? Isn't the only way we are going to be able to match entitlements with resources?

Mr. HORTY. Absolutely. I think that the committee, as most committees do, considered a number of possible benefits that could be offered. Some of us on the committee felt strongly that more benefits should have been offered, but when we came down to the end and looked it square in the face, we decided that under the present system that was all we could offer, both for economic reasons and also from the standpoint of what the system is capable of bearing at the present time.

What we did was to face squarely the fact that benefits and entitlements will, in fact, increase as time goes on and we must move in the direction of providing better facilities, better manpower, and a better organization within which to give these benefits. That you cannot do overnight and even the program of moving from the present system to Ameriplan is a 4 or 5 year program, merely in getting started the kind of grants and loans that would be necessary to move the local people to establish health care corporations, set them up, bring the facilities together, the providers together, the physicians together.

This is not an overnight process, and we could not in our opinion establish more entitlements than we have right now and do it in a reasonable fashion over a reasonable period of time. So that we are heartily in agreement with that and that is exactly why the program is what it is.

Senator MILLER. That is a fair response to my question. However, when you say that health care corporations are going to provide for comprehensive care—health maintenance, primary care, specialty

care, restorative care, and health-related custodial care—you cover the waterfront.

Mr. HORTY. That is right.

Senator MILLER. Well, now, how much of each of these is going to be provided in the first year of operation of the corporation, in the second year and in the third year? It would be 10 years at the earliest before we will be able to catch up in some of these areas, or are you going to give the corporation in one area, where the resources may be much greater than in another area, the green signal to increase its coverage? What we are concerned about—what I am concerned about and I know a number of my colleagues are concerned about—is that we not give these members or registrants in a corporation an entitlement that the corporation can't deliver on.

Now, maybe a corporation in Sioux City, Iowa, could deliver on it today but it might take 5 years before some other corporation in another part of the country could deliver on it.

How do we manage this balancing of resources and entitlements under this plan?

Mr. HORTY. Well, our proposal with respect to the new Federal benefits is sharply limited. It is sharply limited to the catastrophic and to health maintenance. What we say is that a health care corporation in order to be chartered must have the potential to have sufficient scale and sufficient efficiency to be able to give all five elements of care.

There are some what I would call incipient health care corporations today that can, in fact, do that. It is clear than we cannot do that in all areas of the country and will not be able to do so in any meaningful fashion immediately or within a short period of time, or even at the same period of time for all. But we do not state that the registrant is entitled to the benefits under any federalized or tax scheme. We insist, however, that the health care corporation have the potential for being able to do it because we feel that if it doesn't have that potential, it is too small, too restrictive, and it is not going to serve the future sufficiently, and we would hope that Congress in its wisdom would not increase entilements faster than the field could bear the burden. But as you well state, that is a cause of concern to all of us and I doubt that that is likely to happen. I certainly hope not.

Senator MILLER. Your No. 1 priority is to cover catastrophic cases.

Mr. HORTY. The catastrophic, the health maintenance, and to provide the standard benefit package under standards which will be laid out by the national health board.

Senator MILLER. Well, suppose that I want to be covered under the catastrophic program, but there is no corporation in my area?

Mr. HORTY. Before the program goes into effect there will be in fact health care corporations in your area which will provide all of the Federal benefits, and, if not, the State is under a mandate to establish them.

Senator MILLER. Thank you very much.

Mr. HORTY. But I would assume that that would not be necessary.

Senator MILLER. Thank you, Mr. Chairman.

Senator Jordan?

Senator JORDAN. Just one question, not related to your plan that you have outlined here but because you are a representative of the American Hospital Association, I would like to ask you a question.

The American Hospital Association members would get patients referred to them by various and sundry group insurance plans and prepaid group practice plans, and so on, would they not?

Mr. HORTY. We do.

Senator JORDAN. A statement was made by a witness this morning who spoke for the Group Health Association of America, and he quoted from the Harvard Law Review and this is what he said:

Measuring annual hospital days per 1,000 persons covered, those under prepaid group practice plans in six major areas of the country were hospitalized about half as much as those covered by other forms of insurance.

Now, can you verify that or challenge it or what is your——

Mr. HORTY. I have no reaction to it whatsoever. I have had sufficient dealings in the past with statistics to want to see what is behind the Harvard Law Review article, what might have produced it. I have no reaction to it whatsoever, Senator. It is as simple as that. I say it is astounding but that is all I know about it.

Senator JORDAN. From your personal experience, you haven't observed that to be true?

Mr. HORTY. I have neither observed it to be true, or not true. It just really—it surprised me as much as——

Senator BENNETT. Mr. Chairman—Mr. Horty, were you in the hall this morning when that was discussed with the representative of the HMO?

Mr. HORTY. Yes.

Senator BENNETT. And you heard this explanation of it?

Mr. HORTY. Yes.

Senator BENNETT. And you still say you have no reaction to it?

Mr. HORTY. I have no—I must say in that regard I am perhaps not as perfect a representative of the AHA as I might be since I am an attorney and not a doctor, but it was a surprise to me and it is one that I would like to see an explanation for, but there are a number of obvious explanations for it, all of them based upon the goodness or badness of the statistics. You can make them what you like.

Senator BENNETT. Does Mr. Williamson have any comment to make on that?

Mr. WILLIAMSON. Well, we have heard for some years that in the Kaiser permanente system which is on the Pacific coast, there has been a 25 to 40 percent less inpatient bed utilization by the members belonging to that plan than resulted in the normal practice of medicine outside that plan on the Pacific coast. Those figures at various times have been challenged and questioned.

I think, however, they have been studied enough so that, at least in my mind, they present a very great challenge to the hospitals of this country, and to the medical care system of the country because if it is a fact that you can so organize medical practice to substantially reduce inpatient care, then it needs to be looked at very carefully and I think that the delivery system, the sort of controlled delivery system envisioned in Ameriplan, is moving definitely, Senator, in that direction.

Senator BENNETT. Have you read the Harvard Law Review article? Are you aware of it?

Mr. WILLIAMSON. No. I wasn't aware until I heard it quoted this morning.

Senator BENNETT. I think both of you would want to get a copy of that article and read it quite carefully. I haven't read it either.

The CHAIRMAN. While we are wandering outside your particular expertise, I would like to ask you this question. Have you ever read the book "The Citadel"?

Mr. HORTY. No. I know of the title.

The CHAIRMAN. Well, the author was a doctor and a good one. After writing a number of fine books he decided to write one about his own profession. Does that strike a chord with you, sir?

Mr. WILLIAMSON. Yes. I couldn't comment specifically.

The CHAIRMAN. It sort of amazes me that here is a doctor indicting the medical profession in a beautiful book, absolutely lovely book.

He, speaking as a doctor, indicted doctors for doing more to hurt health than they did to help health. The book sold more than a million copies.

Do you mind explaining why a doctor or an administrator of a hospital would write a book like that? His name is A. J. Cronin. He pointed out how many of the greatest things achieved in medicine were by men who did it over the opposition of the medical fraternity. Pasteur was one of those he included, as well as a great number of others. I would recommend it to you because the ancient woes that that man described in his book are still here. You ought to read the book just to see what might be done about some of our problems.

Let us talk about something that still exists and see if you know something about it. Have you ever heard of a drug product named Serpasil?

Mr. HORTY. No.

The CHAIRMAN. A drug named Reserpine?

Mr. HORTY. No. I know the general family.

The CHAIRMAN. Have you ever bought them?

Mr. HORTY. No.

The CHAIRMAN. Have you ever heard of the drug prednisone?

Mr. HORTY. No.

The CHAIRMAN. A product named Meticorten?

Mr. HORTY. Yes.

The CHAIRMAN. What is that?

Mr. HORTY. I do not know. I know the name.

The CHAIRMAN. Well your hospitals buy those drugs every day. They buy them at cost and sell them at a big profit, and I would just be curious to know how you go about buying them.

Mr. HORTY. Well, if they are brand-named drugs, they are brought from a pharmaceutical house that sells brand-named drugs.

The CHAIRMAN. Well, let's see if you can answer the next question. You don't know what they are but let's see if you can understand this. They are basically all the same thing. That is, prednisone is the same thing as Meticorten. Serpasil is the same thing as Reserpine. But if you buy the drug as Meticorten it would cost you $11 at wholesale. Only one outfit manufactures it under that name. That is——

Senator BENNETT. In packages.

The CHAIRMAN. Exactly. That is the Schering Co.

Senator BENNETT. They don't call it prednisone; their name is Meticorten.

The CHAIRMAN. Meticorten costs you $11. The point is exactly the same, though.

Now, the generic name for the drug is prednisone. Generically, it can be bought for $2. All right, Merck and Upjohn make prednisone and so do others.

Now, if the people who manufacture Meticorten can't prove that it is any better than other prednisones, why would you buy Meticorten?

Mr. HORTY. Well, I assume that one of the reasons is that they claim that their brand is better; I don't know.

The CHAIRMAN. Oh, no, they don't.

Mr. HORTY. Well, they do in many——

The CHAIRMAN. Now, would you mind explaining to me why the public should be shaken down by paying five times as much for something called by a fancy name and wrapped in a different package?

Mr. HORTY. Let me answer it, first, generally, then specifically. Obviously if you phrase the question that way, the general public should not be. It is as simple as that. However, I think the drug problem generally is one part of the whole problem and that one of the difficulties of dealing with it is dealing with it separately, and I think that one of the things—this was considered by the committee exhaustively, and we feel that one of the health care corporation's major jobs is to control exactly the kind of problem that you are addressing yourself to, the difference between generic and brand names in drugs, since the Health Care Corporation has the responsibility to the State to deliver care at a reasonable cost. We'll have to address that problem, and I don't expect that they will be 100 percent successful any more than I suspect that anything will be 100 percent successful, but what I do say is it must be approved as one portion of the total as catastrophic care should be approved as one portion of the total, and you ought to reorganize the system in such a way that you do all of it, and that you put the responsibility upon someone and that is exactly why we are suggesting the Health Care Corporation.

The CHAIRMAN. Now, are you the administrator of a hospital?

Mr. HORTY. No; I am not.

The CHAIRMAN. Is your associate an administrator of a hospital?

Mr. WILLIAMSON. No.

The CHAIRMAN. Are you testifying as a lawyer for them?

Mr. HORTY. I am testifying as a member of the Special Committee.

The CHAIRMAN. What are your credentials for service on the committee?

Mr. HORTY. My credentials are an interest in the health field and in its organization. I have been a lawyer in the health field for the past 12 years.

The CHAIRMAN. You are a lawyer, so you are here because you are a lawyer.

Might I suggest to you, sir, that next time you bring my friend, Charlie Gage. He was a classmate of mine in school. He speaks for the Louisiana Hospital Association.

Mr. HORTY. I know Charlie very well.

The CHAIRMAN. He could name those drugs and he would know something about the drugs.

Mr. HORTY. Well, I know something about the problem. The problem is the problem of generic- and trade-named drugs.

Mr. WILLIAMSON. I think, Senator, the association has recognized the problem you are speaking of for a good many years. We have been for some years now, a good many years, encouraging the establishment of drug and therapeutics committees within hospitals. We have encouraged and have over many years issued official statements supporting generic drugs. We have encouraged the drug and therapeutics committee, physicians and pharmacists, and others within the hospital to look at drugs and the makeup of drugs and to purchase the drugs that will serve the purpose at the best price, and I think that it is exactly in the direction which you are indicating is in the public interest.

The CHAIRMAN. Well, the average hospital administrator, if he is a decent guy, and 99 percent of them are, will buy necessary drugs on a bid basis if they are confident of the quality of the bidders. And they will sell them to patients for a lot more than that. They will require doctors to agree to use the drugs purchased at that hospital. They then proceed to use those drugs and thus make a substantial profit for the hospital but it all goes for a good cause. It all goes into the kitty to help with the overall costs. But when these drug people are permitted to engage in all kinds of chicanery to get doctors to prescribe a particular drug product at 10 times what it would cost to buy something else that is equally as good, somebody, some time ought to tell the public the truth about all of that. When they come in here and try to get the Government to pay 10 times what it ought to be paying for something, someone who is qualified ought to come in here and explain just exactly what the facts are.

Now, here is a document evaluating drugs prepared by the American Medical Association.

In the introduction you will note reference to a man named John Adriani, M.D., professor of surgery at the school of medicine of Tulane University, professor of clinical surgery and pharmacology, Louisiana State University School of Medicine, and director of the department of anesthesiology, Charity Hospital, New Orleans.

That fellow spent some time as chairman of the Council on Drugs of the American Medical Association—as honest a man as the Good Lord ever put in any job. That man had the courage to come in here and say the kinds of things to which I have referred.

Dr. Adriani was recommended to this administration to take a key position in the Food and Drug Administration in the Department of Health, Education, and Welfare. He wasn't appointed for a very good reason. He just possesses too much honor and conscience.

But why don't you people come up here and testify what your integrity tells you is right and that is that you shouldn't pay 10 times or even twice what you ought to pay for a drug?

I don't know why you people don't come in here and testify that is the way hospitals buy them. Why don't you testify for us to buy drugs that way?

Mr. HORTY. Well, I can speak personally at least to say I have no brief for any drugs which are purchased for more than a reasonable price. I agree entirely with you. You and I are not disagreeing in the least. You are really saying, Senator——

The CHAIRMAN. My impression is the AHA agrees with me and what I can't understand is why you are not up here testifying for it.

Mr. WILLIAMSON. We will be glad to bring in an individual who is practicing in the field and experienced in purchasing drugs, and on a drug and therapeutics committee, who can talk with some authority on the subject, Senator.

The CHAIRMAN. Well, all I want to do is do what is right.

Now, I don't know of a single hospital administrator in my State who doesn't think that Doctor Adriani is right about this. And when people such as Doctor Adriani have the courage to stand up and be counted for honor and conscience, I don't know why they should be demoted and thrown out rather than promoted as our form of government should ordinarily operate.

Mr. HORTY. As I have told you, I agree entirely with what you say.

The CHAIRMAN. Well, I am glad you answered the question.

Mr. HORTY. I agree entirely.

The CHAIRMAN. Thank you, gentlemen. I appreciate that.

The CHAIRMAN. The next witness will be Mr. Ned Parish, executive vice president of the National Association of Blue Shield Plans.

STATEMENT OF NED F. PARISH, EXECUTIVE VICE PRESIDENT, NATIONAL ASSOCIATION OF BLUE SHIELD PLANS, ACCOMPANIED BY JAMES D. KNEBEL, ASSISTANT EXECUTIVE VICE PRESIDENT

Mr. PARISH. Thank you, Mr. Chairman.

I am Ned F. Parish, executive vice president—President-elect of the National Association of Blue Shield Plans. Accompanying me today is James D. Knebel, assistant executive vice president of the association.

Our 73 Blue Shield Plans currently provide medical-surgical and other health care protection to 65.7 million Americans, and serve an additional 13.4 million persons under Federal health programs. Thus, Blue Shield is serving 79 million persons—more than one out of every three Americans.

In 1970, we paid out $3.8 billion in benefits under our regular programs and government-financed programs. Combined operating costs for Blue Cross and Blue Shield Plans are about 7 cents per subscriber dollar.

When Blue Shield started some 30 years ago, there was considerable doubt about the feasibility of medical-surgical protection. But the idea took hold and grew because the basic concept was sound—people joining together in their common interest to protect themselves against the uncertainties of illnesses and accidents.

With this heritage, it is obvious why Blue Shield plans have been community oriented. We believe we have a major obligation to make coverage available to the whole community without regard to health status or employability. And we are dedicated to giving the public the greatest return on its health care dollar.

Today, we continue to increase our enrollment and we are providing a broader scope and depth of benefits. The Nation's largest industries select us as carriers in most instances, yet we have not neglected smaller employers. There are thousands of small companies with as little as four employees which have Blue Shield group contracts. And millions more are enrolled in "non-group" programs.

Our pioneering efforts, record of success, and vast experience was recognized when it came time to implement medicare and medicaid. We were asked to help. We responded. And we are continuing to play significant roles in these programs.

We have membership standards (attached to this document) which are more exacting than State regulations. To retain the Blue Shield name and symbol, our plans must demonstrate standards of fiscal soundness, adequacy of performance, reasonableness in benefit patterns and levels of payment, honesty and clarity in advertising, due attention to utilization review and cost containment, and—most importantly—acceptable return of benefits to the subscriber.

Despite our vast contributions, we find ourselves criticized for shortcomings in the health field. I submit that Blue Shield has made a major contribution to the Nation's well-being. Who else can match our pioneering innovations? What other health care carriers—and there are thousands of them—can live up to Blue Shield's membership standards?

A recent survey by Louis Harris showed that 62 percent of Americans believe they would be covered financially in case of a major illness. We believe this is a strong indication that—despite the critics—many things are right about health care financing in our Nation; that the need for health financing is reasonably well met for a majority of the population.

Complex problem: We commend the chairman for addressing the initial hearings of the committee to the broad issues involved in considering proposals for national health insurance.

Improving the health of our Nation is a complex undertaking. Among others, it will require major attention to the problems of poverty and to environmental factors.

We will have to deal not only with adequacy of income, but with teaching families to purchase nutritious foods, to follow proper sanitary practices, and to make proper use of health care facilities.

Environmental improvement will require reducing air and water pollution, expanding safety programs, and conducting health and research projects to make our communities better and healthier places to live.

And obviously what we consider as necessary expenditures for health services will have to compete for tax dollars with such on-going demands as defense, education, housing, urban renewal, and agriculture.

It is against this complex and multifaceted backdrop that the best courses of action must be determined. An assessment will have to be made of what is working and what is not working in the current delivery and financing of health care. A determination will have to be made on the most pressing health care needs. And a realistic decision will need to be made of what can be done within the limitations of competing national priorities and what the hard-pressed taxpayer is willing to fund.

Current needs: Because of our day-to-day involvement with the citizen as patient, we are mindful about his needs and are attempting to do something about them.

While there may be disagreement on the dimension of the problem, I believe we all agree that we must train more physicians, other health professionals, and allied health personnel.

Currently, there is strong interest in prepaid group practice as a delivery form that will reduce future costs by emphasizing preventive care and ambulatory care, and minimizing the incidence of high cost hospital care. Our Blue Shield plans are willing to provide the public with this alternative delivery form and we are striving to reduce costs while maintaining quality medical care.

We are also working with and studying the experience of free-standing facilities. These, Mr. Chairman, are facilities which can accommodate operations requiring general anesthesia without placing the patient in the hospital. Here again, the emphasis is on keeping the patient out of the high-cost hospital bed.

In the various proposals that the committee will study, there will be recommendations for altering the delivery of care.

We are for changes if they will bring real improvement. We urge, however, that these proposals be thoroughly tested—as to public acceptability and cost savings—before they are implemented on a broad scale.

Cost containment: Containing the cost of care—while assuring quality care—is, of course, of primary importance. This can best be accomplished through utilization review activities.

While most health insurance organizations now recognize the importance of meaningful utilization review, Blue Shield more than 10 years ago decided that one of our most important subscriber services was to maintain controls over the use of contracts and benefits.

The techniques of utilization review—like many aspects of medicine—have been dynamic. The need for greater sophistication in reviewing an ever-mounting influx of claims and the development of electronic data processing technology have contributed toward making this a highly refined process. We have worked for progress in this area by making effective utilization review and its documentation a membership standard in our association.

While utilization review efforts are making significant impact, their savings could be easily wiped out through poor planning.

We spoke earlier of the universally recognized shortage of health personnel. It has never proven possible to put greatly increased amounts of money into health services without inflating costs. This is because of the current shortage of supply, which cannot over the short term be significantly expanded.

It seems to us that this is a key factor—albeit not a pleasant one—that must be kept in mind when legislation is being considered.

Catastrophic illness: Currently, there is renewed interest in the need for protection against catastrophic illness. This is a real problem, and one which requires proper action.

I say renewed interest because as early as 1954, Blue Shield testified before the Senate Committee on Labor and Public Welfare on what it was doing to protect against catastrophic illness.

High on the list of dread diseases at that time was poliomyelitis. While polio has been largely eradicated, thanks to new vaccines, the specter of catastrophic illness is still with us.

But today—because of the vast strides made in financing health care—it is important that we consider catastrophic illnesses or injuries in precise ways.

As a general rule, when a person has good basic coverage and supplemental benefits for services not paid by basic benefits, he has quite good protection against an episodic serious illness or accident.

However, when an individual with this same type of coverage experiences a catastrophic illness or accident which requires substantial continuing care over a period of years, he is going to need additional help. An example of this would be a person who undergoes a serious kidney operation, after which he can be kept alive only through regular treatment by a kidney dialysis machine.

To describe a good basic coverage and supplemental benefits program, I would refer you to the high-option Federal employee program and some of our other large group contracts.

As a result of the Blue Cross and Blue Shield combination of basic and supplemental benefits under the Federal employee program, there have been many examples of extraordinarily large claims being paid. For example, a man on the west coast received nearly $110,000 in benefits for treatment of a urinary and kidney disease, a woman's benefits for treatment of a disease of the central nervous system totaled nearly $80,000, while treatment of a disease of the endocrine system resulted in payment for one man's care of more than $63,000.

While the coverage for these highly dramatic cases prevented financial disaster and helped those who were seriously ill to secure the best care available, we are aware that other individuals fall victim to severe illnesses that will be chronic with them for years, and they should receive help.

We would recommend, therefore, that serious thought be given to the limits of private prepayment and health insurance protection, and protect those individuals who fall victim to catastrophic, chronic illnesses. We suggest that normal reinsurance principles can apply if Government develops the necessary funding to reimburse private expenditures for those uninsurable costs.

Though Government financed, the program should be administered by the carriers who would be in the best position to supplement private benefits when the basic and supplemental coverage leaves off and the uninsurable catastrophic, chronic costs begin.

Coverage for the poor: There is no doubt that we must develop more effective and more generally available health care programs for the poor and medically indigent.

As in housing and education, the health problems of those with reduced incomes are the most difficult to solve.

We have tried various health care programs for the poor and medically indigent, and I do not believe any of us are satisfied with the results.

We, therefore, support the concept of an underwritten program for the poor using private carriers. We believe the poor and the medically indigent should be able to purchase health care benefits broadly available to the public through funds provided by government.

A key rationale for an underwritten system for the poor is that it would avoid a separate Government-administered system with attending duplication of costs and lack of integration. A separate system, accurately or not, may also imply separate standards of quality, and we believe that the poor and medically indigent should have access to mainstream care.

At the same time, Mr. Chairman, and we believe this to be most important—we believe a realistic system of qualification of carriers should be developed. Carriers should be able to provide coverage of broad scope and depth, provide effective utilization review, have low operating expenses and a commitment to returning maximum benefits for each subscriber dollar, and a system of communications with physicians which will strengthen understanding and support for the program.

There is little question that not all health insurance carriers live up to the standards that the public and many experts believe are necessary. We believe consideration should be given to the development of regulations at the State or Federal levels to improve the manner in which these carriers operate.

National health policy: It seems to us that at this point in time—and in the future—the Nation needs a rational method of arriving at orderly priorities for improving our health delivery and financing systems. These priorities should be realistically structured and priced to meet specific objectives. They should lead to a defined national health policy.

This policy—as we have indicated in our testimony—should consider such items as the relative costs and benefits of programs for producing health personnel; programs for modifying environmental factors influencing health; programs for assuring adequate family income; and the programs for the financing of personal health services. It should also explore the potential of new approaches to health care.

We propose, therefore, that a national council on health policy be established, within the office of the President. The council would develop and submit to the President a statement of national health priorities, based upon specific objectives necessary to promote the Nation's health. It would also submit a legislative program, with recommended appropriations, to achieve those objectives.

The program would include a continuing assessment of the strengths and weaknesses of the delivery and financing systems, and would be aimed at achieving specific results through an orderly process of innovation and development.

Conclusion: In conclusion let me again compliment the committee for addressing itself initially to the broad considerations involved in national health insurance. We believe that while there are significant problems in the delivery and financing of health care, there are many valid and strong features in the current system that should be retained.

We believe very strongly that we must set orderly health care priorities as a Nation, and not adopt programs which could further complicate and increase the total cost of health care. We must look realistically at our capabilities, assess our financial resources, and within the context of the possible, develop programs that can be sensibly implemented.

We would like to reiterate the need to develop underwritten programs for the poor and the medically indigent. Government-financed programs should also be made available for the unfortunate victims of catastrophic illnesses and accidents which leave them with chronic conditions and financial drains that the overwhelming majority of families cannot endure.

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Mr. Chairman, may I echo some of Senator Percy's comments with reference to the monumental tasks facing this committee.

All of the wisdom, experience, and judgment represented by you and your distinguished colleagues, and assisted by your highly competent staff, will have to be called into play in reaching an equitable solution. If we can be of any assistance to you in this task, I hope you will call on us.

Thank you for this opportunity to present our view.

The CHAIRMAN. Thank you very much.

Senator Jordan?

Senator JORDAN. No. Nothing. A very good statement.

The CHAIRMAN. Would you agree that government should make maximum use of those Blue Shield Plans which do a good job and dispense with the services of those Blue Shield Plans which are consistently inefficient and uneconomical?

Mr. PARISH. Our office is not always privy to information collected by the Bureau of Health Insurance on our Plans' performance. However, when we are informed by the Bureau of deficiencies, we have consistently offered our assistance in correcting them. Of course, if our efforts and those of SSA are unable to bring about the necessary corrective action, we certainly would agree that a replacement carrier should be secured.

The CHAIRMAN. As an expression of that policy, hasn't medicare just terminated one Blue Shield Plan and added cancellation clauses to the contracts of at least six other Plans?

Mr. PARISH. Yes. However, in the instance of the Blue Shield Plan which has been informed that its contract would not be renewed, our staff had been effective in correcting most deficiencies and evidence was just beginning to become available which would demonstrate that this Plan could administer the program efficiently and effectively. We are now confident that the replacement carrier will be handed a "clean" operation, trouble-free and with a minimum number of claims on hand. We regret that Social Security was unable to wait an additional 90 days before making its decision final. As to the other six Plans, NABSP and the Bureau of Health Insurance are cooperating in providing expert assistance to correct deficiencies quickly and effectively.

The CHAIRMAN. If Blue Shield were given an expanded role, could it function, as the government's agency, on an "arms length", public interest basis in dealing with physicians? Or, does your basic organizational structure prevent that "arms length" relationship?

Mr. PARISH. We believe firmly that Blue Shield has served in the public interest and will continue to do so. To the extent that Blue Shield serves contractually with government in administration of its programs, it would also, of course, administer its responsibilities in the public interest.

As to whether or not Blue Shield Plans can work "at arms length" with physicians, we believe that they do relate "at arms length" in matters of benefit payment provisions. Traditionally, however, Blue Shield has developed, in close cooperation with physicians, programs for low or modest income persons and families which are actuarially below community-wide costs.

Furthermore, Blue Shield Plans work closely with physician representatives in utilization review, peer review, participation agreements, in community health planning and in experimentation.

Blue Shield has developed substantial capability for working with the medical profession in these areas, albeit "at arms length" as appropriate, in the conviction that cooperation benefits the public, and with the knowledge that indifference to the needs of either would defeat our purposes. This capability is certainly available to the government if it wishes to contract for it.

The CHAIRMAN. Have you seen the Bureau of Health Insurance composite rating of Carrier performance in medicare?

Mr. PARISH. We had not been provided with a copy nor had we seen it until yesterday afternoon.

The CHAIRMAN. How many Blue Shield Plans were rated as below par?

Mr. PARISH. Twenty-five.

The CHAIRMAN. If you were in government's shoes, what would you do about that kind of inadequate performance?

Mr. PARISH. Mr. Chairman, we cannot agree that this report fairly evaluates the Carriers' performance. As we indicated, we only received the report yesterday. We will ask for a staff evaluation of the work, but it appears at this time to be little more than an exercise, in arithmetic. NAESP's comparative rating system of Blue Shield Plan performance, although still under development, is a more scientifically accurate evaluation. We assure you that the results of that evaluation would in no way indicate that 25 of our 33 Blue Shield Plans' performance under medicare could in any way be considered below par. We can only assure you that we will discuss the wide disparities between our two systems with SSA, and where it is apparent that these satistical results do indicate inadequate performance, we will take corrective action.

The CHAIRMAN. In your statement, you referred to Blue Cross-Blue Shield combined operating costs as "seven percent." What are Blue Shield's costs percentage exclusive of Blue Cross?

Mr. PARISH. The Blue Cross-Blue Shield combined operating expense figure of 7 percent was cited as an agglomerate figure because that is standard procedure in making comparisons in the health care field. The Social Security Bulletin of February, 1971, for example, notes that operating costs for all insurance policies exclusive of Blue Cross and Blue Shield was 21 percent.

Blue Shield's operating expense per subscription dollar for 1970 was 10.97 percent. Blue Shield's operating expenses are higher than the combined Blue Cross and Blue Shield figure because for a given amount of money paid out in claims Blue Shield generally handled more claims than Blue Cross. Not only is the Blue Shield claim generally smaller than Blue Cross', but the gross number of claims submitted by physicians is greater than the number of hospital claims.

The CHAIRMAN. Thank you, Mr. Parish.

Mr. PARISH. Thank you.

(An attachment to Mr. Parish's statement follows:)

APPENDIX I.—MEMBERSHIP STANDARDS OF NATIONAL ASSOCIATION OF BLUE SHIELD PLANS

PREAMBLE

These Membership Standards provide objective criteria for evaluating the effectiveness of a Plan's service to the public, to the medical profession, and to

Blue Shield as an interdependent association of Plans. The intent of each standard is clear, and it is to be met. It shall be the duty and responsibility of the Board of Directors as provided in Chapter VI of the Bylaws to determine a Plan's adherence to these Standards.

Section 1. Plan approval

A Plan shall have substantial support of the medical profession, evidence of which shall be approval of the Plan by the appropriate medical society or societies.

Section 2. Nonprofit operation

A Plan shall operate on a not-for-profit basis. A Plan organized under laws other than nonprofit enabling acts shall include in its bylaws a specific provision for operation on a nonprofit basis. No director, officer, or any other individual shall receive, directly or indirectly, any profits from the operation of a Plan. Compensation for services performed or reimbursement for expenses incurred shall not be considered profit.

Section 3. Free choice of physician

Subject to express provisions of law, there shall be free choice by the patient of any duly licensed physician practicing in the area served by the Plan.

Section 4. Participating physician agreements

If a Plan utilizes Participating Physician Agreements, which in any way affect the services and/or benefits provided in the subscribers' certificates, such Plan shall secure and maintain the participation of not less than 51 per cent of the eligible doctors of medicine practicing in the area served by the Plan.

Section 5. Patient-physician relationship

The personal relationship between patient and physician shall not be abridged.

Section 6. Subscriber benefits

Benefits may be provided on a service or indemnity basis, or both.

A service benefit Plan shall provide acceptable proof of an adequate attempt to provide a maximum family income limit high enough to include potentially a substantial majority—75 per cent or more—of the population in its area of operation. Such income limits shall be related to a schedule of maximum payments for eligible services that is based upon the normal average medical charges for such professional services rendered in the area for persons within the income levels specified for service benefits.

An indemnity Plan shall provide acceptable proof of an adequate effort to establish and maintain a schedule of payments that approximates the normal average medical charges for eligible services rendered in that area for persons in the lower and medium income groups, comprising a substantial majority—75 per cent or more—of the population in its area of operation, thus providing its subscribers in these income groups with a reliable assurance that the Plans' payments will meet the actual costs of the services covered by their contracts.

Where indemnites are paid to the subscriber, it shall be clearly stated that these indemnities are for the purpose of assisting paying the charges incurred for medical service and do not necessarily cover the entire costs of medical service, except under specific conditions.

Each active member Plan shall make available a paid-in-full program, based upon the usual, customary and reasonable charges of physicians and which takes into consideration the patterns of charges for similar services provided under comparable circumstances in the same geographic area. Such programs shall show evidence of professional support; shall contain provision for the development and maintenance of individual physicians' charge patterns; and shall have regular professional review and analysis consistent with Plan responsibility to both physicians and the general public.

Effective June 1, 1970, such program shall include the Blue Shield Comprehensive Contract as approved by the membership on April 6, 1970.

Section 7. Public policy

A Plan shall be organized and operated to provide the greatest possible service to the subscriber.

A. A Plan's subscribers' certificates shall state clearly the benefits and the conditions under which such benefits will be provided. All exclusions, waiting periods, and deductible provisions must be clearly indicated in promotional literature and in the certificates.

B. A Plan's promotional activities shall be reasonable and shall avoid any misleading statements.

C. A Plan's medical/surgical claim expense over a reasonable period shall be not less than 75 per cent of earned subscriber income.

D. A Plan shall submit evidence that its practices provide for utilization review and control designed to safeguard the interests of all persons served by the Plan. Criteria for measuring the effectiveness of a Plan's utilization review program shall be established by the Board of Directors.

Section 8. Reports and records

A. A Plan shall maintain such records as may be required by the Board of Directors and shall submit such reports and information as the Board may require.

B. A Plan shall notify the National Association of Blue Shield Plans of any changes pertaining to the operation of the Plan, such as changes in its bylaws, major policies, membership of governing board, officers, certificates, rates, fee schedules, promotional literature, or other items of importance.

Section 9. Financial responsibility

A. A Plan shall maintain such reserves as are legally required; they shall also be reasonably sufficient to protect subscribers' and physicans' interests.

B. A Plan shall establish and maintain accounting practices which conform with recognized accounting principles and will afford a reliable financial statement. All operating statement data submitted to the Board of Directors shall be on an accrual basis.

C. A Plan shall provide adequate liabilities for medical/surgical claims reported but not yet paid and unreported medical/surgical claims, and shall reflect these liabilities in its operating statement.

Plans having less than 1.25 months of average monthly medical/surgical claims expense in this liability account shall submit at the request of the Board of Directors satisfactory evidence that its liability account for claims outstanding is adequate.

D. A Plan shall maintain an adequate reserve for contingencies over and above all liabilities. A Plan's reserves, exclusive of liability items included in paragraph (C.) above, shall be sufficient to meet medical/surgical and operating expenses for a period of three months.

A Plan which does not meet this requirement, and has not added at least 2 percent of gross income to its contingency reserves during the preceeding twelve-month period, exclusive of liability items included in paragraph (C.) above, shall produce evidence satisfactory to the Board of Directors that its financial policies are sound.

E. A Plan shall submit to the Board of Directors a certified annual audit report, containing a minimum of such information and certifications as the Board may require.

Section 10. Professional relations

A Plan shall maintain, as part of its regular organizational structure and operation, an active program of professional relations directed toward securing and maintaining close cooperation with practicing physicians and with its approving medical societies, which shall include the following:

A. A Plan shall submit to the governing board of its approving medical society(ies) an annual report of Plan operations and progress, and shall solicit and welcome the advice and guidance of its approving medical society(ies) in all matters of medical policy, in the composition of Plan boards and committees having jurisdiction over medical matters, and in the formulation of administrative procedures affecting professional relations.

B. A Plan shall utilize committees of the approving medical society or shall establish and maintain a committee or committees, a majority of whose members shall be doctors of medicine, responsible for recommendations concerning (1) the establishment, review and modification of schedules of payment for professional services; (2) the review of medical claims requiring individual consideration and the establishment of claims administration policy.

C. A Plan shall publish a physician manual which shall include its schedule of benefits and other basic information pertaining to the operation of the Plan.

Section 11. Plan performance

Each Plan shall be expected to effectively administer all programs in which it participates, based on guidelines established by the Board, and, where indicated, the Plan shall be expected to take corrective action to improve performance to acceptable levels within a reasonable period of time.

Section 12. Interplan obligations of members

Active membership in the Corporation involves the following obligations, in addition to those set forth elsewhere in the Bylaws and Membership Standards.

Each active Member shall participate in the following programs as presently operated or as may be duly changed by action of the Corporation:

(1) The Interplan Pooling Agreement on Name and Symbol.

(2) The Interplan Transfer Agreement.

Section 13. On-site surveys

The National Association of Blue Shield Plans shall periodically review each Plan's adherence to the Membership Standards by whatever means may be deemed appropriate.

On occasion, such review may include an on site survey of the Plan. A written report on the survey shall be submitted to such Plan and to the Board of Directors. Within thirty days of the receipt of such report, the Plan may submit its comment to the Board of Directors.

**Section 14. Standards subordinate to laws governing plans*

The foregoing Membership Standards, and each section and clause thereof, are subordinate to any law or governmental regulation governing the operation or activities of a member Plan, and the foregoing standards shall not be interpreted, construed or applied to require any Plan to violate the law or governmental regulation governing its operation or activities, or to impair a Plan's membership in the National Association of Blue Shield Plans, if the Plan is acting under requirements of law or governmental regulation.

The CHAIRMAN. I have a statement concerning my catastrophic health insurance bill. I will distribute it to the press. I simply submit that this is a minimum of what should be done. It has less complexities than any of the proposals that have been made. If we are to do anything I should think that this is a minimum.

I have listened with a great deal of interest during the course of these hearings as the sponsors and the major supporters of various national health insurance bills have described their proposals.

I have been impressed by the fact that a number of Senators of both parties have not only recognized a need for improved health insurance coverage, but have also obviously done a great deal of thinking in developing a variety of approaches to the problem.

I have further been impressed by the many issues that must be resolved and the many questions that must be answered as we try to deal with the problem of improving health insurance protection for our citizens. In my opening statement, I mentioned questions regarding the adequacy of present health insurance coverage; the capacity of our health system to supply more services; and the impact of any expanded program on the providers of health care and the quality of care which they render.

The testimony I have heard thus far has raised further issues which must be resolved. Two issues of particular importance are:

* For the membership year beginning in April 1971, this section will be renumbered Section 15, and a new Section 14 added, which reads as follows:

Section 14. Public representation

Each Plan shall provide for public participation in its affairs through adequate representation of the public on its Board of Directors. The adequacy of such representation shall be evaluated by the National Association of Blue Shield Plans Board of Directors.

(1) What are the advantages and disadvantages of governmental versus private administration of any federally supported health insurance programs?

(2) To what extent does the method of payment alone actually affect the delivery of medical services?

All of these questions must be carefully considered and I believe that the debate which is opening before this committee will have a very healthy effect on sharpening answers to these and other questions.

As we in Congress have seen many times over, sound legislation is developed through just this kind of careful debate and deliberate consideration.

We will continue that debate and deliberation, but at the same time I believe that we should move forward on a modest expansion of our Federal health insurance coverage which would give protection to the most unfortunate among us—those American families struck down by catastrophic illness or injury.

This is a step that we can take and a step that we should take—now. The oldest role of government is to help citizens deal with problems which are beyond their ability to solve as individuals. Almost any family regardless of their station in life can be devastated by a catastrophic illness. Financially, catastrophic illnesses have become far more common over the past decade as medical science has developed sophisticated and highly expensive methods of saving lives that would have been lost only a few years back. Patients with severe burns, spinal cord injuries, congenital heart defects, and kidney diseases are living in 1971 who would not have had a chance to survive 10 or 20 years ago. They have been saved by the medical wonders which we have grown used to reading of—open heart surgery, modern burn treatment, and kidney dialysis.

I believe that Government should keep pace with this medical progress, and develop a method of easing the financial effects of these illnesses through our social insurance system.

Last year I sponsored an amendment to the pending social security bill which would have established a catastrophic health insurance program within social security. I was proud to see this amendment pass in the Finance Committee by a vote of 13 to 2 after careful consideration. In an attempt to spur passage of a social security benefit increase in the closing days of the last congressional session, the catastrophic health insurance amendment was laid aside to speed floor debate on the social security bill.

This year I have reintroduced the proposal as it was passed by the committee last year. It is before us now as S. 1376, the catastrophic health insurance program.

I would ask at this point that the section from the Finance Committee report on H.R. 17550, the Social Security Amendments of 1970, which concerns the catastrophic health insurance program be inserted in the hearing record and I will merely summarize the major provisions of the bill.

(The excerpt referred to follows. Hearing continues on page 280.)

[Excerpt from S. Rept. 91–1431, Report of the Committee on Finance to accompany H.R. 17550, the Social Security Amendments of 1970]

V. Catastrophic Health Insurance Program

The Committee on Finance is concerned about the devastating effect which a catastrophic illness can have on families unfortunate enough to be affected by such an illness. Over the past decades science and medicine have taken great strides in their ability to sustain and prolong life. Patients with kidney failure, which until recently would have been rapidly fatal, can now be maintained in relative good health for many years with the aid of dyalysis and transplantation. Patients with spinal cord injuries and severe strokes can now often be restored to a level of functioning which would have been impossible years ago. Modern burn treatment centers can keep victims of severe burns alive and can offer the victim restorative surgery which can in many instances erase the after effects of such burns.

These are but a few examples of the impact which recent progress in science and medicine has had. This progress, however, has had another impact. These catastrophic illnesses and injuries which heretofore would have been rapidly fatal and hence not too expensive financially, now have an enormous impact on a family's finances. The newly developed methods of treating catastrophic illnesses and injuries involve long periods of hospitalization, often in special intensive care units, and the use of complex and highly expensive machines and devices. The net cost of a catastrophic illness or injury can be and usually is staggering. Hospital and medical expenses of many thousands of dollars can rapidly deplete the resources of nearly any family in America. These families are then faced not only with the devastating effect of the illness itself, but also with the necessity of accepting charity or welfare. Catastrophic illnesses do not strike often, but when they do the effects are disastrous—particularly in the context of soaring health care costs.

The Committee on Finance believes that Government and social insurance programs should be able to respond to the progress made in medical science. Medicine and science are now often able to mitigate the physical effects of a catastrophic illness or injury, and the committee believes that government, through our established social insurance mechanism should act to mitigate the financial effects of such catastrophes.

The committee has adopted an amendment which would establish a Catastrophic Health Insurance Program.

The program would be designed to complement private health insurance which has played the major role in insuring against basic health expenses. About 80 percent of people under age 65 have insurance against hospitalization expenses, but these policies all have a limit on hospitals days which they will cover. The most common policies cover 60 days of care. Similarly, existing private policies designed to cover medical expenses have upper limits of coverage. Private major medical insurance plans are available, but are held by only 20 to 30 percent of the population. In addition, even the major medical plans have maximum benefits per spell of illness, usually ranging from $5,000 to $20,000.

The committee's Catastrophic Health Insurance Program would be structured to take maximum advantage of the experience gained by medicare. The program would use medicare's established administrative mechanism wherever possible, and would incorporate all of medicare's cost and utilization controls.

ELIGIBILITY

The committee amendment establishes a new Catastrophic Health Insurance Program (CHIP) as part of the Social Security Act financed by payroll contributions from employees, employers and the self-employed. Under the committee's provision all persons under age 65 who are fully or currently insured under the social security program, their spouses and dependent children would be eligible for CHIP protection. All persons under age 65 who are entitled to retirement, survivors, or disability benefits under social security as well as their spouses and dependent children would also be eligible for CHIP. This constitutes about 95 percent of all persons under age 65.

Persons over 65 would not be covered as they are protected under the medicare program which, in spite of its limitation on hospital and extended-care days, is a program with a benefit structure adequate to meet the significant health care needs of all but a very small minority of aged beneficiaries. The largest noncovered groups under age 65 are Federal employees, employees covered by

the Railroad Retirement Act, and State and local governmental employees who are eligible for social security but not covered due to the lack of an agreement with the state. (There are a small number of people who are still not covered by social security or other retirement programs; the majority of these are domestic or agricultural workers who have not met the necessary social security coverage requirements.)

Federal employees are, however, eligible for both basic and major medical catastrophic health insurance protection under the Federal Employees Health Benefits Act, with the Federal Government paying 40 percent of the costs of such coverage. To assure equitable treatment of those Federal employees who also are eligible for social security, a special provision of the committee bill would require the Federal Employees Health Benefits program to make available to Federal employees who have sufficient social security coverage to be eligible under CHIP, a plan which supplements CHIP coverage; if such a plan is not made available to Federal employees, no CHIP payments will be available for services otherwise payable under the FEHB plan.

BUY-IN FOR STATE AND LOCAL EMPLOYEES

Under the committee bill, State and local employees who are not covered by social security could receive coverage under CHIP if the State and local governments exercise an option to buy into the program to cover them on a group basis. When purchasing this protection, States would ordinarily be expected to include all employees and eligible annuitants under a single agreement with the Secretary. A determination by the State as to whether an individual is an annuitant or member of a retirement system or is otherwise eligible to have such coverage purchased on his behalf would, for purposes of the agreement to provide CHIP protection, be final and binding upon the Secretary. Each State which enters into an agreement with the Secretary of Health, Education, and Welfare to purchase CHIP protection will be required to reimburse the Federal Catastrophic Health Insurance Trust Fund for the payments made from the fund for the services furnished to those persons covered under CHIP through the State's agreement with the Secretary, plus the administrative expenses incurred by the Department of Health, Education, and Welfare in carrying out the agreement. Payments will be made from the fund to providers of services for covered services furnished to these persons on the same basis as for other persons entitled to benefits under CHIP. Conditions are also specified under which the Secretary or the State could, after due notice terminate the agreement.

BENEFITS

The benefits that would be provided under CHIP would be the same as those currently provided under parts A and B of medicare, except that there would be no upper limitations on hospital days, extended care facility days, or home health visits. Present medicare coverage under part A includes 90 days of hospital care and 60 days of post-hospital extended care in a benefit period, plus an additional lifetime reserve of 60 hospital days; and 100 home health visits during the year following discharge from a hospital or extended care facility. Part B coverage includes physicians' services, 100 home health visits annually, outpatient physical therapy services, laboratory and X-ray services and other medical and health items and services such as durable medical equipment.

The major benefits excluded from medicare, and consequently excluded from this proposal, are nursing home care, prescription drugs, hearing aids, eyeglasses, false teeth and dental care. Medicare's limitations on inpatient care in psychiatric hospitals, which limit payment to active treatment subject to a 190 day lifetime maximum, and the program's annual limitation on outpatient services in connection with mental, psychoneurotic and personality disorders are also retained. An additional exclusion would be for items or services which the Secretary of Health, Education, and Welfare rules to be experimental nature.

DEDUCTIBLES AND COINSURANCE

The committee believes that in keeping with the intent of this program to protect against health costs so severe that they usually have a catastrophic impact on a family's finances, a deductible of substantial size should be required. The committee's proposal has two entirely separate deductibles which would parallel the inpatient hospital deductible under part A and the $50 deductible under part B of medicare.

The separate deductibles are intended to enhance the mesh of the program with private insurance coverage. In order to receive both hospital and medical benefits, both deductibles must be met. If a person were to meet the hospital deductible alone, he would become eligible only for the hospital and extended care benefits. Similarly, if a family were to meet the $2,000 medical deductible, they would become eligible only for the medical benefits.

HOSPITAL DEDUCTIBLE AND COINSURANCE

There would be a hospital deductible of 60 days hospitalization per year per individual.

After an individual has been hospitalized for a total of 60 days in one year, he would become eligible for payments toward hospital expenses associated with continued hospitalization. The program would thus begin payment with the 61st day of his hospitalization in that year. Only those posthospital extended care services which he receives subsequent to having met the 60-day deductible would be eligible for payment.

After the hospital deductible has been met, the program would pay hospitals substantially as they are presently paid under medicare, with the individual being responsible for a coinsurance amount equal to one-fourth of the medicare inpatient hospital deductible applicable at that time. Extended care services which are eligible for payment would be subject to a daily coinsurance amount equal to one-eight of the medicare inpatient hospital deductible. In January 1971, this coinsurance will amount to $15 a day for inpatient hospital services and $7.50 a day for extended care services. Thus the coinsurance could rise yearly in proportion to any increase in hospital costs.

MEDICAL DEDUCTIBLE AND COINSURANCE

There would be a supplemental medical deductible initially established at $2,000 per year per family. The Secretary of Health, Education, and Welfare would, between July 1 and October 1 of each year (beginning in 1972), determine and announce the amount of the supplemental medical deductible for the following year.

The deductible would be the greater of $2,000 or $2,000 multiplied by the ratio of the physicians' services component of the Consumer Price Index for June of that year to the level of that component for December 1971. Thus, the deductible could rise yearly in proportion to any increase in the price of physicians' services.

After a family has incurred expenses of $2,000 for physicians' bills, home health visits, physical therapy services, laboratory, and X-ray services and other covered medical and health services the family would become eligible for payment under the program toward these expenses. For purposes of determining the deductible, a family would be defined as a husband and wife and all minor and dependent children.

After the medical deductible had been met, the program would pay for 80 percent of eligible medical expenses, with the patient being responsible for coinsurance of 20 percent.

DEDUCTIBLE CARRYOVER

As in part B of medicare, the plan would have a deductible carryover feature—applicable to both the dollar deductible and the hospital-day deductible—under which expenses incurred (or hospital days used) but not reimbursed during the last calendar quarter of a year would also count toward the satisfaction of the deductibles for the ensuing year. For example, an individual admitted to a hospital with a cardiac condition on December 10, 1972, and continuously hospitalized through February 19, 1973, would not, in the absence of the carryover provision, meet the hospital-day deductible unless he were to be hospitalized for at least another 10 days in 1973. With a carryover provision, however, the individual described above would meet the hospital deductible on January 30, 1973. Similarly, if a family's first eligible medical expenses in 1972 amount to $1,200 and were incurred during the months of November and December, and an additional $3,000 in eligible medical expenses are incurred in 1973, the family would, in the absence of a carryover provision, be eligible for payment towards only $1,000 of their expenses in 1973. With a carryover provision, however, the family described above would be eligible for payment toward $2,200 of their expenses in 1973.

ADMINISTRATION

Payments made to patients, providers, and practitioners under this program would be subject to the same reimbursement, quality, health and safety standards, and utilization controls as exist in the medicare program. Reimbursement controls would include the payment of audited "reasonable costs" to participating institutions and agencies, and "reasonable charges" to practitioners and other suppliers. However, the committee expects that appropriate modifications will be made to take into account the special features of this program, including a modification to exclude "bad debts" from those costs eligible in computing reasonable cost payments to institutions.

The utilization of services would be subject to review by present utilization review committees established in hospitals and extended care facilities and by the professional standards review organizations established under another committee amendment. The committee believes that all of the above controls should be applied to reimbursement of expenses for serviecs rendered under the proposed catastrophic illness insurance program. In addition, the Office of the Inspector General for Health Administration established under another committee amendment would be expected to closely monitor the administration of the program and can be expected to provide valuable information with respect to increasing the efficiency of the program.

The proposal contemplates using the same administrative mechanisms used for the administration of medicare including, where appropriate, medicare's carriers and intermediaries. Using the same administrative mechanisms as medicare will greatly facilitate the operation of this program. The proposal also would encompass use of medicare's statutory quality standards, in that the same conditions of participation which apply to institutions participating in medicare would apply to those institutions participating in CHIP. These standards serve to upgrade the quality of medical care and their application under this program should have a similar salutary effect.

The Social Security Administration, utilizing its network of district offices, would determine the insured status of indivduals and relatonships within families which are necessary to establish entitlement to CHIP benefits. The determination of whether the deductible expenses had been met would also be handled by the Social Security Administration in cooperation with carriers and intermediaries. The proposed administrative plan envisions establishing a $2,000 minimum expense amount before individual bills would be accepted. This would protect the administrative agencies from being inundated with paperwork.

FINANCING

The first year's cost of the program is estimated at $2.5 billion on an incurred basis and $2.2 billion on a cash basis. The committee provision would finance the program on a $9,000 wage base with the following contribution schedule: 1972–74, 0.3 of one percent of taxable payroll on employees and 0.3 on employers; 1975–79, 0.35; 1980 and after, 0.4. Rates for the self-employed would also be 0.3, 0.35, and 0.4 respectively.

The contributions would be placed in a separate Federal Catastrophic Health Insurance Trust Fund from which benefits and administrative expenses related to this program would be paid. The complete separation of catastrophic health insurance financing and benefit payments is intended to assure that the catastrophic health insurance program will in no way impinge upon the financial soundness of the retirement, survivors, or disability insurance trust funds or medicare's hospital and supplementary medical insurance trust funds. Such separation will also focus public and congressional attention closely on the cost and the adequacy of the financing of the program.

To provide an operating fund at the beginning of the program (in recognition of the lag in time between the date on which the taxes are payable and their collection), and to establish a contingency reserve, a Government appropriation would be available (on a repayable basis without interest) during the first 3 calendar years of the program. The amount which could be drawn in any such calendar year could not exceed the estimated amount of 6 months of benefit payments during that year.

RELATIONSHIP WITH MEDICAID

The catastrophic illness insurance program would be supplemental to the medicaid program with regard to public assistance recipients and the medically

indigent in the same way in which it will be supplemental to private insurance for other citizens. Thus, medicaid will continue to be the State-Federal program that is intended to cover the basic health needs of categorical assistance recipients and the medically indigent. The benefit structure of medicaid varies from State to State, but in general it is a basic rather than a catastrophic benefit package.

In addition, medicaid will continue to play a substantial role in financing the cost of nursing home care, which represents a catastrophic cost to many people, especially the aged. The catastrophic health insurance program will, of course, lessen the burden on the medicaid program to some degree, since those covered by medicaid who are eligible would have a large proportion of their catastrophic expenses covered by this program, leaving only the deductible and coinsurance amounts for the medicaid program to pay. This factor will not only enable the States to contain the costs of their programs, but may also encourage them to improve coverage of basic services.

CONCLUSION

The committee estimates that more than one million families of the approximately 49 million families in the United States annually incur medical expenses which will qualify them to receive benefits under the program. Of course, nearly all American families will receive the benefit of insurance protection against the costs of catastrophic illnesses. The program is not intended to meet the health costs which the population incurs for short-term hospitalization and acute illness. This program is intended to insure against those highly expensive illnesses or conditions which, although a potential threat to every family, actually strike only a relatively few. The committee believes that individuals should, during their working years, be able to obtain protection against the devastating and demoralizing effects of such costs.

These provisions and the taxes to pay for them would become effective January 1, 1972.

The CHAIRMAN. The bill would establish a national program of catastrophic health insurance for people under 65 which would be administered by social security and which is designed to supplement and mesh with existing private health insurance and medicaid. Medicare would continue for those over 65. Medicaid would also continue providing basic health insurance coverage to the poor.

The program would have the same benefits as medicare except that there would be no upper limits on hospital days. Because the program is designed to provide coverage against catastrophic illnesses it contains substantial deductibles of 60 days' hospitalization and $2,000 of medical expenses which would have to be met before the individual would become eligible for coverage under the program. The majority of working people either have or can obtain private insurance coverage for their first 60 days of hospitalization and their first $2,000 of medical expenses. For poor families medicaid would play a role in meeting the deductible.

The program would be administered by social security in the same fashion as medicare. All payments to patients, providers, and practitioners would be subject to the same reimbursement controls as are applied in medicare. Similarly, quality, health and safety standards, and utilization controls used in the medicare program would apply in the catastrophic health insurance program.

The plan would be financed through payroll contributions from employees, employers, and the self-employed on a $9,000 wage base. The tax rate on each would be 0.3 percent in 1972, 0.35 percent in 1975, and 0.4 percent in 1980 and thereafter. The cost of the proposal is estimated to be $2.5 billion in the first full year of operation.

S. 1376 is administratively feasible. It makes use of an administrative structure that is in operation today. No new bureaucracy need be created. No new administrative techniques need to be developed.

The proposal I have outlined is not inflationary. It incorporates all of the cost controls that we are building into medicare. Further the program would not generate frivolous demands on our health care system. The people who will receive financial relief from this program are in large part already receiving services so we need not worry about the possible inflationary effects of overall increased demand.

The proposal I have outlined has been carefully and deliberately considered in committee previously. Most important, it meets a very pressing national need by closing one of the most serious gaps in our present health insurance programs.

A large number of the individual cases described to us by Senators over the past few days as examples of the need for expanded Government health insurance coverage would have been provided with financial relief if my proposal were in effect.

Before concluding, I would like to state again that I am open to modifications in my proposal. Frankly, I was initially interested in building into my proposal a variable deductible feature in which poorer families would have lower deductibles. I realize that what is financially catastrophic for one family may not be as financially damaging to another. However, I received a good deal of expert advice that a variable deductible posed enormous administrative problems.

Incidentally, I found during my exchange with the representatives of the AFL–CIO yesterday that the deductible feature of my bill was the subject of some misunderstanding. If a family were poor, and did not have private insurance coverage so that they were unable to pay for their first $2,000 of medical services, they would still be eligible for benefits under my proposal. The $2,000 deductible relates to expenses incurred by a family, not to bills paid. So every American family covered under social security regardless of their financial position would benefit from my bill once medical expenses for the family reached $2,000 in a year.

On balance I feel that the best way to assure comprehensive and equitable coverage for poor families would be to make certain that our basic health program for the poor has a benefit structure which is adequate to meet both catastrophic deductibles. In many States, medicaid currently provides 60 days of hospital care and I would hope that as we consider medicaid, especially in the context of the President's family health insurance modifications, we can build in an adequate national benefit structure.

There are other potential modifications which might be made in the program. My proposal covers the disabled. If Congress chooses to cover the disabled under medicare, it will substantially lower the cost of covering this group under the catastrophic proposal. This "savings" might be used to expand the benefits in the catastrophic program or to broaden its population coverage. I have requested estimates from the Social Security Administration on the costs, for example, of extending catastrophic coverage to those over 65 and of including skilled nursing home care as a benefit.

Finally, I am aware that a few voices have been raised in opposition to the catastrophic health insurance proposal. This opposition has all been on the same grounds. A few observers feel that passage of the catastrophic health insurance proposal will destroy the chances of passage of a national health insurance bill.

I feel that these people are mistaken. If basic health insurance protection for the population as a whole is inadequate, and if the health care system needs a complete restructuring, I think Congress will recognize these needs in the course of a national debate and act appropriately.

In the meantime, I think it is somewhat cynical to hold those who are suffering from catastrophic illnesses "hostage" in an attempt to build a drive for national health insurance on their misfortune.

If the citizens in this country and their elected representatives feel there is a need for a national health insurance system after a thorough debate, then we will initiate such a system. But in the meanwhile let us help the most unfortunate among us—those with catastrophic illnesses.

This concludes the hearings for now. Of course, this is just the beginning of this committee's study on this issue. We will go into this matter in greater depth at a later date and we hope that all those interested in this issue will study the statements that have been made, as well as the questions and answers, and develop constructive suggestions based on a study of this record.

Thank you very much.

(Whereupon, at 4:10 p.m. the hearing adjourned to reconvene at the call of the Chair.)

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