92d Congress
1st Session

COMMITTEE PRINT

NATIONAL HEALTH INSURANCE

BRIEF OUTLINE OF PENDING BILLS

COMMITTEE ON FINANCE
UNITED STATES SENATE
RUSSELL B. LONG, *Chairman*

APRIL 26, 1971

Prepared by the staff and printed for the use
of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
50-789 WASHINGTON : 1971

S 362-6

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CONTENTS

	Page
S. 3—Health Security Act—Senator Edward M. Kennedy	1
A. General Approach	1
B. People Covered	1
C. Scope of Benefits	1
D. Payment to Providers	1
E. Administration	2
F. Financing	2
G. Cost Estimates	2
H. Other Major Provisions	2
S. 191—National Catastrophic Illness Protection Act—Senator J. Caleb Boggs	3
A. General Approach	3
B. People Covered	3
C. Scope of Benefits	3
D. Payment to Providers	3
E. Administration	3
F. Financing	3
G. Cost Estimates	3
H. Other Major Provisions	
S. 836—National Health Insurance and Health Improvements Act—Senator Jacob K. Javits	5
A. General Approach	5
B. People Covered	5
C. Scope of Benefits	5
D. Payment to Providers	5
E. Administration	5
F. Financing	5
G. Cost Estimates	6
H. Other Major Provisions	6
S. 987—Health Care Insurance Assistance Act—Senator Clifford P. Hansen	7
A. General Approach	7
B. People Covered	7
C. Scope of Benefits	7
D. Payment to Providers	7
E. Administration	8
F. Financing	8
G. Cost Estimates	8
S. 1376—Catastrophic Health Insurance Program—Senator Russell B. Long	9
A. General Approach	9
B. People Covered	9
C. Scope of Benefits	9
D. Payment to Providers	9
E. Administration	9
F. Financing	9
G. Cost Estimates	9

S. 1490—National Health Care Act—Senator Thomas J, McIntyre 11
A. General Approach 11
B. People Covered 11
C. Scope of Benefits 11
D. Payment to Providers 12
E. Administration 12
F. Financing 12
G. Cost Estimates 12
H. Other Major Provisions 13

S. 1598—Health Rights Act—Senator Hugh Scott 15
A. General Approach 15
B. People Covered 15
C. Scope of Benefits 15
D. Payment to Providers 16
E. Administration 16
F. Financing 16
G. Cost Estimates 16
H. Other Major Provisions 16

S. 1623—National Health Insurance Partnership Act—Senator Wallace F. Bennett 17
A. General Approach 17
B. People Covered 17
C. Scope of Benefits 17
D. Deductibles and Coinsurance 17
E. Payments to Providers and Practitioners 18
F. Administration 18
G. Financing 18
H. Cost Estimates 18

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 support 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.

59-789—71——2

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

Present methods under private insurance, except that, under the State health care plans, payments would be limited to the 75th percentile of reasonable charges for professional services or 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.

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 (½) 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.

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