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BRIEF COMPARISON OF MAJOR HEALTH CARE FINANCING BILLS INTRODUCED IN THE 91ST CONGRESS

Sept. 25, 1970

NOTE: This material has been prepared by the staff of the Committee on Ways and Means for the purpose of assisting Members in responding to inquiries. This document has not been considered by the Committee on Ways and Means or any Member thereof.

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Brief Comparison of Major Health Care Financing Bills Introduced in the 91st Congress

Proposal	H.R. 24 Dingell	H.R. 15779 Griffiths	H.R. 18567 Fulton (Tennessee)	H.R. 19050 (and others) Annunzio, Corman (and others)	S. 3711 Javits (No House bill)
General approach	Workers with a recent attachment to the work force, and their dependents, would be eligible for a comprehensive set of benefits. Would not replace medicare but States could buy the protection for medicaid eligibles with Federal financial help.	A comprehensive national health insurance proposal following the general idea of medicare but applied to the total population. Provisions are included designed to improve health care delivery system. Repeals medicare and medicaid.	Pays for health insurance premiums of the poor. Decreases Federal contribution toward the approved health insurance policy as Federal tax liability goes up. Peer review organizations, based on State medical societies, would be set up in each State.	A national health insurance plan, administered by the Federal Government, applied to all U.S. residents, comprehensive in benefits and financed by a combination of payroll taxes and general revenues. Provisions are included designed to improve quality and efficiency of health care delivery system; medicare would be repealed but medicaid would continue.	A national health insurance plan through a gradual expansion of medicare program to the general population. Medicare and medicaid would be continued. No part B premium under medicare.
People covered	Workers who meet any of several alternative work requirements, plus the indigent who are covered under a State plan to pay costs on their behalf.	Every individual in the United States except recent immigrants and members of the Armed Forces would be covered. No exclusions based on income or health would be made.	The total population would be covered. Those with a Federal tax liability under $300 would be covered at no cost. Federal share gradually decreases from 100 percent until those with a tax liability of $1,300 or more would get a tax credit of 10 percent of the premium cost.	All U.S. citizens and aliens admitted for permanent residence would be covered.	Medicare would be extended to the disabled effective July 1971. Effective July 1973, the program would be extended to all citizens and aliens admitted for permanent residence.
Benefits provided	(1) All medical services, including preventive, diagnostic, and therapeutic services. (2) Home nursing services. (3) 60 days of hospital care in 2 years. (4) Auxiliary services, including laboratory services, physical therapy, eye care, expensive drugs, and special medical appliances. (5) Other services which are found to be practical and essential to good health care. TB and mental hospitals would not be included.	(1) Comprehensive health services including physician' services, preventive care, mental health care, diagnostic services, and physical examinations. (2) Institutional (including hospital and nursing home) services and home health services. (3) Eye care, dental services for children, drugs, prosthetic devices and durable medical goods. There would be no deductible or coinsurance except for $2 charge for each service other than institutional services; could not exceed a total of $50 in a year.	Approved policy would have to provide a minimum of: (1) 60 days of hospital care with $50 deductible; (2) Outpatient hospital services, subject to 20-percent coinsurance on first $500; and (3) Physicians' services. Optional benefits could include: (1) Drugs subject to $50 deductible; (2) Additional hospital days subject to 20-percent coinsurance; (3) Blood; and (4) Other diagnostic and therapeutic services, with 20-percent coinsurance.	(1) Comprehensive health benefits. (2) Exclusions: (a) Dental care for adults. (b) Outpatient drugs except under group practice or for chronic conditions. (c) Nursing home care in excess of 120 days. (d) Mental hospital care in excess of 45 days. (3) No deductibles or coinsurance.	Same benefits as under medicare at the beginning: 1. 90 days of hospital care with $52 deductible and coinsurance after 60th day. 2. Posthospital extended care. 3. Physicians and related services including outpatient diagnostic services, home health services, and physical therapy. Additional benefits as follows: July 1971—Maintenance drugs for chronic conditions. 1973—Annual physical examinations. 1973—Dental care for children under 8.
Payment procedures	Fee schedule, per capita, or other basis as decided by administering State agency.	Physician and dentist groups can contract to receive predetermined payment and pay their members as they choose (including fee for service). Individual primary physicians and dentists may elect per capita, salary, or combination of methods and receive an allowance to pay for services of specialists and other health professionals. Hospitals: Negotiated budget that includes allowance for nursing home and home health services.	Present methods under private insurance.	Physicians and dentists: Regional funds allocated first to those in group practice or selecting capitation, salary, or per-session basis. Residual allocated to local payment authorities to pay those selecting fee-for-service or per-case basis. Hospitals, nursing homes, home health agencies: Negotiated budget designed to pay reasonable cost for efficient organization.	Until July 1, 1973, reasonable cost for hospital and institutions and reasonable charges for physicians (as under medicare). Thereafter, new methods, developed in interim, may be employed.

Administration	Decentralized to the States and then further to local health service area administrator. Emphasis is on local administration.	Establishes a National Health Insurance Board for direct Federal administration of program. Private insurance carriers or intermediaries would not be used.	Establishes Health Insurance Advisory Board to write policy and regulations. Private carriers would each administer their own approved policy.	There would be direct Federal administration by HEW. Regional officer would be given strong discretionary powers. No health insurance organizations would be used under the plan.	Essentially the same as medicare. Direct Federal administration using carriers, intermediaries, and State health agencies for appropriate role. New public corporations could administer if private carriers could not.
Financing	Not specified, but implied that revenue would come primarily from payroll taxes. Appropriation to special account would equal 3 percent of payrolls on $6,600 annual tax base.	Financed by payroll tax of 3 percent on employers, 1 percent on employees, and 3 percent from Federal general revenues, on first $15,000 of annual earnings, increasing as earnings levels increase.	Costs would be met by Federal general revenue expenditures and reduction in income tax collections.	Financed by a payroll tax on employers (35 percent of costs); on employees (25 percent of costs); and the balance (40 percent) from general revenues. Annual tax base would be $15,000, workers with earnings below $4,000 a year would pay no tax.	Financed by payroll taxes (3.3 percent needed in 1975 and later) with Federal general revenue contributions equal to one-half of the payroll tax. Annual tax base would be $15,000.
Costs	No estimate available.	AFL-CIO estimate: Would have been $45,000,000,000 in 1969.	American Medical Association estimate, $10,000,000,000. Social Security Administration estimate, $15,800,000,000.	UAW estimate: Would have cost $40,000,000,000 in fiscal year 1969. HEW estimate: $77,000,000,000 in first year of operation (fiscal year 1974).	Estimate by Social Security Administration—$66,400,000,000 in 1975.
Other major provisions		(1) Grants-in-aid are to be provided for the planning and development of comprehensive health delivery systems. (2) Preference for grants and loans toward the construction or remodeling of health facilities under the Hill-Burton program would be given to those comprehensive health plans undertaking a total responsibility for providing, or for arranging for, the benefits covered by the bill. (3) Subsidized loans for the initial staffing of comprehensive health delivery systems would be provided. (4) A 5-percent bonus would be extended to any hospital, medical, or dental group which undertakes to provide, or arrange for, all benefits under the bill.		Authorizes a total of $1,200,000,000 to be used for improving the health delivery system in preparation for the program. After the program is in effect (beginning with fiscal year 1974) the ongoing program would support all types of activity to improve the health delivery system. Establishes national standards for providers and incentives for group practice.	Individuals can elect to take coverage from private carriers offering comparable or better protection. Employer plans may qualify if they pay 75 percent of the cost and the protection is better than the Government plan.

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