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THE WHITE HOUSE

WASHINGTON

December 20, 1975

ADMINISTRATIVELY CONFIDENTIAL

MEMORANDUM FOR: JIM CANNON
JIM LYNN

FROM: JIM CONNOR JEC

SUBJECT: Health Initiatives

The President reviewed your recent undated memorandum on the above subject and approved the following:

Option II - which would:

-- Limit Medicare reimbursement increases to 7% for hospitals and 4% for physicians (savings of $988 million in 1977);

-- as in Option 1, consolidate the health services programs ($1.4 billion) but add Medicaid for a total $10 billion State Health Revenue Sharing proposal. States would be required to provide basic health services to the poor before spending those funds on non-priority programs; and

--mandate that employers who offer health insurance also offer catastrophic health insurance protection (with specific limits to be defined).

Please follow-up with appropriate action.

cc: Dick Cheney

THE WHITE HOUSE
WASHINGTON

Jim -

I took this decision from the table ---- Do you want this confirming memo to go or are you holding it for something?

Trudy

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

DECISION

DECISION

MEMORANDUM FOR: THE PRESIDENT

FROM: JIM CANNON
JIM LYNN

SUBJECT: Health Initiatives

I. PURPOSE

The purpose of this memorandum is to present for your decision two alternatives for your health initiatives in the 1977 Budget. As we discussed yesterday, your decision will move you closer to or further from your previous position on national health insurance.

II. BACKGROUND

The House is currently holding hearings on national health insurance. In the Senate, Senators Long and Ribicoff have again recently introduced their proposal for universal catastrophic coverage and a federally funded basic benefit package for the poor population to replace Medicaid. In short, the national health insurance issue is politically inescapable during the next year.

III. OPTIONS

Description of Option I (Domestic Council)

Option I would be a clearly specified time-phased approach to national health insurance which makes progress at each stage contingent upon accomplishment of the previous stage. Stage I would save $700 million in FY 1977 from an unconstrained estimate by imposing an 8% limit on all hospital rates.

Over a 5-year period, States would be required to regulate both physician's fees and hospital rate increases. Under separate legislation, the health services programs ($1.4 billion in 1975), would be consolidated, with the exception of Medicaid.

Stage 2 would be implemented only after the Stage I mechanism has been legislated. In Stage 2, Medicare cost-sharing reforms would be instituted. A low cost catastrophic program for the entire population and expanded maternity and child care would be provided. The increased costs of these proposals would be met by adjustments in cost control levels and cost sharing for the new benefits and by using the $1.7 billion "saving" produced by Medicare reform. These benefits would be funded primarily through private insurance plans, however, for those not covered by a private plan, Federal coverage would be available. Stage 3 would consist of a comprehensive health insurance program based on a private plan coverage, tailored to reflect the experiences of Stages 1 and 2, to become effective when fiscal policy permits. (Estimated increased Federal costs of $8 billion in 1975 dollars)

Description of Option II (OMB)

Option II would:

-- limit Medicare reimbursement increases to 7% for hospitals and 4% for physicians (savings of $988 million in 1977);

-- as in Option I, consolidate the health services programs ($1.4 billion) but add Medicaid for a total $10 billion State Health Revenue Sharing proposal. States would be required to provide basic health services to the poor before spending those funds on non-priority programs; and

-- mandate that employers who offer health insurance also offer catastrophic health insurance protection (with specific limits to be defined).

At a later stage, other liberalizations, e.g., special coverage for early retirees and the working poor not now offered health insurance, could be required as the economic situation improves.

IV. BASIC ISSUES

The options differ substantially in terms of the Federal role in cost control and coverage.

Cost Control

Option 1 would require Federal regulation of all hospital and physician charges. States would be encouraged to assume these functions, but Federal controls would be imposed for those who do not.

Option 2 would place limits only on Medicare hospital and physician reimbursements in FY 1977.

Coverage

Option 1 would provide continuation of Medicaid. Stage 2 would mandate private plan coverage of catastrophic and maternal and well-child care. Benefits for those not covered for catastrophic and maternal and well-child care under private plans would be federally financed.

Option 2 would provide an average of $400 per low income person for States to provide basic health services for the poor. Employers who offer health insurance plans would be required to offer catastrophic protection. Individuals would not be required to purchase insurance to pay for budgetable expenses, e.g., well-child care.

V. ARGUMENTS IN FAVOR OF AND AGAINST THE OPTIONS

Arguments in Favor of Option I

1. This approach clearly maintains a presidential commitment to national health insurance when economic and fiscal conditions permit.

2. By coupling cost control measures with expanded benefits it offers a better chance of achieving enactment of cost control.

3. For all the substantive reasons that CHIP was endorsed by the Administration, this approach is oriented in that direction--with emphasis on private-sector financing of the employee plan, with emphasis on significant cost-sharing, with emphasis on State administration, etc.

4. Its time-phasing character--and particularly its emphasis on cost-control first--renders it fiscally responsible. Further, it provides an opportunity for public policy makers to "look before they leap"--in that Stage II experience may be used to consider modifications in the approach to Stage III.

5. It allows the President to have a positive, fiscally responsible, program of his own--in an area of wide public concern. It would also be likely to improve the President's capacity to sustain vetoes, as necessary.

6. This option would preserve your flexibility to propose a "cash out" of health services financing as part of welfare reform.

Arguments Against Option I

1. Option I would require permanent Federal regulation and additional Federal employment to set hospital and physicians' fees for those States that fail to do so. The equity and quality considerations in these areas would be highly judgmental and controversial.

2. The inequities of the Medicaid program would be continued unless eventually eliminated by added Federal spending. Federal Medicaid spending for the poverty population ranges from $84 to $740 per capita among States.

3. It shifts the major cost burden away from State and local governments to the Federal budget and is directly contrary to the general Federal policy of increasing reliance on States. Increased Federal financing would reduce State incentives for health cost control.

4. It requires more extensive Federal reform and regulation of health insurance and financing than some of the proposals now before the Congress. The Administration has opposed 100% Federal financing of new health benefits since it would lead to federalization of the health industry.

5. This option would withdraw support for the $1.7 billion Medicare cost-sharing proposal which has some merit in affecting overutilization. Reductions elsewhere would be required.

6. The mandating of new benefits to be financed by employers would mean, in effect, an increase in sales taxes.

7. This option places the "stick" of hospital reimbursement and physician fee regulation "before" the "carrot" of increased benefits.

8. A presidential endorsement of national health insurance in concept may, in an election year, induce Congress to enact some form of comprehensive national health insurance with a delayed effective date.

Arguments in Favor of Option II

1. A $10 billion grant consolidation proposal for health benefits for the poor would constitute a dramatic proposal on your part. Moreover, the proposed average $400 per poor person offers an equitable and easily comprehensible Federal policy for contributing to health care for the poor.

2. A fixed grant permits the Federal Government to review budget needs and priorities annually and determine the appropriate Federal contribution for financing health services for the poor. Moreover, it would more equitably be related to the number of poor people in the various States, rather than the current system which favors wealthier States.

3. A clearly limited Federal payment will encourage States to control health care costs, e.g., through health planning, licensure, prospective hospital budgeting and rate regulation, improved delivery systems.

4. The proposal would permit States broad flexibility to design programs to meet health needs of their population and to balance their health spending against other spending priorities.

5. This option provides more time before committing to any specifics of health insurance, but does not preclude any alternative form of health insurance being proposed at a later date.

6. This option does not add more Federal regulation of the private sector and limits Federal involvement only to those cases in which the Federal Government pays the bill.

7. The savings of $1.7 billion in Medicare can contribute to meeting the 1977 budget totals.

Arguments Against Option II

1. Limiting Medicare reimbursement in 1977 does not get at the long term inflationary spiral of health costs. Increased costs might be shifted to the non-Medicare patients, resulting in increased costs to the middle class through direct payment to providers or through increased health insurance premiums.

2. States may attempt to spend the funds they receive on the non-poor or to provide a lower or different level of care for the low income. There is the possibility that the poor would only be treated in county hospitals.

3. Politically, Option II represents a marked departure from the Administration's earlier Comprehensive Health Insurance Plan (CHIP) proposal. It would make it more difficult to eventually integrate low income health care into a national health insurance plan, thereby making your political position on this issue more difficult in the year ahead.

VI. DECISION

☐ Option I — Jim Cannon

☑ Option II — Jim Lynn
Alan Greenspan
Robert T. Hartmann
Max Friedersdorf
"Option II is more fiscally sound and provides more time before committing to specifics on health insurance. I sense a lot of steam has gone out of health insurance and I would be surprised if there is massive support on the Hill next year. I don't want to see the President out front on this issue. Option II keeps us in the game, but not as the coach."
Jack Marsh