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Department of Health, Education and Welfare
October 1976

A COMPARISON OF THE COST OF MAJOR NATIONAL HEALTH INSURANCE PROPOSALS

This paper summarizes the findings of a recent report on the comparative cost of major national health insurance proposals prepared for the Department of Health, Education and Welfare by an independent actuary. Estimating health expenditures under national health insurance is a difficult task because these estimates must often be based on limited information. In addition, the cost of a proposal may depend on how it is implemented. The Department of Health, Education and Welfare has recognized these limitations and, to the extent possible, the report has applied uniform estimating methods and procedures to all the proposals with the objective of producing a consistent comparison of the likely expenditures under the various proposals considered. The actual expenditure levels of the proposals may differ from those forecast, but the relative magnitudes should remain in the same proportion.

The six national health insurance proposals selected for this report include five bills introduced in the 94th Congress plus the bill introduced in the 93rd Congress on behalf of the Administration, commonly known as the Comprehensive Health Insurance Plan (CHIP). The Administration did not introduce a national health insurance bill in the 94th Congress. These six bills are named below, using the names commonly given to them, and classified according to their broad characteristics.

(1) Catastrophic Protection: The Long-Ribicoff Bill provides a program for the general population which would be limited to persons with unusually large medical expenses. This program would be financed by social security taxes and administered by the Federal government. The proposal also would set up a Federal medical assistance program to replace Medicaid.

(2) Mixed Private-Public Plans: The Comprehensive Health Insurance Plan (CHIP), and the proposals of the Health Insurance Association of America, the American Medical Association, and the American Hospital Association are all broadly similar in general approach. They all would establish (1) a plan requiring employers to offer specified private health insurance to their employees, (2) a plan for the poor financed and administered by the Federal or State governments, or both, and (3) continuation of the Medicare program or provision of other special coverage for the aged.

(3) Federal Program: The Health Security Bill would establish a program financed by social security taxes and Federal general revenues and administered by the Federal government.

<u>The "Cost" of National Health Insurance</u>

What is the "cost" of national health insurance? The report offers several answers to this question which are summarized in the attached table. This table shows first, personal health care expenditures which represent the total amount spent on health care by or for individuals from all sources and thus exclude funds for research, construction, public health and similar activities. Adoption of a national health insurance proposal will cause changes in the sources of payment for health expenses, for example, by shifting or transferring expenses previously paid out-of-pocket by individuals to payment through health insurance plans. It may also increase the total spending for health care, for example, by encouraging more use of health services covered by the plan, adding administrative expenses for the extra insurance and paying for bad debts and charity services. Some provisions of the plan, such as controls imposed on fees and charges, may tend to reduce costs. But the net effect of adopting any of the six proposals considered in the report would be to increase total personal health care spending. While this increase is largely paid for through the national health insurance program, national health insurance may also affect health costs outside the program so that the increase, reflected in the table, is shown in conjunction with total expenditures rather than just for national health insurance program costs.

<u>Total Health Insurance Spending and National Health Insurance</u>

The table also shows health expenditures that would be covered by all public and private health insurance plans as well as by the national health insurance program. The former represents a broader measure of coverage because, for example, while some proposals cover Federal employees under national health insurance and others do not, health coverage will no doubt continue for this group. Also, many employers and individuals can be expected to purchase private insurance which will cover some types of non-covered health services or the deductibles and coinsurance, or both, of the national health insurance plan.

In the report, national health insurance coverage is defined to include insurance paid under the plan or plans of the proposal and under the Medicare and Medicaid programs if these programs are retained. Some proposals eliminate Medicare and provide other special arrangements for its beneficiaries while others continue it. The Long-Ribicoff bill would replace Medicaid. All the other programs would retain a residual Medicaid program with services mainly limited to intermediate care and long-term facilities.

Federal government health spending, shown in the table, includes all Federal personal health care—expenditures under the national health insurance program, other Federal insurance plans, and direct service facilities including those operated by the military, VA and PHS.

Summary of Findings

In preparing these estimates, all the proposals were assumed to go into effect in July 1977. The estimates themselves refer to fiscal year 1980, by which time these proposals are assumed to be fully operational. Total U.S. health expenditures are projected to be $223 billion at that time assuming no national health insurance program is in effect, with $59 billion paid by the Federal government. Private and public health insurance plans are projected to cover $127 billion of the total. (Many of the estimates in the body of the full report are in constant 1976 dollars.)

Total U.S. health expenditures under the national health insurance proposals considered in the report would vary roughly in proportion to the increase in additional health insurance resulting from adoption of the proposal. This would be expected because the increase in insurance coverage of health expenses, by encouraging greater use of health services, is the most significant factor in inducing greater demand for health services. Thus, the increased costs range widely from about $10 to $25 billion reflecting an increase in new insurance of some $18 to $64 billion.

The differences in additional insurance largely reflect variation in the benefit provisions of the proposals, although all six proposals examined cover a broad range of diagnostic and treatment services (broader, for example, than the Medicare program). The Long-Ribicoff, CHIP, and HIAA proposals tend to use a variety of cost-sharing mechanisms, limit preventive services to children, and concentrate most of their additional spending on the poor, while the AMA, AHA, and Health Security proposals tend to have little or no cost-sharing, provide preventive services to everyone, and increase insurance coverage broadly for the general population. Thus, the first group would induce some $10 to $11 billion in added health spending, while the second group would result in $20 to $25 billion in additional expenditures.

The rise in Federal expenditures for personal health care services reflect primarily the relative use of Federal vs. private financing under the various proposals. All six plans would add several billions to the Federal health care budget primarily to provide improved health services for the poor. But the range of some $8 billion to $130 billion in additional Federal spending reflects largely the extent to which health insurance funds for the general population are funnelled through a Federal health insurance mechanism or through private health insurance.

Table Cost Implications in 1980 of Alternative National Health Insurance Proposals

Personal Health Care Expenditures	No NHI Program	Alternative National Health Insurance Proposals					
		Long-Ribicoff	CHIP	Health Insurance Assoc.	American Medical Assoc.	American Hospital Assoc.	Health Security
Total U.S. health expenditures....................................	$223.5	$233.5	$234.8	$243.5	$243.8	$248.6	$248.3
Additional expenditures resulting from adoption of proposal 1/..	---	+9.8	+11.3	+11.0	+20.3	+25.1	+24.8
Federal Government health expenditures 2/.........................	59.3	74.9	68.7	67.0	82.0	95.8	189.4
Additional expenditure resulting from adoption of proposal......	---	+15.6	+9.4	+7.7	+22.7	+36.5	+130.1
Health expenditures covered by all insurance (private and public) 3/..	127.5	145.2	152.3	153.6	161.2	177.2	191.4
Covered by the National Health Insurance Program 3/.............	---	80.4	121.5	125.9	140.0	159.0	181.7
Additional insurance resulting from adoption of proposal......	---	+17.7	+24.8	+26.1	+33.7	+49.7	+63.9

1/ Represents the additional costs that would result from the national health insurance programs, for example, from increased use of health services.
2/ Represents total Federal expenditures for personal health care including health insurance programs and military, VA and PHS facilities.
3/ The national health insurance program is defined to include the plans established under the proposal, and the Medicare and residual Medicaid programs if these programs are retained under the proposal. The total for health insurance includes the NHI program and other coverage not required under some programs, for example, health coverage for Federal employees and additional insurance benefits, beyond those provided by law, purchased by employers and individuals.

NOTE: All expense data in the body of the report are in constant 1976 dollars. The data in this table and Appendix D of the report, from which they were derived, have been adjusted to 1980 price levels using the official inflation estimates of the Council of Economic Advisors.

A COMPARISON OF THE COSTS

OF

MAJOR NATIONAL HEALTH INSURANCE PROPOSALS

Prepared For The

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

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By

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TABLE OF CONTENTS

Introduction 1

I. Methodology 4

A. General Description 4
B. Definition of Cost . . . .
C. Policy Assumptions 8
D. Basis for Estimating Spending 10
E. National Health Spending Net of Taxes 14
F. Estimates of Population Covered 15
G. Transferred Services 20
H. Induced Costs 29
I. Analysis and Results 45

II. Estimated National Health Spending in Fiscal Years 1976-1980 as a Basis for Estimating Spending Under National Health Insurance Proposals 46

III. Estimates of Spending for Personal Health Services Net of Taxes 52

IV. Detailed Analysis of Major Proposals 54

A. Long-Ribicoff Bill 54
B. Comprehensive Health Insurance Program (CHIP) 68
C. Health Insurance Association of America Proposal 81
D. American Medical Association Proposal 95
E. American Hospital Association Proposal 107
F. The Health Security Proposal 120

V. Comparative Cost of Major National Health Insurance Proposals 127

Appendices

A. Principle Policy Assumptions
B. Estimates of Health Spending in this Report Compared to Social Security Administration National Health Expenditure Estimates
C. Projection of Future Spending for Personal Health Services
D. Estimates in Terms of 1980 Dollars

INTRODUCTION

A. Purpose and objectives

The purpose of this study is to compare the cost of major proposals for national health insurance.

The objectives of the study are to:

1. Define the "cost" of national health insurance.

2. Develope a methodology for estimating the cost of national health insurance proposals.

3. Provide a basis for comparing the relative cost of alternative proposals.

4. Develop a framework for analyzing the cost implications of the principal issues in the design and implementation of national health insurance proposals.

5. Compare the cost of six major representative proposals.

B. Scope of Report

Six major proposals were examined; they are:

1. Long-Ribicoff Proposal; introduced by Senators Long and Ribicoff and Representative Waggoner.

2. The "Comprehensive Health Insurance Program" ("CHIP"); introduced in the 93rd Congress on behalf of the Administration by Senator Packwood and Representatives Mills and Schneebeli.

3. The Health Insurance Association of America ("H.I.A.A.") Proposal; introduced by Representative Burleson and Senator McIntyre.

4. The American Medical Association ("A.M.A.") Proposal; introduced by Senator Fulton.

5. The American Hospital Association ("A.H.A.") Proposal; introduced by Representative Ullman.

6. The Health Security Proposal; sponsored by the AFL-CIO and introduced by Congressman Corman and Senator Kennedy.

The formal titles of these bills and principal sponsors are outlined in Table 1.

Estimates were prepared for spending for personal health services in fiscal 1980 under present law and under each of the aforementioned proposals. The year 1980 was selected as a time when the proposals, if enacted, could be fully effective. To facilitate understanding,estimates are presented in terms of the present value of the currency, i.e., in terms of fiscal 1976 dollars. To obtain estimates of actual spending in 1980, the estimates in this report must be adjusted for the change in the value of the currency between fiscal 1976 and fiscal 1980 (a period of 4¼ years). To do this, each estimate should be multiplied by the ratio of the average of the C.P.I. index during fiscal 1980 to the average for fiscal 1976.[1/]

The degree of accuracy that can be obtained in estimates of this kind is limited. The degree of uncertainty could be conveyed by showing ranges for each item estimated. A range for each of the hundreds of items for which estimates are included in this report, however, would make the analysis and presentation confusing and difficult to understand. Further, the principal objective is to obtain reliable relative estimates. Point estimates may be useful for this purpose, even if all the estimates are too high or too low. To

1/ The Council of Economic Advisors is currently projecting the C.P.I. to increase by 24% from fiscal 1976 and fiscal 1980. Thus estimates comparable to the projections of the Council of Economic Advisors can be obtained by multiplying all estimates of spending in the body of the report by 1.24. Appendix D restates the major estimates in the report on this basis.

TABLE 1. LISTING OF NATIONAL HEALTH INSURANCE BILLS INCLUDED IN REPORT[1/]

Name of bill	First Sponsor		Bill number		Supported by national organization	Short reference
	House	Senate	House	Senate		
Catastrophic Health Insurance and Medical Assistance Reform Act.....	Waggonner.....	Long-Ribicoff..	H.R. 10028..	S. 2470...	....	Long-Ribicoff
The Comprehensive Health Insurance Act of 1974......................	Mills-Schneebeli....	Packwood.......	H.R. 12687..	S. 2970...	....	CHIP
The National Health Care Act of 1975............................	Burleson......	McIntyre.......	H.R. 5990...	S. 1438...	Health Insurance Association of America..........	HIAA
Comprehensive Health Care Insurance Act of 1975......................	Fulton........	....	H.R. 6222...	....	American Medical Association.......	AMA
The National Health Care Services Reorganization and Financing Act..	Ullman........	....	H.R. 1......	....	American Hospital Association.......	AHA
The Health Security Act............	Corman........	Kennedy........	H.R. 21.....	S. 3......	AFL-CIO, Committee for National Health Insurance	Health Security

1/ All bills listed were introduced in the 94th Congress, except the Comprehensive Health Insurance Act of 1974 which was introduced in the 93rd Congress on behalf of the Administration.

facilitate understanding and analysis, a single best estimate is presented for each item analysed. It should be understood that the actual results could vary somewhat from the estimates.

C. Contents

The following sections contain: a detailed discussion of the methodology followed, the results of the projections of personal health spending to fiscal 1980, estimates of the impact of taxes on spending for personal health services through each channel of payment, individual sections analyzing the cost of the six major proposals analysed, and a comparison of the cost of these proposals according to alternative definitions of cost. Also included are an appendix which lists the major policy assumptions employed in the analysis, an appendix which outlines the differences between the estimates of spending for personal health services in the report and those prepared by the Social Security Administration, and an appendix which restates the estimates of spending in the report on a basis comparable to the official estimates of the Council of Economic Advisors.

I. METHODOLOGY[1/]

A. General Description

The purpose of this study is to provide a basis for comparing the cost of proposals for national health insurance. The primary emphasis in developing this basis is placed on assessing the relative costs of the different proposals as opposed to calculating the most likely cost of any particular bill.

The national health insurance bills examined are very broad and complex proposals which would in some cases produce many far reaching changes in the financing and delivery of medical services in the United States. The extent to which such changes would occur under any particular bill cannot be forecast accurately. Furthermore, the bills analyzed typically set forth general policies which could be implemented in ways that result in widely differing levels of cost. Also, any bill must be implemented in an unknown economic and political environment. In view of the many sources of uncertainty necessarily present, it is impossible to estimate the cost of any proposal with a high degree of accuracy.

Much of the uncertainty as to the impact of national health insurance, however, depends on factors common to some degree to all or most of the bills. By adopting the same assumptions as to the effect of any uncertain factors common to all proposals, much of the effect of forecast error and uncertainty as to the policies to be adopted and their effect can be reduced. Similarly, where different approaches to a common problem are specified in the various bills, the relative impact of the approaches taken may be assessed more accurately than the absolute effect of any particular provision. Thus it is possible to develop valid cost comparisons without necessarily providing accurate forecasts. This is especially true

1/ The methodology is essentially the same as that followed in the estimates contained in "Estimated Health Expenditures Under Selected National Health Insurance Bills, A Report to the Congress", July, 1974, which were also prepared for H.E.W. by Gordon R. Trapnell, Consulting Actuaries.

of estimates of the increase in total spending for personal health services estimated to occur as a result of national health insurance. It is in this vein that the cost estimates in this report are developed.

A methodology has been adopted which is as consistent as possible in estimating the relative cost of different bills. In fact, when there was a choice, the approach was followed that would lead to the fairest comparison between the bills rather than one which would lead to the most reliable estimate of a particular bill.2/ Also, as many assumptions as possible were removed from the estimates of individual bills and were made part of the projections of spending, common to all bills, in fiscal years 1976-1980.

To facilitate comparisons, a single best estimate was made for each bill, based on the policies most likely to be followed should that bill be passed. To make the comparisons realistic in terms of the facilities and manpower that would be available, estimates were prepared for fiscal 1980, a year in which a national health insurance proposal could have been in operation long enough for the full impact of the proposal to begin to appear, but before any major change in the health facilities and manpower available could take place. Each of the proposals was assumed to become fully effective in July 1977. To help compare the size of projected national health insurance spending with present spending for other purposes, the estimates were prepared in terms of the present value of the currency, taken as fiscal year 1976, a year for which general Federal spending is known.3/ The projection of health expenditures to 1980 as a base for estimating each of the proposals is likely to increase the errors in forecasting. Since those errors affect each bill in approximately the same way, the comparative costs of the proposals are not materially affected.

2/ For example, the same basic distributions as to the use and cost of health services by age, sex, income, etc., were used for all bills, despite the availability of better sources of information as to the cost of some plans.

3/ Budget estimates for the fiscal year in progress have proved to be only moderately understated in recent years.

B. Definition of Cost

The cost of a national health insurance proposal can be considered from a number of different perspectives. A proposal may set up one or more new Federal programs through which health services will be provided, and modify existing programs. Spending through these new programs provides one concept of the cost of a proposal. The aggregate increase (or reduction) in Federal outlays for personal health services resulting from a proposal provides another concept of the cost of a proposal.

In addition to increasing Federal expenditures for health, a proposal may reduce or increase the tax revenues received by the Federal government.4/ To maintain the same balance of income and outgo in Federal spending (i.e., the same level of borrowing or creation of money by the Federal government), taxes must be increased to offset any revenue loss as well as any increase in overall Federal spending.5/ None of the proposals analysed in this report would repeal these tax subsidies or "tax expenditures". Several of the proposals analysed would increase the subsidies substantially.6/

4/ There are at present strong subsidies to the purchase of health insurance. Group health insurance is strongly subsidized by the Federal government through excluding the value of the insurance paid for by an employer from the income taxes of employees. Thus for example, if an employer paid the average cost of group health insurance as added salary to an employee who used the extra salary to buy a health insurance policy with the same benefits, the employee would have to pay Federal and state income taxes on the added salary. The tax would be at the rate of the highest tax bracket reached by the employee. Premiums for individual insurance are taxed by states (except for the "service" plans in most states) and subsidized by allowing part of the premiums to be deducted in computing income taxes. Direct expenditures for medical services above 3% of income are also deductible.
The present system of tax deductions for insurance premiums and medical expenses and programs for the aged, disabled, and poor may in fact be regarded as a present national health insurance system.

5/ According to budget procedures followed by the Congress, the level of surplus or deficit in Federal spending is set according to economic needs.

6/ It would be desirable to trace each of these tax effects back to each class of payments by households. For example, if purchases of individual insurance were not subsidized, it would be more expensive to the purchaser. But as a result, less would be purchased and more medical services would be purchased directly. This in turn would reduce the level of medical services consumed. The tax adjustments in this study do not allow for any change in purchases of insurance and the like.

A national health insurance program may require other parties, such as employers, to finance health services or the Federal government may offer additional financial incentives to private or local government spending. The concept of program outlays can be extended to include such private or governmental expenditures that result from Federal requirements or that are induced by Federal incentives.

A national health insurance plan can be expected to produce a number of changes in the health services that are furnished and in the ways in which funds are provided. The cost of a proposal can be taken as all of these changes in the flow of funds to finance medical services. For example, a service paid for through a Federal program that would have been paid for directly out-of-pocket is both a cost to Federal taxpayers and a saving to the patient.[7/] A proposal may result in a total increase in payments for health services for the country as a whole. This aggregate or national cost measures the overall extent to which increased resources are devoted to furnishing health services as a result of a proposal.

This study focuses on each of the definitions of cost enumerated above. Primary emphasis is placed on the effect of the proposal on how households collectively pay for health services and on the total cost to the country.[8/]

Estimates are also included as to the outlays under each of the major new programs that would be set up by a proposal. These are estimates of the funds that must be disbursed by the Federal government or other sponsors for the specific programs established or modified by the proposal. In the case of

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7/ The cost can also be defined in terms of the effect of a national health insurance proposal on the net income and outgo of the particular types of families, for example for different levels of family income or the number of members. Measurement of this type of cost is beyond the scope of this report.

8/ The view is taken that households ultimately pay for all health expenditures. They do so directly in cash, through health insurance, through gifts, through salary foregone in lieu of group insurance, or through taxes. The modes of payment through which households collectively pay for health services are referred to as the "channels" of payment.

government programs, this is the amount that would have to be budgeted and appropriated and indicates the size of the responsibilities that will be directed by a Federal or state agency in administering a bill.

C. Policy Assumptions

Each of the national health insurance plans analyzed would have extraordinarily complex effects on the financing and delivery of health services in the United States. In addition to uncertainties of what the actuarial and economic impact of proposed policies would be, there is uncertainty as to what policies would be followed. Many key provisions of the bills have not been specified precisely, but are left to the discretion of the officials responsible for implementing and administering the program. In some proposals, some of the benefits and population groups that would be covered are left to regulatory action. Other important decisions are left to providers or patients affected; for example, as to whether to participate in a new program or where to purchase coverage. There is also a tendency of some bills to cite general goals rather than specific coverage and regulatory provisions. Consequently, a wide range of costs is typically possible for a bill depending on how it is implemented and how providers and patients react to choices provided to them. Further, there is the added uncertainty of the combined effect of a variety of new but important innovative provisions for which there are no adequate precedents on which to base estimates.

In order to estimate the cost of a national health insurance proposal, assumptions must be made as to what policies will be followed in implementing and administering the proposals. The assumptions adopted to resolve such uncertainties are referred to as "policy assumptions." The actual policies implemented could vary considerably from those assumed. They concern decisions

that will be made by officials appointed by a future president. They will be influenced by political pressures that have yet to develop from persons who will be affected by the decisions.

The task of establishing realistic assumptions, however, is not impossible. A number of major pressures and constraints that will influence any official with the responsibility of implementing the programs can be identified. Previous experience in implementing other major new Federal health insurance programs can indicate how political pressures affect decisions. To the extent possible, the process followed and decisions reached in implementing Medicare and Medicaid and the reaction of providers and patients to these programs are used as a basis for establishing policy assumptions.[9/]

Additional insight into how a proposal would be implemented may be furnished by the political coalition supporting it. The effect of sponsorship, however, has been minimized in selection of policy assumptions. Where there is ambiguity as to the type of benefit or policies intended by a proposal, weight is given to the stated policies of the sponsors, and the assumption is explicitly noted in the text.

A different type of problem is presented by provisions that could not be implemented as written, or are in conflict with other provisions in the same proposal. In some cases, such provisions are technically impossible and in other cases they appear to be based on unrealistic assumptions as to the behaviour of people or institutions affected. Since cost estimates must be prepared on the basis of an assumed feasible set of events, it has been necessary to assume that some provisions are altered in ways apparently not indicated by the drafters. In each case the proposals are assumed to be amended so as to come as close as

9/ The author was responsible for estimating the cost of many of the important decisions made in the implementation of the Medicare program.

possible to the general intent of the sponsors.[10/] Such assumptions have been stated clearly in the policy assumptions along with the reasons for their adoption.

The principal policy assumptions followed are described in Appendix A. Those applying to all proposals and those applicable only to a particular bill are listed separately. Those applicable to each proposal should be taken into consideration in interpreting the estimates in this report.

D. Basis for Estimating Spending

The cost of any national health insurance proposal will be largely determined, at least initially, by the health services being supplied, the facilities in place, and the public's expectation as to the level of care. Thus the first step is to project the spending for personal health services in fiscal year 1980 that would occur in the absence of any major change in Federal legislation. These estimates of the supply of health facilities and manpower available and used in fiscal 1980, and the level of compensation to health personnel and owners of the debt and capital equipment of health facilities, are a set of common parameters underlying the estimates for the different proposals.

A second essential step in estimating the cost of the national health insurance proposals is to derive a matrix of sources and uses of spending for personal health services in fiscal 1980. Spending for the various types of health services and the way households pay for these services -- by direct payments out-of-pocket, by purchasing insurance, by employer-purchased insurance in lieu of wages, through tax supported programs, etc. -- can be thought of as a matrix in which the services and sources of payments comprise the elements. The effect of a national health insurance program is to alter the elements of this matrix. An

10/ For example, the A.M.A. proposal would have the subsidized supplemental benefits for persons over age 65 furnished through individual private insurance policies. Both premium rates and benefits, however, would depend on income, which could not be determined by a private insurance company. It is assumed in the estimates, that these benefits are financed through an extension of the Medicare program.

estimate of such a spending matrix in the current fiscal year (1976) was compiled and projected through 1980 for this purpose. The sources of funds are referred to as the "channels of payment," to emphasize that it is households that must ultimately pay for health services. Insurance companies, government programs, etc., are mere channels through which these payments are made.

The base for these projections is the national health expenditures series compiled by the Office of Research and Statistics (O.R.S.) of the Social Security Administration.[11/] Several types of adjustments were made to the O.R.S. methodology to obtain an appropriate base for national health insurance estimates.[12/]

1. The conceptual basis of the O.R.S. series differs in some respects from that required for national health insurance estimates.[13/] For example, the O.R.S. series excludes some services that are explicitly covered by some of the proposals,[14/] and uses definitions that are inconsistent with the reimbursement basis typically used in insurance programs.[15/]

2. The O.R.S. classifications by type of service were revised to conform more to those used in insurance program or policy definitions and to obtain the detail needed to determine those services that would be transferred to a national

11/ Mueller, Gibson: National Health Expenditures, Fiscal Year 1975; Research and Statistics Note No. 20-1975. (November 21, 1975). Supplemented by detail from the estimates furnished by Robert M. Gibson.

12/ For a comparison of the estimates of national health spending by O.R.S. and as adopted in this report as a basis for estimating the cost of national health insurance see Appendix B.

13/ In general, the conceptual basis of the O.R.S. series is similar to that used to compile the G.N.P. National health insurance proposals, being legal documents, follow the concepts underlying insurance contracts and legislation.

14/ For example, education specialists, certain outpatient mental health facilities and workers, etc.

15/ For example, the O.R.S. series includes all hospital revenues and capital expenditures. Third party reimbursements are based on costs or charges including depreciation.

health insurance program.[16/]

3. The O.R.S. classifications of "sources of funds" (called "channels of payment" in this study) were revised to conform to the tax treatment of health expenditures. Premium payments to government programs, which may be deducted on tax returns, are classified separately. Direct payment for workmen's compensation claims and premiums for private workmen's compensation liability insurance are classified as private expenditures, those to a state fund being included in government-sponsored insurance.

4. The O.R.S. estimates contain projections of a number of items from periods prior to fiscal 1975. Projections consistent with the methodology used to project fiscal years 1976-1980 were substituted for the O.R.S. projections. The base period for projections of future spending is thus the last period for which data is available, rather than the O.R.S. estimate for fiscal 1975. The estimates in this report include increases in population growth, aging of the population, more frequent use of services per capita, changing quality of services, increasing use of specialists, etc., as well as measured price changes.

5. Several types of expenditures may be understated in the official government sources used by O.R.S. (notably Department of Commerce data as to spending for drugs, eyeglasses, etc.). Where there was evidence that the source data do not include all spending that might be transferred to a new national health insurance program, an allowance was made for the estimated amount of understatement.[17/]

16/ For example, both private insurance policies and public health insurance programs typically restrict payments for hospitalization with a psychiatric diagnosis, and distinguish between acute and custodial care.

17/ This applies particularly to spending for drugs and sundries, vision care services, private nurses, home health agencies, and other practitioners. See Appendix B for specific adjustments made.

6. Spending for health research and construction was omitted, since the scope of the report is confined to "personal health services". Allowances for the depreciation of health facilities, however, are included in spending for institutions.

Future spending for health services will be affected by a number of variables, including economic conditions and further Federal and state legislation. Although future spending can be reliably projected for a few years the potential cumulative forecast error to 1980 is substantial. The projection methods will be satisfactory, however, if they do not result in spending estimates that tend to bias the relative cost estimated for any particular bill. Thus what matters is that the relative amounts of spending for the different channels be in the correct proportion.

A mathematical forecasting model was used to project spending for each type of service separately.[18/] Each projection equation was specified to depend primarily on two independent variables: The rate of inflation[19/] and the rate of increase in average wages.[20/] When used to project future spending, additional elements were added to some equations to represent predicted departures from past trends. For example, the rate of increase in spending for most types of service were adjusted for estimates of the effect of rising malpractice premiums. The principal projection equations used are summarized in Appendix C.

The projected spending through a particular channel was estimated for each

18/ The general methodology follows that in Gordon R. Trapnell, "Actuarial Estimate of the Impact of the Economic Stabilization Program on Spending for Health Services in Fiscal Years 1975 and 1976," prepared for Cost of Living Council. In this report spending (without cost controls) on a basis comparable to the O.R.S. methodology was estimated (in March 1974) as $117.1 billion in fiscal 1975 and $133.3 billion in fiscal 1976. Actual spending reported by O.R.S. for fiscal 1975 was $118.5 billion. It is estimated that the final revised O.R.S. figure for fiscal 1975 (to be reported in 1977 or 1978) will be about $2.8 billion higher. If the estimates for the Cost of Living Council are adjusted for the higher actual rate of inflation than assumed (average of 9.9% actual versus 8.3% assumed) and changes in O.R.S. methodology (e.g., omitting approximately $350 million in school health services), the projected revised O.R.S. figure would be close (within 1%) to the March 1974 estimates.

19/ Measured by the C.P.I. for all goods and services.

20/ Measured by the Bureau of Labor Statistics, average wages in all employment.

service using the same formulas as used to estimate the overall increases. Adjustments were made where spending through that channel was expected to grow faster or slower than the component services. For example, spending for dental and vision care services was estimated to increase rapidly. Adjustments were also made to force the sum of the spending for a service through all channels to be the same as projected for that service, by changing those channels believed most likely to absorb any differences. The results of the projections of spending for personal health services in fiscal years 1976-1980 are summarized in Chapter II.

E. National Health Spending Net of Taxes

The existing Federal and state tax laws, especially those that provide for the exclusion from personal taxable income of all employer paid insurance premiums and part of individual insurance premiums, alter the incidence of payment for health services. The tax laws have the effect of transferring part of the spending for health services from individuals, employees, employers, and voluntary givers to Federal and local taxpayers. These subsidies are in effect a present form of national health insurance, which would not be repealed by any of the national health insurance bills analyzed. The major Federal subsidies are:

(1) Out-of-pocket payments for health services in excess of 3% of income may be claimed as itemized deductions under the personal income tax.

(2) One-half of premiums paid by individuals for health insurance, up to $150 a year (including employee contributions for group insurance), may be claimed as an itemized deduction.

(3) Employees pay no tax on their employers' contributions for group health insurance. If an employer raised wages and salaries by the amount of such contributions in lieu of purchasing insurance, and if the employees collectively purchased identical insurance, the employees would pay income and payroll taxes on the full amount of the employer contribution.

(4) Voluntary donors to health organizations are entitled to income tax deductions.

Most states taxing personal incomes provide similar subsidies. On the other hand, most states tax health insurance premiums although most exclude the service plans (Blue Cross-Blue Shield) and prepayment group practice plans. The rates range from 1% to 3% of premiums and average around 2.4% for all insurance companies taxed.

The average factors used to estimate the effect of taxes on net spending for health services are as follows:[21/]

	Federal Tax Subsidy	State Tax Subsidy	State Premium Tax
Out-of-pocket payments	-5.4%	-0.3%	0
Individual policies	-6.8%	-0.4%	+1.6%
Group premiums paid by employees	-6.8%	-0.4%	+1.2%
Group premiums paid by employers	-30.5%	-1.4%	+1.2%
Private philanthropy	-30.0%	-1.7%	0
Workmen's compensation premiums	0	0	+1.2%
Medicare premiums	-6.8%	-0.4%	0

F. Estimates of the Population Covered

National health insurance proposals typically affect different groups in the population in very different ways. For example, many of the proposals pay for a larger proportion of the medical bills for low income individuals and families. Some proposals concentrate most of government spending in special programs for the poor. Thus the income of the eligible population and their relative use of services become major variables in determining the cost of such proposals. Income related benefits introduce major elements of

21/ The factors for Federal income tax rates were derived from data compiled by the I.R.S. The Federal factor for group premiums paid by employees includes 7.5% for the average marginal tax rate for the Social Security programs, based on data supplied by the Social Security Administration.

uncertainty in the estimates. This is especially significant for institutionalized and severely disabled persons who have very high medical expenses.

The principal characteristics of the population that must be taken into account in estimating the cost of the national health insurance proposals are as follows:

1. Composition of the population by age, marital status, and family composition,

2. Number of adults and children included in a family according to each of the definitions used in the proposals,

3. Employment status of adults and their eligibility for government transfer programs,

4. Distribution in the population of disabled persons and others with unusually large medical expenses, and

5. Distribution of family income, according to the definitions of incomes and the procedures that would be used to determine income in the bills analyzed.

The principal unit of coverage in most of the bills analyzed is the family. There are three general classifications of family used in the bills:

1. Census family - consisting of all persons living together who are related by blood, marriage, or adoption;

2. Income tax family - consisting of persons included in the same income tax return, including those filing separately although a recognized family member (e.g., a spouse); and

3. An insurance family - normally consisting of a husband and wife,

dependent unmarried children under age 18, and children who are full time students under age 22.[22/]

The insurance definition of a family is used typically in those proposals which expand the present system of group health insurance to cover most of the population. The income tax definition of a family is appropriate for proposals which finance coverage through tax credits related to income. The census definition of a family is most appropriate for programs that relate eligibility for medical expenses to eligibility for transfer payments.

The cost of medical care per capita for institutionalized persons and severely disabled persons is several times that of non-disabled adults. Consequently, the method by which they are covered under a national health insurance proposal has an important bearing on the cost. Many of the proposals shift institutionalized and disabled persons from an existing to a new program and fund a much larger proportion of their health expenses through public programs.

As noted above, most of the proposals analyzed concentrate government spending on low income persons. The distribution of eligible persons by income is, therefore, a critical element of the cost estimates.

Income is defined in a variety of different ways in the bills. At least one uses the definition of income employed by the Supplemental Security Income program. Others use adjusted gross income as defined by the income tax laws. In each case the income that is important for purposes of preparing cost estimates is the number produced by a governmental administrative process

22/ The ages through which children are covered vary among insurance policies. Some cover full time students through age 25 and other children to age 19 or 20. Other policies cover children who were disabled at age 18 as long as they continue to be disabled.

(e.g., the "income" used to determine welfare payments, the amount appearing on income tax returns, etc.). In the important government programs that base benefits on income, there is a very complex set of rules and procedures that must be followed. The definition of income typically is altered and made more complex through appeals processes, legislative amendments, and judicial review. The amounts determined as income in such processes may be quite different from that which is typically reported in the surveys available as bases for cost estimates.

The principal basis used to estimate the distribution of the population by the characteristics enumerated above is the population model developed by the National Health Insurance Model Team. This model was developed from the 1973 March Current Population Survey, and has been projected through fiscal year 1977. The model allows for the increases in earned income of the population and the changes in the population projected by the Bureau of the Census.

As a basis for the cost estimates in this report, the distributions of the population according to this model were adjusted for the following factors:

1. The total number of aged persons, children under age 20, and other adults was adjusted to agree with the projections of the Office of the Actuary, Social Security Administration, for March 1980.

2. Family composition was adjusted to reflect a decrease in family formation, and an increase in single parent families.

3. The number of full time employees was adjusted to reflect the growth in female participation in the work force projected by the Office of the Actuary from Bureau of Labor Statistics data.

4. The number of persons eligible for disability insurance benefits under Social Security was adjusted to equal the projections for fiscal 1980 of the Office of the Actuary.

5. The estimates of the number of persons receiving Supplemental Security Income, aid to families with dependent children, and general relief were adjusted to coincide with independent projections of these classes of transfer payment recipients.

6. The number of persons with unemployment compensation income was adjusted to the level of persons who actually received such payments in 1973.

7. The distribution of income of persons receiving welfare payments was adjusted to exclude the effect of part-year eligibility.

Thus adjusted, the population model was used to determine the number of persons covered by each proposal according to age, employment status, simulated transfer payment eligibility status,[23/] disability status[24/] family income, and composition of the family to which they belonged.

23/ Types of transfer payment eligibility status used were:
- Disability insurance, eligible for Medicare (including persons with chronic renal disease)
- Disability insurance, not eligible for Medicare
- Supplemental Security Income
- A.F.D.C. or foster care
- General relief
- Veterans Administration disability pensions
- Workmen's compensation payments
- Unemployment insurance
- Retired servicemen and survivors receiving military pensions

24/ Types of disability status used were:
- Institutionalized
- Disability insurance, eligible for Medicare
- Disability insurance, not eligible for Medicare
- Supplemental Security Income
- Other severely disabled
- Occupationally disabled
- Early retirements due to poor health

Additional problems were presented by proposals which permit individuals and families a choice as to whether or not they wish to be covered under a specific program. The effect of voluntary decisions may be that a larger proportion of persons in poor health may choose to join an insurance program than those in relatively good health. This will result in a higher level of morbidity in the insurance program than in the general population.

G. Transferred Services

The primary impact of the national health proposals is to transfer spending from one payment channel to another. This reallocation, to the extent that total spending and services rendered are not changed, is referred to as the "transferred costs" of a proposal.[25/]

Transferred costs are determined in three principal tasks, which are outlined in the following.

1. Covered Services

The first task in determining the services transferred under each bill is to isolate the spending that occurs under present law for health services which will be eligible for reimbursement under that proposal. These "covered services" will be paid for by a proposal, after allowing for cost sharing, payment rates, payments from other programs which cover the same services, etc. Covered services are those which (a) meet the specific definitions in

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25/ A precise definition of transferred costs can be given as follows: If all services furnished remained unchanged (i.e., all people did the exact same things) and all prices or other remuneration were constant when a program was implemented, then the transferred cost for any channel is the difference between the spending in that channel under the proposal and if no proposal were adopted. (All price elasticities are thus assumed to be zero and it is assumed that there are no new services performed.) There are some anomalies in this concept. For example, if a proposal increases the services financed through third parties, there is no allowance for administrative costs. The cost of each national health insurance proposal analyzed is substantially greater than the costs transferred to it.

the bill as to type of medical procedures eligible for reimbursement, (2) are performed by a type of provider that is eligible for reimbursement, and (3) are performed for eligible patients (considering the effect of any applicable age or income limits). Covered services include those not reimbursed as a result of deductibles, etc., cost sharing, any excess of fees or costs over that recognized by the reimbursement formula, any services not reimbursed (or reimbursed at a lower rate of payment) because they were purchased by a member of an HMO from an unaffiliated provider), and services not reimbursed because they were paid for by another program (e.g., workmen's compensation, veterans hospitals, etc.).

Covered services indicate the comprehensiveness of a proposal. Total spending for personal health services can be analyzed into those for:

1. Prevention of disease,
2. Active medical diagnosis or treatment of an accident or disease,
3. Custodial care of persons whose ability to take care of themselves has been impaired by an accident or disease, and
4. Alleviating the risk of financial hardship resulting from paying for medical services.

In general, the national health insurance proposals analyzed in this report concentrate coverage on services which are primarily used to diagnose and treat accidents or acute illnesses. These proposals concentrate most benefits on non-psychiatric hospital and physician care and services normally associated therewith,(e.g., laboratory charges, ambulances, legend drugs, etc.). Some bills analyzed also provide coverage of personal care for persons in poor physical condition. These proposals typi-

cally include services where the personal care component is relatively large, such as health-related custodial care or other long term care services.

2. Program Transfers

The next principal task in determining transferred costs is to estimate that portion of each type of covered services which will be transferred to each major program set up or revised by a proposal. These are determined in two steps as follows.

The first step is to distinguish those services which are not paid for as a result of (a) limits on the extent to which the fees of a provider (or other basis of payment) are eligible for reimbursement, and (b) regulatory or administrative procedures set up by a bill.[26/] Such services are not transferred.

The second step is to determine the effect of any cost sharing provisions; e.g., deductibles,[27/] copayments,[28/] coinsurance,[29/] fee schedules,[30/] or other limits on payment.

26/ Some providers may be found ineligible as a result of the regulatory procedures set up by a proposal (e.g., peer review of all services, drug formularies, minimum standards for hospitals, etc.). The immediate effect of such regulation may be to transfer spending for such services from a third party channel to payment directly out-of-pocket. A secondary effect may be the termination of such ineligible services by consumers able to obtain free or subsidized services from other providers.

27/ A "deductible" is defined to be a fixed dollar amount deducted from all charges for covered services before reimbursement during a period (e.g., a $100 deductible applicable to all outpatient covered services).

28/ A "copayment" is defined to be a fixed dollar amount deducted from charges for each service before payment begins (e.g., a $2 copayment per prescription).

29/ "Coinsurance" is defined as a percentage not paid by the insurance program (e.g., the program pays 80% of charges for covered services; the other 20% is coinsurance).

30/ A "fee schedule" is defined to be a series of reimbursement amounts for different types of services (e.g., a $10 payment for office visit, $300 for an appendectomy, etc.).

The principal basis of the estimates of the amounts transferred to new national health insurance programs is the national health insurance model developed by the National Health Insurance Model Team in the Social Security Administration. This model combines distributions of spending for health services by age, sex, disability status, etc. with the population model discussed earlier. Spending for personal health services is simulated for each population group for each of four composite types of services. Overall spending is adjusted to agree with independent estimates of covered services (using a least squares procedure which leaves critical cells unadjusted).[31/]

A number of adjustments were made to the outputs of this model.

a. Spending for disability insurance beneficiaries, Supplemental Security Income, welfare payments, and disabled persons eligible for Veterans Administration and workmen's compensation benefits were removed from both the population base and the spending distributions. Independent estimates for the effect of national health insurance plans on these groups were substituted, applying an appropriate distribution to independent estimates of total spending for each of these groups.

b. Persons for whom the primary source of medical care was the Medicaid program were also removed from both the population estimates and the simulated estimates of spending.

c. The proportions that would be transferred to each national health insurance program estimated were adjusted for the change in the relative value of medical services and earned income between fiscal 1977 and 1980.

d. Independent estimates of the proportion of long term hospital and psychiatric hospital services that would be found to be chronic and acute were substituted for those used in the model.

31/ This procedure, known as "End-just", was developed for the Social Security Administration by Marshall Wood.

e. The proportions of services for component groups of the population by employment status and family composition were adjusted to reflect changes noted earlier made to the population model.

f. All outputs from the model were used as factors to determine proportions of expenses transferred. Such factors were in all cases applied to independent estimates of the total spending for the population group to which it applied.

The projected national health insurance expenditures in fiscal 1980 were broken down by the proportions spent for the following population groups:

- Aged persons eligible for Part A of Medicare
- Other aged persons
- Active Federal employees and their families enrolled in the Federal employee health insurance program
- Retired Federal civil servants and their families enrolled in the Federal employee health insurance program.
- Active military personnel and their dependents
- Retired military servicemen, their families and survivors eligible for the military service medical programs.
- Disabled Social Security beneficiaries and persons with chronic renal disease eligible for Medicare
- Other disability insurance beneficiaries
- Disabled and blind recipients of Supplementary Security Income
- Other cash recipients eligible for Medicaid
- Disabled persons eligible for workmen's compensation benefits
- Disabled veterans whose primary care is furnished by Veterans Administration facilities

- Other institutionalized persons
- State and local employees and their families
- Employees of private employers
- Unemployment insurance recipients and their dependents
- Other persons

An appropriate factor was derived from the model as adjusted for each of these groups to determine the proportion for each composite medical good that would be transferred to each new program set up by a national health insurance proposal. Similar factors were derived to determine the amount transferred from each of the other channels and the amount of supplemental insurance retained.[32/]

The approach described above was followed in order to base an estimate of the cost of health services for each population group primarily on what is presently being spent for that group, projected to fiscal 1980. Consequently, the spending for each group was to the extent possible isolated, and the transfers and induced costs for that group estimated relative to what was projected to be spent under present law. Also, since most of the programs provide extensive coverage for the low income groups and for those persons now covered by Medicaid, vendor assistance programs, etc., this procedure minimizes the bias introduced into the relative cost estimated for different bills.

The overall transfers determined in this way were reviewed for accuracy and consistency with other sources of data and other methods of estimating

32/ For some programs, many of these steps were not necessary. For example, the Health Security bill simply transfers virtually all covered services to a Health Security program.

transfers.

3. Transfers from other channels. To determine from which channels spending is transferred to new and revised programs, the following general principles were followed:

a. Individual Direct Payments

To the extent that a service which would otherwise have been paid for directly out-of-pocket is covered by a new insurance program, individual direct payments are reduced.

b. Supplemental Insurance Coverage

A large proportion of the population now has insurance which pays the full cost of inpatient hospital and physician services without cost sharing. For estimating purposes it was assumed that if a national health insurance program does not include such first dollar coverage of hospital and surgical bills, that (a) most employers who now offer first dollar coverage to employees will purchase supplemental group insurance to pay for that portion now paid in full, and that (b) half of the remaining population who would otherwise have had first dollar coverage will purchase individual supplemental coverage. It is also assumed that employers will continue to pay through group insurance for all other types of services now covered which are not transferred to a new program.[33/]

c. Association Group Insurance

Many professional societies and other groups offer their members a standardized health insurance policy with limited underwriting, pooled ex-

33/ The reason for this assumption is that none of the proposals analyzed would repeal the present strong subsidies to group insurance.

perience, and low administrative costs. A national health insurance proposal that places major emphasis on a standard set of benefits is assumed to substantially increase this type of private coverage.

d. Taft-Hartley Plans

Many unions whose membership tend to have many employers (e.g., construction unions, printing crafts, etc.) have established health and welfare trusts which receive employer contributions and provide or purchase health insurance for their members. National health insurance proposals which mandate that employers offer a particular set of benefits to employees are assumed to require employers contributing to Taft-Hartley Plans to fund the required benefits, even though the employees may not have worked long enough for any one employee to be eligible for an employer plan.

e. Services Provided Through Federal Facilities

Where services provided through Federal facilities are of a type eligible for payment through a new program, it is assumed that one-third of the patients newly eligible for payment if served by private providers obtain services elsewhere. Services furnished by veterans hospitals and Public Health Service hospitals are thus assumed to be reduced by one-third of services eligible for payment through a new national health insurance program. It is assumed that a corresponding proportion of spending is transferred to the new program.[34/]

Appropriations for Defense Department facilities are assumed to be unaffected by any national health insurance proposal.[35/]

34/ Appropriations for these facilities, however, are assumed to be reduced by only half of the amount transferred. This results in an induced cost equal to one-half of the services transferred.

35/ The primary basis for appropriations for Defense Department facilities are the needs of national defense, not services required by servicemen and their families.

f. State Medicaid Programs

It is assumed that state and local governments will pay for 85% of any services transferred from Medicaid programs (including cost sharing) but not absorbed by new insurance programs for persons receiving cash assistance and two-thirds of such services for other persons who are eligible under present law. Similar proportions of services are assumed to be paid for persons who would be eligible for the present programs but who are excluded from a national health insurance program replacing Medicaid.

g. Other State Health Programs

It is assumed that state and local government appropriations will be reduced by the amount of any payment available from a new national health insurance program for services currently furnished by state and local government appropriations.

H. Induced Costs

1. Sources of Induced Costs

Increases or decreases in spending are referred to as the "induced costs" arising from a proposal. The principles followed to estimate these induced costs are outlined below.[36/]

An explicit, quantitative methodology has been developed to estimate each of the following types of induced costs:

a. An overall increase in the demand for services, or a demand for more expensive services, resulting from reducing the amounts patients are

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36/ There is at present no conclusive empirical evidence as to the level or incidence of induced costs. The general methodology followed here has been used with reasonable results in several cost estimates for major health insurance programs at the national level. The methodology was used to determine the level of the initial Medicare premium rate, and to estimate the cost of extending Medicare to cover disabled beneficiaries and persons with chronic kidney disease. These estimates proved reasonably satisfactory. The Medicare premium was within a few percent of the incurred cost of the program and adequate to cover claim payments and related administrative expenses. Spending for disabled beneficiaries and persons with chronic renal disease has been within the estimates. In the absence of more precise, empirically based methods, continued reliance is placed on this methodology.

A number of methods were devised to obtain independent estimates of the resulting program totals (a check on the combined methodologies of estimating transferred and induced costs). For example, estimates were derived from group health insurance experience for the average premium rate that would be required for providing national health insurance benefits (CHIP, HIAA, AMA, AHA bills) to employees of employers. This rate was applied to the population covered by the employer plans. The average spending per adult and per child enrolled in these programs was also compared to the estimates prepared by the HIAA actuaries (projecting the latter to fiscal 1980 by the same rates used to project spending and allowing for the change in the value of the deductibles). The estimates were surprisingly close. For example, the net premium for group insurance under the HIAA bill was within 2½% of the rate estimated by the HIAA actuaries.

required to pay out-of-pocket (or believe they will have to pay subsequently).[37/] Some or most of these services supply medical needs that are not met under present law.

b. The coverage of new types of services that are not now generally available, e.g., new classes of medical professional personnel and facilities.

c. Payment for charges previously unpaid despite valid billing of patients, when not offset by lower payments from other sources.[38/] These include bad debts incurred by health credit card programs, which are effectively paid through the program rather than direct by patients.

d. Payment by a new insurance program, or as a result of new programs, of charges which would not have been billed under present law. For example, many physicians accept insurance payments as full compensation for some patients and do not bill for cost sharing. A new program may pay a higher amount, or a physician may bill for cost sharing to offset a low reimbursement rate. Also some institutions that currently do not bill for services may do so in order to obtain income available from new programs.

e. An increase in the use of services, the level of payment for services, or the relative expense of types of services used, resulting from providing a full range of medical services to groups previously covered by a restrictive program. The principal application of this principle is to the cost of replacing Medicaid or public assistance vendor payments with an insurance system similar to that enjoyed by the middle and upper income classes.

37/ This type of induced cost, equivalent to relative price demand elasticity, has been the subject of a number of articles in the economic literature. Of the other types analyzed here, only the general area of utilization review, pre-admission certification, and prospective budgeting for institutions appear to have received much attention.

38/ This type of induced cost is especially important for professional practitioners. Non-profit institutions pass bad debts on to other payers, so that payment of debts may tend to reduce charges to those paying their bills.

f. Payment of the excess of actual over recognized charges for services rendered to patients of physicians who now accept assignments for services covered by Part B of Medicare, if permitted by a proposal.

g. An increase in prices charged by professional providers or personnel in response to an increase in demand for their services, i.e., an increased rate of inflation. (Such price induction can take the form of higher provider charges or higher provider costs under programs that base reimbursement to institutions on allowable costs.)

h. A decrease in services (in addition to those that would occur under present law) resulting from utilization controls, which can be used by properly motivated providers to limit demand for services in short supply.[39/]

i. Reduction in spending for institutional services through limiting spending or reimbursement rates to levels set in advance on the basis of budget reviews or by comparison to other providers. Such regulation can also reduce spending by refusing to pay for services in proposed new facilities.

j. A decrease in the rate of payment for the services of professional practitioners and independent clinics and laboratories, under proposals that prohibit additional charges. Such limits may be set directly, for example by specifying a procedure for calculating maximum fees, or indirectly by specifying only the authority and process.

k. An increase in administrative costs resulting from paying for services through insurance that: (1) were previously paid for directly by patients, (2) were bad debts, or (3) are induced by a proposal. (Such services may include uninsured services, if a system is adopted which required processing for such services. This would be the case with a health credit card or peer review for services not reimbursed.)

39/ These are taken only as offset to increases in demand for services.

l. An increase in administrative cost resulting from increasing the functions performed, the level of accuracy required, or the extent of use of data created. For example, determining a family's income in order to collect the correct premium amounts will increase administrative costs.

m. An increase in Federal or state expenditures to plan, regulate, and evaluate the provision of health services.

n. Reduction in administrative expenses resulting from replacing individual insurance policies with group insurance, insurance pools, government sponsored insurance, or a government program.

o. Reduction in administrative and sales expenses by requiring coverage of all employees and by standardizing health insurance policies.

p. Failure to reduce funding of public programs in proportion to a decrease in demand for services resulting from alternative services made available through a national health insurance program.

q. Use of funds donated by philanthropic institutions for other health purposes, when the original purpose is taken over by a new program.

2. Procedures Used to Estimate Induced Costs

The basic procedures used to calculate induced costs are as follows:

a. Additional services resulting from new third party payments for bills that would otherwise have been unpaid or paid out-of-pocket were estimated separately for each type of medical service.[40/] An average induction factor was applied to the sum of the net decrease in bad debts and the

40/ Induced services probably vary also by the size of the charge, the type of cost sharing, the proportion of the charges already paid by third parties, family income, and many other factors. But, in the absence of better understanding of these factors and of the data necessary for reliable measurement, the induction forces are aggregated into one factor for each type of service.

transfer from direct out-of-pocket payments by individuals to a public or private insurance program. Where price levels under a national health insurance program would be determined by reference to a period before the program began (with increases allowed only for increased costs of providing additional services) the factors applied are as follows:[41/]

Inpatient short term hospitals	25%
Long term and psychiatric hospitals	50%
Skilled nursing and intermediate care facilities	75%
Home health agency services	100%
Routine and preventive services	67%
Family planning services and supplies	67%
Outpatient drugs	25% + Percent increase in outpatient hospital and physician services involving a diagnosis.
Other services necessary to diagnose or treat an injury, pregnancy, or illness	50%

The allowances used for some types of induced services depend on the particular circumstances created by a proposal. These allowances include the effect of increased remuneration for critical personnel employed by providers resulting from an increased derived demand for their services. Demand-related price increases of providers are excluded.[42/] The induced services are assumed to take place over a three-year period.

41/ The induced service factors were chosen after a review of the actuarial and economic literature, but no claim is made that any of the induced service percentages are based on solid empirical foundations. There is a range of reasonable percentages, and those chosen are believed to be in the middle of this range. The general level of the factors have been used in several estimates for new insurance programs that have proven to be within an acceptable range of the actual cost. The factor used for induced hospital services, however, has been reduced from 50% to 25% based on recent evidence that spending for these services has become less elastic (especially in extending Medicare to disabled beneficiaries).

42/ In other words, allowances for increases in provider costs are included in these factors but increases in profit margins are excluded.

b. If a proposal reduces the proportion of medical bills that must be paid out-of-pocket without provision to fix the basis of payment on data from a period prior to the program, additional price inflation is assumed to occur. The allowance made for any price inflation assumed is noted in the special policy assumptions for the proposal concerned.

Similarly, some proposals reorganize the health sector in such a way as to encourage additional organization of health personnel in unions or professional associations that would bargain multilaterally with health providers (or Federal and state governments). Such proposals are estimated to result in wage and fringe benefit increases for institutional personnel of 1% per year more than would otherwise occur, times the proportion of program funding derived from the Federal government.

c. Some proposals would create new types of services that would not otherwise be generally available. Such new services are treated as entirely induced.[43/]

d. Bad debts are assumed to be paid to the extent eligible for third party payment through new insurance programs. Health credit card programs are assumed to pay half of any remaining bad debts for affected services. Half of any services that are now paid for through Medicaid which are transferred to out-of-pocket payments (e.g., through cost sharing, through loss of Medicaid eligibility, etc.) are assumed to become bad debts. In the case of non-profit general hospitals, half of the income resulting from payment of bad debts is assumed to offset future rate increases (the other half is assumed to be used to improve services, raise wages, pay debts, etc.). In addition, most of the proposals analyzed to some extent restrain

43/ Comment is made in the policy assumptions concerning any new services assumed to be created by a proposal.

hospital budgets so that a larger portion of such windfall revenues are used to offset future rate increases.

e. Unbilled services are assumed to be paid to the extent eligible for third party payment through new insurance programs. Health credit card programs are assumed to pay half of any cost sharing for affected services that would not have been billed under present law.

f. Expenditures transferred from Medicaid or public assistance vendor programs to a program which pays providers at a level comparable to Medicare are assumed to be increased by the following percentages.

Hospital services	2%
Skilled nursing facilities	10%
State psychiatric hospitals and intermediate care facilities	20%44/
Physicians, dentists, and other practitioners' services	30%
Drugs	10%

Larger increases are assumed to occur under those proposals recognizing full usual and customary charges or some other payment level, rather than "reasonable charges" as determined under the Medicare program. Increases will also occur for Medicare patients under such proposals.

Under proposals which establish the same rate of payment to hospitals and other institutions for all payers, the rate of payment is assumed to be increased by 5% over the level paid by the Medicare program.45/ Payments by Blue Cross are also assumed to be increased by 5% under such proposals.

g. Amounts not billable for assigned claims due to Medicare reasonable charge screens are assumed to be paid to the extent eligible for third party payment through new insurance programs. Half of that not paid through insurance which becomes payable as a result of a proposal is assumed to be collected.

44/ This factor allows for a major upgrading of the facilities in which care is provided.

45/ This factor allows for the difference between the level of "reasonable costs" as defined by the Medicare program, and the level of revenues currently generated by hospitals.

h. Offsets are assumed for the impact of utilization controls on induced services (generated by payment for services that otherwise would have been paid out-of-pocket or become bad debts). The basic allowances provided for the principal types of controls in the proposals analyzed are as follows:

(1) Pre-admission and post-admission review of hospital and skilled nursing facility stays by PSRO's: Half of induced hospital services up to a maximum of 5% of covered hospital services.[46/]

(2) Restrictions on payments to physicians for professional services:

(i) Claim review by private carriers of services presently paid through Medicaid:[47/] 5% of outpatient Medicaid services

(ii) Peer review of all physician services, through professional standards review organizations: Negligible[48/]

(iii) Consultation with second surgeon and recommendation of family physician prior to surgery (net of additional cost for added visits): 5% surgical fees[49/]

46/ Use of PSRO's is already required for Medicare, Medicaid, and other public programs. In addition, many private insurers have contracted with PSRO's to review admissions for their policyholders as well. Thus, much of the potential effect of pre-admission and post-admission peer review is reflected in the estimates for spending under current law. The effect of the provisions is assumed to be to limit patients to the beds available at the maximum occupancy rate which is consistent with efficient operation and which leaves sufficient beds available for emergency admissions.

47/ Claim review procedures establish that services are necessary to diagnose or treat an illness of a type insured, were rendered to insured persons, were not already paid, etc. Approximately 6% of services submitted under Part B of the Medicare program are rejected for such reasons.

48/ The reductions in services of some providers are assumed to be offset by additional services ordered or performed by others to meet the professional standards, and the administrative costs of the review program.

49/ Allowance includes a reduction in hospital costs, and an increase in fees for consultations.

(iv) Payment for services of specialists only if board certified with additional requirements for continuing education and recertification by boards: Negligible[50/]

(3) Utilization review of usage of prescription drugs: 5% program payment for drugs.[51/]

(4) Increase in prepaid group practice plans or foundations providing comprehensive services for capitation payments: 1.5% growth in HMO expenditures.[52/]

i. Limitations on institutional budgets or reimbursement rates set by independent rate setting commissions are estimated to have the potential to reduce the rate of increase in spending substantially. Two types of reduction were analysed:

(i) An offset to windfall increases in revenues of institutions due to reduced bad debts and/or full payment by all users (including Blue Cross, Medicaid, Medicare).

(ii) A reduction in the rate of increase in hospital expenses due to exclusion from reimbursable costs of specified expenses (especially poorly utilized facilities where alternatives are available, facilities with operating costs per service substantially higher than those of other institutions in the area, etc.).

50/ Increases due to substitution of higher paid specialists is assumed to offset the reduction in income to those who cannot obtain board certification.

51/ Program payments for drugs are estimated to be reduced 15%, but patients are assumed to pay for the other 10% themselves.

52/ HMO's can reduce inpatient hospital patient days per capita for their membership by 7½% to 15%. Such a reduction will lower overall hospital costs by approximately a quarter of the reduction in days of care in the short run and by perhaps half in the longer run (as hospital expansion is reduced). (The HMO obtains a reduction for its members of the full reduction in days of care, but hospital charges to other patients must be increased to cover the lost contribution to overhead). By providing comprehensive services, however, HMO's increase expenditures in other areas, offsetting part of this reduction. Although some of the proposals encourage more rapid growth of HMO's, the effect of such growth on overall program costs is estimated to be small during the first three years.

The impact of such a commission is assumed to depend directly on (1) the degree of effective control exercised over institutional rates in the area, (2) the degree to which there is a direct relationship between the local cost of institutional care and taxes or premiums raised locally to pay for such care, (3) the relationship between the sources of political power over the commission and those who pay the cost of increased services, and in the case of state commissions (4) whether the Federal government can reduce reimbursements for states that appear to have higher than average costs.

The factors used to estimate the impact of institutional rate setting commissions are as follows:

(i) For offsets to windfall revenue increases due to program payment of bad debts, etc. - a reduction of up to all of the portion (50%) of the windfall increase assumed to be otherwise retained by hospitals.

(ii) A reduction ranging from 0% to 5.0% in the rate of annual increase in hospital costs after the first year of the program.

The maximum factors would be used if state or local government commissions set rates paid by insurance plans under which most of the cost of institutional care is raised locally (e.g., financed by employers and state taxpayers). The minimum allowances were used where the commissions were controlled locally and taxes to pay for the programs were raised nationally. Similarly, control of the commissions by providers (or the state department of health) was assumed to lead to more emphasis on the quality of services than the cost. On the other hand, control by payers (employers, state controllers, insurers, etc.) was assumed to result in the most effective programs. For a Federal commission operating under a nationally funded program

(e.g., payroll taxes and general revenues), factors in the middle of the ranges were used.[53/]

j. Several of the proposals analyzed limit the total charge that may be collected from a professional provider to a designated amount. In some proposals, the limits are expressed as a fee schedule, set by state or Federal officials after negotiations with providers. In other bills the limits are set by a statistical procedure similar to that specified in the Social Security Act for Medicare. The following principles were followed in estimating the effect of these limits.

(1) If no specific procedure is specified to determine the level of fees, it is assumed that "reasonable charges" are determined through the procedures specified in the Social Security Act.

(2) If physicians may accept or refuse assignments (i.e., bills for which the provider may not collect the excess of his charge over the reasonable charge or fee schedule amount) on a bill-by-bill basis and may collect their full charge when assignments are not taken (as is the case for Medicare), the level of fee schedules or reasonable charge screens is assumed to be set at the level of reasonable charges under Medicare.[54/]

(3) If the proposal requires a higher proportion of assignments than would be the case if the Medicare rules were followed, it is assumed that the level of payment is raised in proportion to the percentage of billings that are affected.

53/ Financial controls are estimated to be more effective for state governments, which unlike the Federal government cannot create money to finance deficits.

54/ Specifically, it is assumed that the value of a relative value scale unit will be the same in each area for the fee schedule or prevailing charge screen under the proposal as it is for prevailing fees in Medicare.

(4) If all charges by providers are limited to reasonable charges (or similar limits), the level of payments is assumed to be set at the same ratio to prevailing charges as would be determined for Medicare under present law, but increased to the current period by an economic index equivalent to that used in connection with limiting the increase allowed in prevailing fees for the Medicare program.[55/]

(5) The maximum reduction due to limits on the level of charges of professional providers is assumed to be no greater in fiscal years 1978-1980 than the sum of (i) bad debts and unbilled charges paid to such providers as a result of the proposal, (ii) higher payments for services than would otherwise have been paid through Medicaid, (iii) payments in excess of reasonable charges for claims that would have been assigned under Medicare. In other words, it is assumed that at least initially, any reduction in income to physicians and other professional providers through setting maximum fees will be no greater than the windfall increases in physicians' and other practitioners' incomes resulting from the proposal. Providers' incomes will in general be increased by each proposal analyzed despite limits on payments, but only to the extent that there is greater productivity or longer working hours.[56/]

k. The average rates of administrative expense projected under present law for each channel of payment is applied to the estimated total payments through that channel under a national health insurance proposal. The difference

55/ Prevailing fees as determined under the Social Security Act are based on data from a period that averages 1½ years earlier than the period to which they apply. It is thus assumed in the estimates that the level of fees would be higher than Medicare fees by the increase in the economic index for the last 1½ years.

56/ Many informed analysts are of the opinion that a high participation rate by physicians could only be obtained by setting fees at a level that would result in substantially higher incomes without additional hours or productivity. To the extent that this is true, the cost of proposals that rely on such limits are understated.

between the administrative costs so calculated and under present law is the administrative cost induced by new insurance.

For proposals which do not result in substantial additional administrative functions and procedures, administrative costs for policies underwritten by private insurers are estimated as the same average processing cost as at present. Under present law, administrative expenses are projected to be 20% of benefits for association group insurance, 9.5% of benefits for other group insurance, and 60% of benefits for individual policies.

Adjustments were made for any change in the distribution by size of policy and in the composition of the benefit packages. Proposals mandating coverage of all employees would lead to a larger proportion of small plans, which would increase the average administrative cost of group insurance. Similarly, proposals which increase the proportion of prescriptions and ambulatory services included in insurance benefits are also estimated to increase administrative costs. Proposals which pay larger portions of services for which processing is already necessary are estimated to increase only that portion of administrative costs that varies directly with premiums (e.g., premium taxes).

Estimates of the administrative costs of public programs are based on those of Medicare. Allowances are made for any differences in the type of benefits covered, the population group covered, and the administrative functions performed. For example, if the Medicare program covered persons under age 65 for the same benefits, administrative costs would run around 8% (compared to a projected 5.0% for the aged and disabled), after allowing for a smaller average claim size and a lower proportion of inpatient hospital

bills. If prescriptions were covered, administrative costs would be around 9% of benefits for persons under age 65. If premiums were collected from most enrollees, rather than deducting their premiums from Social Security and other transfer payments, this ratio would increase to around 11.5%. If premiums or benefits are related to income and if a health credit card system is incorporated into the proposal, administrative costs would be further increased to about 15%.[57/] These percentages would be reduced somewhat with lower cost sharing since with the credit card essentially all covered expenses must be fully processed.

1. The following factors were used to estimate the additional costs of new administrative functions performed.

(1) Additional statistical recording and processing required to report accurate per capita costs for mandated benefit packages (or as a base for a certification of actuarial equivalence) is estimated to increase administrative costs by 0.3% of benefits paid.

(2) Statistical data equivalent to that maintained under Medicare is estimated to increase processing costs by 0.1% of institutional bills paid, 5% of prescription bills paid, and 1% of other bills paid.[58/]

(3) Use of detailed reasonable and customary fee screens (as in Medicare) by all insurers is estimated to increase processing costs by 2% of medical bills processed.[59/]

57/ All of the costs discussed here assume that most administrative functions are carried out by private carriers. Substantially higher costs would be assumed for direct Federal administration, primarily to reflect higher fringe benefits and Washington based salary scales.

58/ This level of data is assumed unless the proposal clearly would leave the extent of data collection and processing in private hands (e.g., the A.M.A. and H.I.A.A. bills).

59/ Many insurers have already adopted such screens. Most, however, have not. If reasonable and customary charges are determined for services for which no payment is made (e.g., those paid for through a health credit card system), administrative costs are increased accordingly.

(4) Processing of health credit card bills is estimated to increase administrative costs by 0.1% of inpatient institutional bills, 5% of prescription drug bills, and 1% of other bills (exclusive of any bad debt costs, which are treated as an increase in claims paid).

(5) Programs requiring information as to current income for premium collections and cost payments are estimated to increase administrative costs by $50 (in current dollars) for each individual or family not eligible for SSI or AFDC.[60/] Programs requiring point of claim information only are assumed to use a simple declaration by patients (without an extensive effort to check its accuracy), and are estimated to add $1 per declaration to processing costs.

m. Federal and state spending for planning, regulation, and evaluation was estimated to vary directly with the following factors.

(1) The extensiveness of data required to be collected under a proposal.

(2) The extent to which new interaction is required by a proposal between health providers and the Federal and state governments (e.g., to set fees, standards, etc.).

(3) The extent of regulatory and evaluation functions detailed in the proposal.

(4) The degree of duplication between state and Federal functions.

(5) The degree of change introduced into health financing.

n. The expense of administering individual health policies (projected to be 60% of benefits under current law) is assumed to be reduced by the following factors:

60/ This processing cost is based on the administrative costs of the SSI program ($110 per beneficiary in 1975 for all SSI functions).

(1) Reduction in number of policies.

(2) An increase in average policy size.

(3) Standardization of benefit packages.

o. Proposals that mandate a uniform benefit package for all employees are estimated to lower the sales and claim processing costs of policies covering small groups. If mandated benefits are required to be furnished through a separate standardized policy, claim processing and sales costs are estimated to be reduced further, as price competition forces insurers to pass on the lessened need for sales forces and the lower claims processing costs resulting from standardized benefits. Provisions for pooled coverages among insurers are estimated to reduce the cost of administrative services to a level comparable to those of the state "65" plans which were replaced by Medicare.

p. All of the proposals analyzed would provide funding in alternative facilities for patients currently utilizing Veterans Administration and Public Health Service hospitals and clinics. It was assumed in determining transfers that one-third of such patients would switch to private facilities.[61/] The estimates of induced costs are based on the assumption that appropriations will be reduced by one-half of the decrease in patient load, resulting in an induced cost equal to the other half of such decrease.[62/]

q. All of the programs analyzed would to some extent pay for services that are now funded through philanthropic contributions. It is assumed that three-quarters of funds replaced by new programs will be diverted to other health related purposes.

61/ The transfer was calculated to be one-third of the payment that would be made to Federal facilities if they were an eligible provider.

62/ The costs of these institutions would not be reduced in proportion to the reduction in patient load. Further past history suggests that appropriations for Federal facilities are not strictly related to patient load.

I. Analysis and Results

The final step is the analysis of each proposal, in terms of the coverage of the population by health insurance, spending under the major new programs set up by a proposal, transferred costs, induced costs, and the net fiscal impact on the Federal unified budget. This analysis may involve such elements as estimates of the population eligible for each plan set up by a proposal, average premiums for any private insurance policies required, and the ways in which households pay for personal health services, etc.

The estimates for each proposal are highlighted by comparing the spending under the proposal and the net fiscal impact on the Federal budget of all spending for personal health services with what is estimated to occur without any major change in current law. Standard formats are used to display these principal results. The policy and actuarial assumptions peculiar to the estimates for a particular bill are described in a section of Appendix A devoted to that proposal.

Finally the estimates for all the proposals analysed are compared in Section V of the report. The comparisons highlight the overall increases in spending for personal health services estimated to occur as a result of national health insurance, the contribution to such increases of the major types of induced costs analysed, the overall spending through each channel under the proposals, and the net fiscal impact of the proposals on the Federal budget.

II. ESTIMATED NATIONAL HEALTH SPENDING IN FISCAL YEARS 1976-1980 AS A BASIS FOR ESTIMATING SPENDING UNDER NATIONAL HEALTH INSURANCE PROPOSALS

The first step in estimating the relative cost of national health insurance proposals is to project the spending for personal health services that would occur in the absence of any major change in legislation. The cost of any proposal will be largely determined, at least initially, by the health services being supplied, the facilities in place, and the expectations of the public as to the desired level of care. Further, the impact of any changes in the financing of these services will depend on the methods by which the services are being funded otherwise.

A second essential step in estimating the cost of national health insurance is to derive a matrix of sources and uses of funds spent for personal health services for the years in which the programs would be effective. Such a matrix shows the extent to which households pay for each type of medical service through each "channel", e.g., through direct payments out-of-pocket, through purchasing insurance, through employers in lieu of wages, through tax supported programs, etc. The principal effect of a national health insurance program would be to alter the elements of this matrix, by changing the relative amount for each service funded through each channel and in general by increasing the overall spending for health services.

An estimate of such a spending matrix in the current fiscal year (1976) was compiled and projected through 1980. The sources of funds are referred to

as the "channels" of payment, to emphasize that it is households, ultimately, which must pay for health services. Insurance companies, government programs, etc. are regarded as merely channels through which these payments are made.

The matrix of national spending for personal health services in fiscal 1976 by type of service and channel of payment is summarized in Table 2.1. Total spending for personal health services (exclusive of any expenditures for research, construction, education, or training) are estimated to be $140.4 billion in fiscal 1976. Approximately 43% or $59.7 billion are estimated to be for institutional services for persons confined in hospitals and nursing homes. Some 39% ($55.1 billion) is estimated to be spent for the services of professional practitioners and for ambulatory services provided by institutions. Another 13% ($17.6 billion) is estimated to be spent for eyeglasses, appliances, prescriptions, and other drugs and drug sundries. Finally, around 6% ($8.1 billion) is estimated to be spent for administration and planning, including the Federal spending in connection with the furnishing or regulation and planning of personal health services.

Approximately 33% of these services ($46.6 billion) are estimated to be paid for directly out-of-pocket by persons using the services. Approximately 28% ($39.1 billion) are estimated to be paid by private insurance policies, and an additional 1% is estimated to be paid by private philanthropy and employer health services. About 2% ($2.6 billion) is estimated to be paid through government insurance programs, such as the voluntary premium payments for Part B of Medicare. Some 25% ($35.1 billion) is estimated to be paid by Federal taxpayers, and 11% is estimated to be paid for by state and local tax-payers.

TABLE 2.1 SPENDING FOR HEALTH SERVICES IN FISCAL YEAR 1976 BY TYPE OF SERVICE AND CHANNEL OF PAYMENT
(Millions of Fiscal Year 1976 Dollars)

	TOTAL	PRIVATE				PUBLIC			
		TOTAL	DIRECT	INSURANCE	OTHER	TOTAL	INSURANCE	FEDERAL	STATE & LOCAL
INPATIENT INSTITUTIONAL SERVICES	59,660	28,170	9,540	18,280	350	31,490	270	23,240	7,980
General Hospital	37,680	21,360	3,350	17,740	270	16,320	250	14,090	1,980
Long Term Hospital	1,150	440	260	150	30	710	10	240	460
Psychiatric Hospital	4,550	1,190	810	360	20	3,360	10	370	2,980
Federal Hospital	4,960	20	20	0	0	4,940	0	4,940	0
Skilled Nursing Facilities	7,820	4,460	4,400	30	30	3,360	*	2,030	1,330
Intermediate Care Facilities	3,500	700	700	0	*	2,800	*	1,570	1,230
PROFESSIONAL & OUTPATIENT SERVICES	55,100	37,200	21,620	14,390	1,190	17,900	2,040	9,720	6,140
General Hospital	5,460	3,780	1,740	1,980	60	1,680	440	830	410
Home Health Agencies	490	230	170	20	40	260	30	230	0
Mental Health Facilities	2,830	700	240	160	300	2,130	0	650	1,480
Physicians	26,900	21,150	10,320	10,820	10	5,750	1,550	3,540	660
Dentists	8,740	8,270	7,180	1,090	*	470	*	300	170
Public Health	3,980	0	0	0	0	3,980	0	1,560	2,420
Other Professionals & Facilities	6,700	3,070	1,970	320	780	3,630	20	2,610	1,000
OTHER HEALTH SERVICES & SUPPLIES	17,630	16,500	15,500	1,000	*	1,130	20	640	470
Eyeglasses & Appliances	2,900	2,760	2,670	90	*	140	10	90	40
Prescriptions	9,520	8,600	7,730	870	0	920	10	510	400
OTC Drugs & Sundries	5,210	5,140	5,100	40	0	70	0	40	30
ADMINISTRATION & PLANNING	7,995	5,885	0	5,475	410	2,110	300	1,530	280
TOTAL	140,385	87,755	46,660	39,145	1,950	52,630	2,630	35,130	14,870

The estimates in this report were prepared using assumptions as to increases in the Consumer Price Index (C.P.I.) of 6½% per year, and increases in average wages of 7½% per year.[1/] To highlight the parametric nature of these assumptions and to facilitate interpretation of the estimates, spending is shown in terms of fiscal 1976 dollars throughout the report. To facilitate comparisons with budget projections and to remind the reader that actual totals will be higher, the principal results are restated in Appendix D in terms of nominal dollar outlays, using the official projections of the Council of Economic Advisors as to the future value of the dollar.

Table 2.2 summarizes the estimated spending for each type of health service in fiscal years 1976-1980 (in fiscal 1976 dollars).[2/] As can be seen from these tables, the rate at which national resources are devoted to personal health services is estimated to continue to increase rapidly, especially for institutional care, even when the effect of inflation has been eliminated.

Total spending for personal health services is estimated to increase from $140.4 billion in fiscal 1976 to $180.2 billion in 1980, an increase of 28%. Almost half of such spending is for inpatient institutional services. These services are projected to increase from $59.7 billion in fiscal 1976 to $79.3 billion in fiscal 1980. Approximately two-thirds of the services are in short-term general hospitals, the costs of which are expected to increase at a more rapid rate than those of other institutional services. Spending for skilled nursing facilities and intermediate care facilities is also projected to grow rapidly, as the level of care in these institutions is improved and as larger

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1/ These assumptions relate to the ratio of the average in fiscal year 1976 to the average for fiscal year 1975, etc.

2/ Fiscal year 1976 began in July; fiscal years 1977-1980 will begin in October. (No estimate is shown for the transition quarter, July - September 1976.)

TABLE 2.2 PERSONAL HEALTH SPENDING AND PERCENTAGE DISTRIBUTION IN FISCAL 1976-80 BY TYPE OF SERVICE

	Millions of Fiscal Year 1976 Dollars					% of Personal Health Spending				
	1976	1977	1978	1979	1980	1976	1977	1978	1979	1980
TOTAL	140,385	152,185	161,320	170,705	180,165	100.0	100.0	100.0	100.0	100.0
INPATIENT INSTITUTIONAL SERVICES	59,660	65,230	69,610	74,380	79,250	42.5	42.8	43.1	43.5	43.9
General Hospital	35,840	39,560	42,370	45,510	48,680	25.5	26.0	26.2	26.6	27.0
General Hospital Psychiatric	1,840	2,030	2,170	2,330	2,490	1.3	1.3	1.4	1.4	1.4
Private Psychiatric	470	510	560	600	650	.3	.3	.4	.4	.4
State & Local Psychiatric	4,080	4,120	4,160	4,200	4,240	2.9	2.7	2.6	2.4	2.3
Long Term Hospital	1,150	1,170	1,180	1,190	1,200	.8	.8	.7	.7	.7
Federal Hospital	4,960	5,170	5,350	5,530	5,720	3.6	3.4	3.3	3.2	3.2
Skilled Nursing Facilities	7,820	8,570	9,260	10,060	10,890	5.6	5.6	5.7	5.9	6.0
Intermediate Care Facilities	3,500	4,100	4,560	4,960	5,380	2.5	2.7	2.8	2.9	2.9
PROFESSIONAL & OUTPATIENT SERVICES	55,100	60,160	63,960	67,610	71,240	39.2	39.5	39.6	39.5	39.5
Hospitals	5,460	6,360	7,170	8,010	8,880	3.9	4.2	4.4	4.7	4.9
Mental Health Facilities	2,830	2,960	3,060	3,180	3,300	2.0	1.9	1.9	1.9	1.8
Home Health Agencies	490	610	670	720	770	.3	.4	.4	.4	.4
Physicians	26,900	29,640	31,540	33,220	34,750	19.2	19.5	19.6	19.4	19.3
Dentists	8,740	9,350	9,850	10,370	10,920	6.2	6.1	6.1	6.1	6.1
Public Health	3,980	4,210	4,380	4,510	4,680	2.8	2.8	2.7	2.6	2.6
Other Professionals & Facilities	6,700	7,030	7,290	7,600	7,940	4.8	4.6	4.5	4.4	4.4
OTHER HEALTH SERVICES & SUPPLIES	17,630	18,100	18,520	18,930	19,360	12.6	11.9	11.5	11.1	10.7
Eyeglasses & Appliances	2,900	3,050	3,180	3,310	3,450	2.1	2.0	2.0	2.0	1.9
Prescriptions	9,520	9,730	9,920	10,100	10,290	6.8	6.4	6.1	5.9	5.7
OTC Drugs & Sundries	5,210	5,320	5,420	5,520	5,620	3.7	3.5	3.4	3.2	3.1
ADMINISTRATION & PLANNING	7,995	8,695	9,230	9,785	10,315	5.7	5.8	5.8	5.9	5.9

proportions of the aged and disabled populations become institutionalized.

Ambulatory services furnished by institutions are also projected to grow very rapidly in terms of constant fiscal 1976 dollars. For example, spending is projected to increase by 63% for outpatient hospital services, and 57% for home health agencies. Spending for outpatient mental health facilities is projected to increase only moderately, by 18%, as a result of the primary dependence of these facilities on state and local government funds.[3/]

Total spending for the professional services of physicians are projected to rise by approximately 29% during the period 1976-1980. The primary factors contributing to this increase are projected to be malpractice insurance premiums, services performed as defensive measures to avoid malpractice suits, the long term trends toward new and more specialized procedures, greater use of specialists, and more frequent use per capita of physician services. Dentists' services are projected to rise by 25% for reasons similar to those for the increase in physician services, except that a much lower rate of increase is assumed in malpractice premiums. Services of other practitioners and laboratories not owned by physicians and dentists are projected to rise by 19% in this period. Spending for other health services and supplies is projected to rise from $17.6 billion in fiscal 1976 to $19.4 billion in fiscal 1980, an increase of 19%.

Table 2.3 shows the estimated spending through each channel of payment in fiscal years 1976-1980 in fiscal 1976 dollars. As can be seen from these tables, the rapid increase in the cost of health services is reflected in the cost of government and private programs that pay for these services and in out-

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3/ Increased Federal funding would result in a more rapid rate of growth.

TABLE 2.3 PERSONAL HEALTH SPENDING AND PERCENTAGE DISTRIBUTION IN FISCAL 1976-80 BY CHANNEL OF PAYMENT

	MILLIONS OF FISCAL 1976 DOLLARS					% of Personal Health Spending				
	1976	1977	1978	1979	1980	1976	1977	1978	1979	1980
TOTAL U.S.	140,385	152,185	161,320	170,705	180,165	100.0	100.0	100.0	100.0	100.0
PRIVATE SECTOR	87,755	94,875	100,340	106,215	112,095	62.5	62.3	62.2	62.2	62.2
Out of pocket payments	46,660	49,480	51,610	54,050	56,490	33.2	32.5	32.0	31.6	31.3
Through insurance:										
Individual policies	5,750	6,340	6,780	7,260	7,730	4.1	4.2	4.2	4.2	4.2
Employee contributions	8,605	9,380	9,930	10,445	10,950	6.1	6.2	6.2	6.2	6.1
Employer contributions	22,680	25,345	27,490	29,740	32,005	16.2	16.6	17.0	17.4	17.8
Workmen's compensation & TDI	2,110	2,330	2,490	2,650	2,820	1.5	1.5	1.6	1.6	1.6
Philanthropy	1,170	1,180	1,190	1,200	1,210	.8	.8	.7	.7	.7
Employer health services	780	820	850	870	890	.6	.5	.5	.5	.5
PUBLIC SECTOR	52,630	57,310	60,980	64,490	68,070	37.5	37.7	37.8	37.8	37.8
Government insurance:	2,630	2,750	2,840	2,930	3,000	1.9	1.8	1.8	1.7	1.7
Workmen's compensation & TDI	710	770	830	890	940	.5	.5	.5	.5	.5
Medicare premiums	1,920	1,980	2,010	2,040	2,060	1.4	1.3	1.3	1.2	1.2
Federal taxpayers	35,130	38,910	41,930	44,820	47,790	25.0	25.6	26.0	26.3	26.6
Through third parties:										
Medicare	15,870	18,220	20,060	21,890	23,730	11.3	12.0	12.4	12.9	13.2
Medicaid	8,420	9,210	9,850	10,430	11,010	6.0	6.1	6.1	6.2	6.2
Maternal & child health	300	310	330	340	350	.2	.2	.2	.2	.2
Vocational rehabilitation	200	220	230	240	250	.1	.1	.1	.1	.1
Veterans Administration	240	260	280	290	310	.2	.2	.2	.2	.2
Defense Department	650	690	720	750	780	.5	.5	.4	.4	.4
Other	700	720	740	750	770	.5	.5	.5	.4	.4
Direct payments:										
Veterans Administration	3,450	3,590	3,720	3,850	3,980	2.4	2.3	2.3	2.2	2.2
Defense Department	2,490	2,590	2,680	2,770	2,870	1.8	1.7	1.7	1.6	1.6
Other	2,810	3,100	3,320	3,510	3,740	2.0	2.0	2.1	2.1	2.1
State & local taxpayers	14,870	15,650	16,210	16,740	17,280	10.6	10.3	10.0	9.8	9.5
Through third parties:										
Medicaid & vendor	6,710	7,270	7,750	8,200	8,660	4.8	4.8	4.8	4.8	4.7
Maternal & child health	290	310	320	330	340	.2	.2	.2	.2	.2
Vocational rehabilitation	40	50	50	50	50	*	*	*	*	*
Direct payments	7,830	8,020	8,090	8,160	8,230	5.6	5.3	5.0	4.8	4.6

of-pocket payments.

Estimated spending for some programs, such as Medicare and Medicaid, also reflect new Federal policies to limit the level of Federal payment. These policies include limiting the recognition of reasonable costs of institutions for providing particular services and limiting the rise in physician fee screens to the increase in an economic index.[4/] The estimated rate of growth in spending under the Medicaid program reflects the anticipated attempts by state governments to control costs by limiting fee increases and recognition of reimburseable institutional costs, the failure to raise the income limits for eligibility as fast as the rate of inflation, the introduction of cost sharing for some services, and the limiting of coverage of some services.

Group insurance is estimated to grow more rapidly than medical care costs generally -- as employees obtain greater advantage of the Federal subsidies to insurance, especially for dental care, vision care, and prescriptions.

Out-of-pocket payments for personal health services are projected to reach $56.5 billion in fiscal 1980. Insurance payments for services and administration are projected to reach $53.5 billion, of which $7.7 billion are through group health insurance policies, and $2.8 billion are through privately funded workmen's compensation and temporary disability insurance programs. $1.2 billion of philanthropic contributions are projected to be used for personal health services (including the cost of solicitation), and $.9 billion is projected to be spent by employers for in-plant health services.

Premium payments for Government sponsored programs are projected

4/ Estimates of spending under the Medicare program are those of the Office of the Actuary, Social Security Administration, adjusted for differences in economic assumptions used.

at $3.0 billion, of which $2.1 billion are for Medicare premiums and $.9 billion are for premiums paid to state workmen's compensation or temporary disability insurance funds. Federal taxpayers will pay for $47.8 billion of personal health services. Spending under the Medicare program is projected at $23.7 billion, with contributions to state Medicaid programs being estimated at $11.0 billion. Other Federal spending is projected to be $2.5 billion for miscellaneous indirect programs and $10.6 billion for Federally owned and operated facilities. State and local government spending is estimated at $17.3 billion, of which the non-Federal portion of the cost of state Medicaid programs is $8.7 billion.

Table 2.4 summarizes the projected matrix of spending for personal health services in fiscal 1980 in terms of fiscal 1976 dollars. This matrix is the common basis used to estimate the cost of each of the national health insurance proposals analyzed in this report.

TABLE 2.4 SPENDING FOR HEALTH SERVICES IN FISCAL YEAR 1980 BY TYPE OF SERVICE AND CHANNEL OF PAYMENT
(Millions of Fiscal Year 1976 Dollars)

	TOTAL	PRIVATE				PUBLIC			
		TOTAL	DIRECT	INSURANCE	OTHER	TOTAL	INSURANCE	FEDERAL	STATE & LOCAL
INPATIENT INSTITUTIONAL SERVICES	79,250	37,570	12,260	24,960	350	41,680	350	31,500	9,830
General Hospital	51,170	28,180	3,600	24,300	280	22,990	330	20,030	2,630
Long Term Hospital	1,200	500	320	160	20	700	10	290	400
Psychiatric Hospital	4,890	1,320	840	460	20	3,570	10	370	3,190
Federal Hospital	5,720	20	20	0	0	5,700	0	5,700	0
Skilled Nursing Facilities	10,890	6,470	6,400	40	30	4,420	*	2,700	1,720
Intermediate Care Facilities	5,380	1,080	1,080	0	*	4,300	*	2,410	1,890
PROFESSIONAL & OUTPATIENT SERVICES	71,240	48,650	27,430	19,880	1,340	22,590	2,270	13,650	6,670
General Hospital	8,880	5,920	2,580	3,280	60	2,960	490	1,900	570
Home Health Agencies	770	320	240	40	40	450	30	420	0
Mental Health Facilities	3,300	870	300	230	340	2,430	0	790	1,640
Physicians	34,750	27,320	13,190	14,120	10	7,430	1,710	4,960	760
Dentists	10,920	10,370	8,540	1,830	*	550	*	350	200
Public Health	4,680	0	0	0	0	4,680	0	2,250	2,430
Other Professionals & Facilities	7,940	3,850	2,580	380	890	4,090	40	2,980	1,070
OTHER HEALTH SERVICES & SUPPLIES	19,360	18,320	16,800	1,520	*	1,040	20	600	420
Eyeglasses & Appliances	3,450	3,310	3,190	120	*	140	10	90	40
Prescriptions	10,290	9,460	8,100	1,360	0	830	10	470	350
OTC Drugs & Sundries	5,620	5,550	5,510	40	0	70	0	40	30
ADMINISTRATION & PLANNING	10,315	7,555	0	7,145	410	2,760	360	2,040	360
TOTAL	180,165	112,095	56,490	53,505	2,100	68,070	3,000	47,790	17,280

III. ESTIMATES OF SPENDING FOR PERSONAL HEALTH SERVICES NET OF TAXES

The estimated effect of taxes on how households pay for personal health services is summarized in Table 3.1. Shown separately are the effect of exempting certain proportions of spending for medical services from Federal income taxation, the effect of exempting similar proportions from state income taxation, and the effect of state and local taxes on insurance premiums.

It is estimated that Federal taxpayers will actually bear approximately $14.7 billion more of the cost of personal health services as a result of tax preferences. Approximately 66% of that sum, $9.8 billion, will be derived from not taxing group insurance premiums paid by employers on behalf of employees. Deduction of individual policy premiums, employee contributions to group insurance, and Medicare premiums shift another $1.4 billion to Federal taxpayers. Deductions of medical expenses in excess of 3% of income is estimated to shift $3.1 billion of the cost of personal health services to Federal taxpayers. Deductions from income taxation for philanthropic contributions and employer health services result in a reduction of Federal income taxes of about $.5 billion.[1/]

Exemptions from state and local income taxes similar to those of the Federal income tax laws are estimated to shift $.8 billion of the cost of personal health services from private payments to state and local taxpayers. The relative size of the transfers by channel is proportional to that for Federal taxpayers.

1/ It is not clear that Federal taxpayers actually bear this cost. In the absence of the deductions available, charitable donations and employer health services might be greatly diminished.

TABLE 3.1 ESTIMATED SPENDING IN FISCAL 1980 FOR PERSONAL HEALTH SERVICES NET OF TAXES
(Billions of Fiscal 1976 Dollars)

	Before Tax Adjustment	Federal Subsidies	State Subsidies	State & Local Taxes	Net Adjustment	After Tax Adjustment
TOTAL U.S.	180,165	0	0	0	0	180,165
PRIVATE SECTOR	112,095	-14,550	-740	+670	-14,620	97,475
Out-of-pocket payments	56,490	-3,050	-170	0	-3,220	53,270
Through insurance:						
Individual policies	7,730	-520	-30	+120	-430	7,300
Employee contributions	10,950	-750	-50	+130	-670	10,280
Employer contributions	32,005	-9,760	-460	+390	-9,830	22,175
Workmen's compensation & TDI	2,820	0	0	+30	+30	2,850
Philanthropy	1,210	-360	-20	0	-380	830
Employer health services	890	-110	-10	0	-120	770
PUBLIC SECTOR	68,070	+14,550	+740	-670	+14,620	82,690
Government insurance	3,000	-140	-10	0	-150	2,850
Workmen's compensation & TDI	940	0	0	0	0	940
Medicare premiums	2,060	-140	-10	0	-150	1,910
Federal taxpayers	47,790	+14,690	0	0	+14,690	62,480
State and local taxpayers	17,280	0	+750	-670	+80	17,360

Most states tax health insurance premiums, including those for workmen's compensation liability insurance purchased from private carriers. These taxes are estimated to add $.7 billion to the cost of personal health services funded through insurance premiums. State and local premium taxes almost exactly offset the subsidies in state income tax laws resulting in a net increase in payments of less than $.1 billion. The overall impact of state and local taxes is to shift a small part of the burden of payment for health services from employees to other purchasers of insurance.[2/] Also part of the cost for those insured through Blue Cross and Blue Shield is shifted to those insured by other insurance companies. Additionally, costs are transferred from those purchasing insurance to those with very large medical expenses.

The net overall effect estimated for the nation is to shift approximately $14.7 billion of the cost of personal health services from private payments to taxpayers. After the effect of taxes, Federal taxpayers are estimated to pay 34.7% of the cost of personal health services, compared to 26.5% of spending before taxes. The proportion of the cost of personal health services estimated to be paid by state and local taxpayers is approximately the same as before taxes. The share paid by employees eligible for group health insurance plans is estimated to be 23.8% before taxes and 18.0% after taxes. The proportion paid through individual policies is estimated at 4.1% after taxes compared to 4.3% before taxes. The proportion paid directly out-of-pocket is estimated to be 31.4% before taxes and 29.6% after taxes.

2/ Since not all states have income tax laws this situation is not true in each state. In those states which have premium taxes but no income taxation, the effect is to simply add to the burden of paying insurance premiums. In those states with income tax laws and premium taxes, the effect of the tax exemptions greatly outweighs the effect of the premium taxes. The average figures for the country mask these differences among the states.

IV. DETAILED ANALYSIS OF MAJOR PROPOSALS

A. Long-Ribicoff Bill [1/]

1. Description [2/]

The Long-Ribicoff proposal, the "Catastrophic Health Insurance and Medical Assistance Reform Act", would establish two new Federal health insurance programs: a universal Catastrophic Health Insurance Program covering acute care services for the entire population, and a Federal Medical Assistance Program which replaces current Federal matching of State Medical Assistance Programs, including acute, preventive, and long term care services. The proposal would also provide for the establishment of certified health insurance policies to provide basic hospital and medical services that complement the catastrophic health insurance benefits.

Those subject to the payroll tax could elect to establish plans furnishing the catastrophic benefits. They would receive a credit against the tax of the actuarial value of the benefits up to the amount of payroll taxes paid. Employers would also receive a tax credit against their income taxes equal to half of payroll taxes (before any credit for insurance premiums), but could not deduct the taxes or premiums for catastrophic coverage from taxable income as a business expense.

1/ Introduced by Senators Long and Ribicoff and Representative Waggoner.
2/ For a detailed description of the Long-Ribicoff bill, see Saul Waldman, National Health Insurance Proposals: Provisions of Bills Introduced in the 94th Congress, U.S. Department of Health, Education and Welfare.

a. Catastrophic Health Insurance Program

(1) Hospital Insurance

(a) Services covered

- Inpatient hospital services (general and psychiatric)
- Day/night care in community mental health centers
- Skilled nursing facility services (100 days in benefit period) 3/
- Home health agency services 3/

(b) Cost sharing

Payments would be made for the full reasonable cost 3/ of services for anyone who has been confined in a hospital for 60 days during the 15 month period consisting of a calender year and the last 3 months of the preceding year. Payment would continue until a patient had not been confined in a hospital or skilled nursing facility for 90 consecutive days.

(2) Medical Insurance

(a) Services covered

- Physicians' services (including visits to psychiatrists 4/)
- Outpatient hospital services
- Outpatient community mental health center services
- Laboratory tests and x-rays
- Immunizations
- Home health agency services
- Outpatient physical therapy
- Medical supplies and appliances
- Ambulance services

With the exception of immunizations, services are covered only if necessary to diagnose or treat an injury, illness or pregnancy.

(b) Cost sharing

Payment would be made for the full reasonable charges for covered services after a family had accumulated more than $2000

3/ These terms have the same meaning as in the Medicare program.
4/ Visits to a pshchiatrist are limited to 5 during any 12 monthe period, unless approved in advance by a professional review organization as necessary to prevent institutional care.

in such services during the 15 month period consisting of a calender year and the last 3 months of the preceding year. 5/ Payment would continue until a family has incurred less than $500 in a 90 day period. The $2000 and $500 amounts would be increased at the rate of the physician fee component of the C.P.I. after the initial year of the program.

(c) Definition of family

A family is defined to be two or more persons related by blood, marriage or adoption living in the same residence, including spouses and their children. Children under age 22 absent from home because they are full time students would be included.

.(3) Financing

The Catastrophic Health Insurance Program would be financed by a payroll tax on self employed persons and employers, including Federal state and local governments. The wage base for the tax would be the same as under Social Security. All those subject to the tax could elect to establish a private plan furnishing the same or greater benefits and take the average cost of catastrophic health insurance benefits in their state as a credit toward the payroll tax. 6/ All taxpayers would receive a tax credit or other subsidy from the Federal government equal to half of the gross taxes payable (before credit for private insurance premiums), but neither the taxes nor the premiums for this insurance could be deducted from taxable income.

5/ Only $500 of services incurred in connection with treatment of mental disorders could be counted toward the $2000 deductible. Once the deductible was met, however, all such services could be covered. Thus if a family spends more than $1500 on non psychiatric covered services, all psychiatric services are covered.

6/ The total cost per employee to an employer with a private plan would thus be the sum of (1) the average gross payroll tax payable (specified in the bill as 1% of earnings covered by social security) less (2) the excess, if any, of (a) the average cost of catastrophic health insurance per employee in the state over (b) the premium rate paid.

(4) Reimbursement

Reimbursement would be made on the same basis as in the Medicare program, i.e., on the basis of reasonable cost or charges as determined under the Medicare program.[7/] Physicians who accept assignments of benefits for any service would have to agree to accept the reasonable charge as payment in full.

b. Medical Assistance Plan

(1) Benefits

The following services are covered to the extent they would not be payable under a private of public health insurance program (including Medicare and the Catastrophic Health Insurance Program).

- Inpatient hospital services (general and psychiatric)
- Skilled nursing facilities
- Intermediate care facilities
- Day/night care in community mental health centers
- Outpatient hospital services
- Outpatient mental health facilities
- Physicians' services
- Laboratory tests and x-rays
- Home health services
- Family planning, counseling and supplies
- Outpatient physical therapy
- Medical supplies and appliances
- Ambulance service
- Premiums for Part B of Medicare

Most such services necessary to prevent, diagnose or treat an injury, illness or pregnancy would be covered, including prenatal and well-baby care, periodic examinations (limited to children under age 18) and immunizations. Care in intermediate care facilities would be limited to persons with a physical or mental condition which requires care only availavle in institutional facilities.

7/ By fiscal 1980, reasonable charges as determined under the Social Security Act are estimated to be 78.5% of actual charges by physicians.

(2) Persons Eligible

The medical assistance plan would cover families with incomes under the following limits;

Single person	$2400
Family of two	3600
Family of three	4200
Family of four or more	4800 plus $400 for each additional person

These limits would be increased at the rate of increase of the C.P.I. after the initial year of the program (assumed in the estimates to be fiscal 1978).

All other families would be covered with a "spend-down" deductible, i.e. a family's income less their spending out-of-pocket (or by a state supplemental Medicaid program) for covered medical services must be less than the applicable eligibility limit. In determining whether a family was eligible on the basis of the spend-down deductible, outlays for other types of medical services would be considered - such as premiums for health insurance, dental care, optometrists, eyeglasses, prescription, etc.

All persons who were eligible for Medicaid when the new program began would be eligible for the new program; and in addition, those who would have been eligible if their incomes had been 5% less would also be eligible. Also, persons who are institutionalized while their families are eligible would continue to be eligible until discharged.

(3) Cost Sharing

Copayments of $3 per service would be required for the first 10 ambulatory services other than preventive care. For individuals or families with incomes above the eligibility limits, there is a deductible equal to the excess of their income over the applicable

eligibility limit, less any spending for health insurance premiums and the other noncovered services that can be counted toward the spend-down deductible.

Benefits for a patient who has been confined for 60 days or more in a long term care facility would be reduced by all such patient's income except $50 per month.

(4) Financing

The plan would be financed by Federal and state general revenues. The state contribution would be based on a constant amount each year equal to the level of state spending in fiscal 1977 through Medicaid for services covered in the new program plus half of the additional amount that would have been spent if the eligibility limits in the state had been equal to those for the new program. Such payment would be reduced, however, by state spending for services that were previously covered by the state's Medicaid program and were matched by Federal funds.

(5) Reimbursement

Reimbursement would be made on the same basis as in the Medicare program, i.e. on the basis of reasonable costs or charges as determined under the procedures specified in the Social Security Act. All participating providers would have to accept the reasonable charge as payment in full.

c. Private Basic Health Insurance Certification

(1) Certification of Health Insurance Policies

The proposal sets critieria for Federally certified health insurance plans, and makes provisions to ensure that such plans are offered in all states. The Federal government would market

certified policies in any state that did not establish a certification program that meets Federal standards. The certified policies would provide medical insurance benefits that complement those in the catastrophic health insurance plans at a rate between 125% and 150% of the average premium rate in the state for small employment groups.

Insurance carriers in a state would be permitted to form pools to offer certified policies, and all carriers would be required to participate in the pools in proportion to their total health insurance premiums. [8/]

(2) Services Covered and Cost Sharing

- Inpatient hospital services (60 day limit per year)
- Physicians services (up to $2000 per year)

Inpatient hospital services could be subject to cost sharing (deductible or copayments) of up to $100 per year and physicians' services could be subject to a deductible of up to $50 per person and 20% coinsurance.

d. Other Provisions

(1) Benefits under Part B of Medicare would be extended to cover immunizations and to pay 80% of charges for psychiatric services up to a maximum of $400.

(2) Payment for skilled nursing facility services under Medicare would be limited to 10% in excess of the payment rate established under state Medicaid programs.

8/ Open enrollment is not required for individual policies. Thus the pools could refuse to insure poor risks. It is unlikely that the pools would offer policies that resulted in losses or differed substantially from those otherwise available. Consequently, the certification program is unlikely to have a significant impact.

2. Estimated Population Covered by Proposal

All permanent residents of the United States would be covered under the new programs. It is estimated that a total of 231 million persons will be eligible for the programs during fiscal 1980.

Estimates of the number of persons who are covered for catastrophic benefits under public and private programs, and the number of persons eligible for full coverage under the Federal Medical Assistnce Plan are shown in Table 4A.1. Approximately 135.3 million persons are assumed to obtain catastrophic health benefits through private insurance, most, 127.7 million, through group plans established by employers. The remaining 7.6 million would utilize individual plans. Another 95.7 million persons will receive coverage through the Federal program.

An estimated 22.5 million persons will be eligible for coverage without a deductible under the Federal Medical Assistance Program. These include 8 million children, 9.5 million adults under age 65 and 5 million persons aged 65 or over for whom the benefits supplement those of the Medicare program. Many additional persons will be covered subject to relatively low spend-down deductibles (or no deductible at all as a result of applying non-covered services to satisfying the spend down deductible).

3. Program Spending Under the Long-Ribicoff Bill

The estimated spending in fiscal 1980 under the new programs set up by the Long-Ribicoff proposal is outlined in Table 4A.2 The outlays of the catastrophic plans are estimated at $11.0 billion for fiscal 1980. Of this. $5.5 billion is estimated to be paid through private plans. Most of this amount, $5.2 billion, would be funded through the group health insurance plans of employers. Spending by the Federal catastrophic program is estimated at $5.5 billion. Since the catastrophic benefits supplement Medicare for

TABLE 4A.1 ESTIMATED POPULATION ELIGIBLE FOR THE CATASTROPHIC HEALTH INSURANCE AND FEDERAL MEDICAL ASSISTANCE PROGRAM IN FISCAL 1980

(Thousands)

	Aged	Adults	Children[2/]	Persons
Catastrophic Health Insurance Program	25,000	131,000	75,000	231,000
Individual plans	1,000	4,030	2,570	7,600
Employer plans[1/]	2,000	80,500	45,230	127,730
Federal program	22,000	46,470	27,200	95,670
Federal Medical Assistance Program	25,000	131,000	75,000	231,000
Full coverage	5,000	9,500	8,000	22,500
Covered with spend down deductible	20,000	121,500	67,000	208,500

1/ Includes Federal civil servants and military servicemen and their families.
2/ Includes children under age 19 and through age 25 if full time students.

TABLE 4A.2 ESTIMATED SPENDING UNDER THE CATASTROPHIC HEALTH INSURANCE AND FEDERAL MEDICAL ASSISTANCE PROGRAMS IN FISCAL 1980
(Millions of 1976 Dollars)

Program	Non-Aged Persons	Aged Persons	All Ages
Catastrophic Health Insurance Program	$9,200	$1,800	$11,000
Individual plans	300	*	300
Employer Plans	5,000	200	5,200
Federal program	3,900	1,600	5,500
Federal Medical Assistance Program	$13,000	$11,500	$24,500
Federal payments	9,700	8,600	18,300
State and local government contributions	3,300	2,900	6,200

* Negligible

aged persons, most of the spending under these programs, $9.2 billion, is for persons under age 65. Most of the $1.8 billion spent for persons over age 65 is for confinement in long term and psychiatric hospitals.

4. Effect of Proposal on Prepayment for Catatrophic Benefits

A comparison of the premiums that would be paid in fiscal 1980 under present law for catastrophic health insurance benefits and the premiums and special payroll taxes that would be paid under the Long-Ribicoff proposal is as follows (Millions of dollars):

Channel	Present Law	Under Proposal	Net Change
All Persons	$4,900	$11,000	$6,100
Employees of Employers	4,200	6,800	2,600
Employee contributions	1,100	0 9/	-1,100
Employer contributions	3,100	5,200	2,100
Federal program	-	1,600	1,600
Others	700	4,200	3,500
Individual policies	700	300	-400
Federal Catastrophic program	—	3,900	3,900

9/ The elimination of employee contributions to group insurance plans providing catastrophic benefits is not assumed to result in a corresponding reduction in total payments by employees. Employee contributions for non-catastrophic benefits are assumed to be increased $900 million so that the overall decrease in employee contributions to group health insurance would be an estimated $200 million.

Of the $6.1 billion estimated increase in premium and payroll taxes to fund catastrophic benefits, $3.4 billion is estimated to be derived from decreases in out-of-pocket payments, philanthropic contributions, and spending for other government programs. The other $2.7 billion results from an estimated $1.0 billion in increased services performed, payment for $1.3 billion of services that under current law would become bad debts, and a net $.4 billion of other induced costs.

5. Estimated Effect of Proposal on Spending Through Medical Assistance Programs

The estimated spending through medical assistance programs in fiscal 1980 under the Long-Ribicoff proposal and under present law are compared in Table 4A.3. Under the present state Medicaid programs, spending in fiscal 1980 is estimated at $19.7 billion. Nearly all of this, $19 billion, will be spent for persons meeting Federal requirements for matching contributions toward the cost of medical services. The Federal contribution is estimated at $11 billion, or approximately 56% of total spending through the state programs. Spending under state Medicaid programs for persons for whom no Federal contribution is made is estimated at $700 million in fiscal 1980. Most of this spending is for persons receiving general relief who do not meet the eligibility requirements for Federal cash assistance programs.

Under the Long-Ribicoff proposal total spending through medical assistance programs is estimated at $28 billion. Spending under the Federal program for persons meeting the specific eligibility criteria in the bill is estimated at $23 billion. Of this, $18 billion is for services that would have been paid for under present law through state Medicaid programs, and another $5 billion is for persons who would not have been eligible under present law. In addition to services for persons meeting the specific criteria set forth in the bill, the new Federal assistance plan would retain or "grandfather" in all

TABLE 4A.3 ESTIMATED SPENDING THROUGH MEDICAL ASSISTANCE PROGRAMS IN FISCAL 1980

UNDER PRESENT LAW AND UNDER LONG-RIBICOFF PROPOSAL
(Millions of Fiscal 1976 Dollars)

	Total	Federal Plan	State Programs	
			Matched	Not Matched
A. Under Present Law				
1. For persons eligible for Federal reimbursement	$19,000	$ 0	$19,000	$ 0
2. For persons not eligible for Federal reimbursement	700	0	0	700
3. Total spending for Federal reimbursement	19,700	0	19,000	700
Paid by state and local taxpayers	8,700	0	8,000	700
Paid by Federal taxpayers	11,000	0	11,000	0
B. Under Long-Ribicoff Proposal				
1. For persons meeting new eligibility requirements	23,000	23,000	0	0
• Persons meeting present law eligibility requirements	18,000	18,000	0	0
• Persons not meeting present law eligibility requirements	5,000	5,000	0	0
2. For persons not meeting new eligibility requirements	2,850	1,500	0	1,350
• Persons meeting present law eligibility requirements	2,600	1,500	0	1,100
• Persons not meeting present law eligibility requirements	,250			,250
3. Services covered under present medical programs that are not covered by new Federal Assistance Program	1,600	0	1,600	0
4. Cost sharing in Federal Assistance Program	550	0	0	550
5. Total spending	28,000	24,500	1,600	1,900
Paid by state and local taxpayers	9,700	7,000	800	1,900
Paid by Federal taxpayers	18,300	17,500	800 1/	0

1/ Through reductions in state contributions to Federal Medical Assistance Programs

persons who had previously received medical assistance payments. Services for such persons are estimated to add $1.5 billion to program payments. In addition to the grandfather provisions in the Federal program, many of the states whose eligibility standards exceed those of the new Federal program are assumed to maintain such standards, especially for persons receiving cash assistance. Spending for services for such persons through these state programs are projected to be $1,350 million in fiscal 1980. Of the latter, $1,100 million is projected to be spent for persons who would have been eligible under present law for Federal matching (but were not eligible prior to fiscal 1978 and thus were not "grandfathered" in) and $250 million would be spent for persons eligible under present law only for general relief.

The Long-Ribicoff proposal provides for the state contribution to the Federal Medical Assistance Program to be reduced by one-half of state spending for services previously covered under a medical assistance program not included in the new Federal program. Most states are assumed to continue to provide these services at a program cost of $1.6 billion. Finally, many of the states are assumed to pay the copayments in the new Federal assistance program. Spending to pay such copayments is estimated at $550 million. Total spending by state and local taxpayers is estimated at $9.7 billion. Of this, $3.5 billion is estimated to be spent for services under state programs. The state contribution to the Federal plan of $7 billion is reduced by $800 million for the Federal matching, leaving a net state contribution of $6.2 billion.

Total spending under medical assistance programs is estimated to rise from $19.7 billion under present law to $28 billion under the Long-Ribicoff proposal. Much of this increase, $5 billion, is due to the coverage of persons not eligible for reimbursement under present law. Most of the remaining estimated increase in spending results from the assumed higher level of payment

TABLE 4A.4 EFFECT OF LONG-RIBICOFF PROPOSAL ON SPENDING FOR PERSONAL HEALTH SERVICES IN FISCAL 1980
(Billions of Fiscal 1976 Dollars)

	Present Law	Increase in Expenditure			Under Proposal
		Transferred	Induced	Total	
TOTAL U.S.	180.2	0	+7.9	+7.9	188.1
PRIVATE SECTOR	112.1	-3.3	+.5	-2.8	109.3
Out-of-pocket	56.5	-3.0	-.3	-3.3	53.2
Through insurance:					
Individual policies	7.7	-.4	*	-.4	7.3
Employee contributions	11.0	-.3	+.1	-.2	10.8
Employer contributions	32.0	+.7	+.5	+1.2	33.2
Workmen's compensation & TDI	2.8	0	0	0	2.8
Other private	2.1	-.3	+.2	-.1	2.0
PUBLIC SECTOR	68.1	+3.3	+7.4	+10.7	78.8
Government insurance	3.0	*	*	*	3.0
Workmen's compensation & TDI	.9	0	0	0	.9
Medicare premiums	2.1	*	*	*	2.1
Federal taxpayers	47.8	+5.2	+7.4	+12.6	60.4
Through third parties:					
Medicare	23.7	*	*	*	23.7
Medicaid contributions	11.0	-11.0	0	-11.0	0
Catastrophic Health Insurance	0	+3.7	+1.8	+5.5	5.5
Federal assistance	0	+12.8	+5.5	+18.3	18.3
Other programs	2.5	-.1	0	-.1	2.4
Federal facilities & direct	10.6	-.2	+.1	-.1	10.5
State and local taxpayers	17.3	-1.9	*	-1.9	15.4
Through third parties:					
Medicaid	8.7	-5.2	*	-5.2	3.5
Contributions to Federal Assistance	0	+6.2	0	+6.2	6.2
Other programs	.4	*	*	*	.4
Direct payments	8.2	-2.9	0	-2.9	5.3

* Less than .05 billion.

for professional and long term care services under the Federal Medical Assistance program. Additional increases are estimated to occur as a result of covering services which become bad debts or are paid out of pocket. The bad debts paid as a result of the new Federal Assistance program are estimated to be $.8 billion. New services resulting from a lower level of cost sharing for those newly covered by assistance programs are estimated at $1.9 billion. Other induced costs resulting from the Federal Assistance program are estimated at $2.5 billion, of which $1.3 billion is for the assumed higher payment level for long term care, and $.5 billion is for the assumed higher payment level for other services currently paid for through Medicaid programs.

6. Effect of Proposal on Spending for Personal Health Services in Fiscal 1980

The detailed effects of the Long-Ribicoff proposal on spending for health services in fiscal 1980 are summarized in Table 4A.4. Overall spending in the private sector is estimated to be reduced by $2.8 billion. Spending out-of-pocket is estimated to be reduced by $3.3 billion, as the liability for payment for $3.0 billion of services paid for directly under present law is assumed by the new programs. Spending for individual policy premiums is estimated to be reduced slightly, by $.4 billion, as some policyholders find the new Catastrophic Health Insurance Program a better buy. Group insurance premiums are estimated to be increased by $1.0 billion, the net of additional purchases of $2.6 billion to provide the required coverage and a decrease of $1.6 billion as some employers find the government program less expensive.

Spending through the public sector is estimated to be increased by $10.7 billion, largely as a result of the new programs. Within the Federal sector, spending is transferred to the new Catastrophic Health Insurance and

Federal Assistance Programs from matching payments to states for the Federal share of the cost of state medical assistance programs. Similarly, states transfer spending from their assistance programs to their share of the Federal programs. The expanded scope of the new programs adds $12.6 billion to total Federal spending. State spending for direct support of medical services is reduced by the new programs by an estimated $2.9 billion, so that total state spending is reduced by $1.9 billion.

The total added cost for the nation is estimated to be $7.9 billion, an increase of 4.4% in spending for personal health services. This increase is estimated to occur as a result of the following factors.

Factor	Amount
Additional services performed	$2.9 billion
Payment of bad debts and unbilled charges	2.1
Full payment for Medicaid services	1.8
Increases in wages of institutional health employees (beyond that financed by windfall increases in revenue)	*
Utilization controls	-.5
Limits on charges by professional providers	-.3
Administration of new insurance	1.1
Additional administrative functions	.7
Reduction in individual insurance expenses	-.2
Maintain Federal facilities	.1
Diversion of philanthropic donations to other health purposes	.2
TOTAL	$7.9 billion

* Less than $.05 billion

7. Net Fiscal impact of proposal on Federal budget

The estimated net fiscal impact of the Long-Ribicoff proposal on the Federal budget is summarized in Table 4A.5. Deductions for out-of-pocket payments, health insurance premiums, and other private spending are estimated to be reduced slightly by the proposal, resulting in an increase in Federal revenues of $.3 billion compared to present law. The new tax credits for Catastrophic Health Insurance, however, are estimated to shift an additional $1.6 billion of the cost of that program to Federal taxpayers[10/] (in addition to the added payroll taxes).[11/] Finally the taxable incomes of employees are estimated to be reduced slightly on balance (after taking into account the effect of the tax credits), so that Federal revenues are decreased by $.1 billion. Altogether, these tax effects result in a decrease in Federal revenues of $1.4 billion compared to present law.

Total spending for personal health services, including tax expenditures, is estimated to be $76.5 billion under the proposal, an increase of $14.0 billion over present law. Thus an additional $14.0 billion in new Federal taxes would be necessary to maintain the same balance of income and outgo in the Federal budget.

10/ The 50% tax credits are more valuable to employers than deductions for payroll taxes, since a large number of employers and self-employed persons pay a marginal tax rate less than 50%. Further, tax credits are payable to nonprofit organizations and local governments, which pay no taxes. Under the general assumptions used to estimate the effect of taxes on Federal revenue, it is assumed that a new payroll tax or health insurance premium paid by an employer results eventually in an equivalent drop in wages or salary — either through lower pay increases or more rapid inflation if employers increase prices to offset the effect of higher payroll taxes. To the extent that the payroll taxes result in lower profits, income taxes would be reduced at a more rapid rate.

11/ The gross payroll tax rate (before credits for the average premium rate in an area for private catastrophic health insurance policies and before income tax credits) is estimated to be 1.2% of payroll in 1980.

TABLE 4A.5 NET FISCAL IMPACT OF LONG-RIBICOFF PROPOSAL ON FEDERAL BUDGET IN FISCAL 1980
(Billions of 1976 Dollars)

	Present Law	Under Proposal	Effect of Proposal
Federal Outlays for Health Services	47.8	60.4	+12.6
Through third parties	37.2	49.9	+12.7
Direct payments	10.6	10.5	-.1
Tax Subsidies for Health Services (by source)	14.7	16.1	+1.4
Out of pocket payments	3.1	2.9	-.2
Premiums paid by individuals	1.3	1.3	*
Employer contributions	9.8	9.9	+.1
Other private spending	.5	.4	-.1
Tax credits for Catastrophic program		1.6	+1.6
Total Budgetary Impact	62.5	76.5	+14.0

*Less than $.05 billion

B. Comprehensive Health Insurance Program (CHIP)[1]

1. Description[2]

The CHIP proposal would establish a three part program including: (1) a private health insurance plan for employees, (2) a state assisted plan for low income and high medical-risk populations, and (3) an improved Federal Medicare program for the aged.

a. Benefits[3]

All three plans would cover the same services. These include services of hospitals (limited for psychiatric diagnoses), skilled nursing facilities (100 days), physicians, laboratories, x-ray's, home health agencies (100 visits), family planning clinics, prescription drugs, medical supplies, and appliances. Also covered for children under age 13 are visual and aural care, well child care, and eyeglasses and hearing aids.

b. Programs

(1) Private Plan for Employees

The employee plan would require employers, including state and local governments, to offer specified coverage to full time employees. The plans would be administered by private health insurers supervised by the states under Federal regulations.

Benefits would be subject to a deductible of $150 per person per year and 25% coinsurance. Prescriptions would be subject to a separate $50 deductible. Total cost sharing would be limited to $1,500 annually per family and $1,050 for individuals. The deductible and maximum cost-sharing

1/ The Comprehensive Health Insurance Program was introduced in the 93rd Congress on behalf of the Administration.

2/ For a detailed description of this proposal, see Saul Waldman, "National Health Insurance Proposals: Provisions of Bills Introduced in the 93rd Congress".

3/ Certain benefits are not defined in the bill, but are left to regulations to be promulgated by the Secretary of Health, Education, and Welfare. For a description of the services assumed to be covered see Appendix A.

amounts would be increased at the rate of the CPI after the initial year. Employers would be required to pay 75% of the premiums.[4/] Temporary Federal subsidies would be provided for employers with increases in payroll costs exceeding 3%. Insurers are required to charge the same rate for all businesses with 50 employees or less.

(2) State Assisted Plans

The state assisted plans would make coverage available to the following groups: (a) individuals and families not covered by an employer plan, (b) low income employees (who would have lower premiums and cost sharing amounts than in the employer plans), and (c) employment groups with high medical risks. Cost sharing would vary with income, with the lowest income groups covered without a deductible and with maximum cost sharing for a family equal to 6% of family income. The highest income group would have the same cost sharing as the employer plans. The plans would be administered by the states under Federal regulations. Private carriers could be contracted to process benefits.

The plans would be financed by premium payments from enrollees which vary by family income. Higher income groups and employers purchasing coverage for all employees would pay a premium rate 50% higher than the average of employer plan premiums. No premiums are required for the lower income groups. The balance of outlays would be paid from Federal and state general revenues. The state shares would vary according to state per capita income and 1975 Medicaid spending and would account for about 25% of the plan's revenues.

(3) Plan for the Aged

The Federal plan for the aged would cover most persons age 65 or over and would be administered by the Federal government in a manner similar to the present Medicare programs.

4/ Employers are required to contribute 65% during the first three years of the program. The cost estimates are based on an employer contribution of 75%.

For the highest income group, benefits would be subject to a deductible of $100 per person per year and 20% coinsurance, but with annual cost sharing limited to $750 per person. Cost sharing is reduced according to income for lower income groups.

The program would be financed primarily by continuation of the present Medicare payroll taxes and by premium payments from the aged. Premiums would be eliminated and cost sharing reduced for the low income aged. Federal and state general revenues would finance the excess of the cost of the program over payroll tax and premium income.

c. Reimbursement

Reimbursement rates would be established by the states according to Federal procedures and criteria. Two classes of professional providers would be established, "fully participating," and "associate participating." Fully participating providers would be paid state-established rates, including the cost sharing, as full payment for their services under all plans. The cost sharing would be collected by the carriers from the patients in monthly payments. Interest charges would be payable on balances that are overdue.
Associate participating providers could charge more than the state rates for patients other than those in the assisted plans or Federal plan for the aged. But they would have to collect the extra charges and cost sharing directly from the patients.

Hospitals and skilled nursing facilities could only be fully participating providers; i.e., they would have to accept the rates set by the states as full compensation for all services.

d. Additional Provisions

(1) States would regulate all providers, including the rates charged and proposed capital expenditures.

(2) Professional Standards Review Organizations (PSRO's) would review all covered services.

(3) The Medicaid program would be limited to certain specified services that are not covered by CHIP.

2. Estimates of Population Covered

Since participation in each of the programs set up by the proposal is voluntary, several choices are open to each family. Insurance may be obtained through the Federal plan for the aged, a private health insurance plan offered by an employer, the state assisted plans, or private insurance policies. In each case, enrollment in an HMO is offered as an alternative to health insurance. In addition, many persons are eligible for coverage through the military service medical programs or for coverage from a previous employer.[5/]

Aged persons are eligible primarily for the Federal plan. They could also purchase coverage privately or go without insurance. Families of active and retired servicemen are eligible for a full range of medical benefits through the military service medical programs, and are unlikely to elect participation in any plan requiring an employee contribution. Families including a Federal employee and a non-Federal employee may elect to join the Federal employee group plan or the other employer's plan.[6/] The choice that such a family will make will probably depend largely on the level of contribution

5/ For example, many retired Federal employees, eligible for continued coverage in the Federal employee health insurance program, work full time for private employers.

6/ An employee who is a member of a family can enroll in an employer plan only for family coverage. There is no such restriction on Federal employees who may enroll as single individuals even though married.

required and the supplemental benefits offered.[7/] Other families with two employees have a similar choice between employer plans. Self-employed and non-employed persons and their families may enroll in the state assisted plans, purchase a private health insurance policy, or remain uninsured.

The choices of coverage assumed to be made by each group in fiscal 1980 are summarized in Table 4B.1. Nearly all persons over age 65, 24.8 million, are assumed to participate in the Federal plan for the aged.[8/] Since no contributions are required, nearly all active and retired military servicemen and their dependents who are eligible would be covered by the military service medical programs. Employees whose income is low enough for automatic enrollment in a state assisted plan without premium payments would not enroll in employer plans. Nearly all active and retired Federal employees and dependents eligible for the Federal employee health insurance programs are assumed to enroll in those plans. The principal exceptions are persons eligible for a military service medical program and those in families of full time employees eligible for a private employer plan with more comprehensive benefits or with lower contributions. Of those employees who must pay a premium to join an assisted plan, only 0.5% are assumed to enroll. Among other employees eligible for an employee plan 97% of single individuals and 98.5% of families are assumed to elect to participate.

Total enrollment in employee health insurance plans in fiscal 1980 (including Federal government plans for civilian and military employees and

7/ For example, the actuarial value of the high option Blue Cross and Blue Shield benefits in the Federal employee health insurance program is approximately 35% higher than that of the employer plan. The amount of the contribution payable, however, may be higher or lower depending on the average cost for Federal employees relative to other employees and the proportion paid for by the Federal government.

8/ Failure to pay the premium required by the Federal health insurance plan does not necessarily result in loss of coverage under the program. Those persons who would be eligible for the hospital insurance program under present law would continue to be eligible for the same benefits.

TABLE 4B.1 HEALTH INSURANCE COVERAGE OF POPULATION IN 1980 UNDER CHIP
(Thousands)

	Enrolled As:		Population:			
	Singles	Families	Aged	Adults	Children 1/	Persons
TOTAL	59,170	52,020	25,000	131,000	75,000	231,000
Federal Health Insurance Plan for the Aged	24,800	0	24,800	0	0	24,800
Employee Health Insurance Plans	19,760	41,220	0	100,000	56,970	156,970
Military servicemen and dependents 2/	1,300	1,800	0	4,770	2,330	7,100
Federal employees and dependents 3/	870	1,980	0	4,680	2,330	7,010
State and local government employees and dependents	2,550	5,480	0	13,210	7,650	20,860
Private employees and dependents 4/	15,040	31,960	0	77,340	44,660	122,000
State Assisted Health Insurance Plans	11,800	7,830	0	22,990	14,100	37,090
Low income employees and dependents	1,530	1,050	0	3,150	1,520	4,670
Other enrollees	10,270	6,780	0	19,840	12,580	32,420
Private Health Insurance Plans	1,070	1,900	0	4,590	2,750	7,340
Not Insured 5/	1,740	1,070	200	3,420	1,180	4,800
Employees and dependents	490	470	0	1,310	520	1,830
Others	1,250	600	200	2,110	660	2,970

1/ Includes dependent, unmarried children under age 19 and through age 25 if in school.
2/ Includes retired servicemen, widows, and dependents eligible for CHAMPUS and care in service facilities.
3/ Includes retired Federal employees and dependents under age 65 enrolled in one of the Federal employee health insurance programs.
4/ Includes employees of employers who purchase all group insurance from the state assisted plans.
5/ Uninsured persons are those with incomes over $5,000 for families and $3,500 for singles who elect not to join a plan for which they are eligible.

their families) is estimated to be 100.0 million adults and 57.0 million children. An additional 3.2 million adults and 1.5 million children who are eligible for employee plans are assumed to be enrolled in state assisted plans. Together these comprise over 99% of persons eligible for an employer plan.

Among persons not eligible for an employee plan, the choice of type of coverage is assumed to depend on the relative size of the premium rates for the state assisted plan and private policies. It is expected that private insurers would offer policies at rates ranging from 10% to 25% below the premium rate for the assisted plan. Underwriting techniques would be used to obtain an average selection of risks that can be profitably underwritten at such rates. In general, younger persons, persons in above average health, and self-employed professionals eligible for an association group policy could find coverage available at rates lower than that of the state assisted plans. It is estimated that 4.6 million adults and 2.8 million children will be in the families electing private coverage. Most of the remainder are assumed to be enrolled in a state assisted program. Total coverage under state assisted plans is estimated to be 23.4 million adults and 14.1 million children.

The relatively few persons not assumed to elect some form of health insurance coverage include 3.4 million adults and 1.2 million children.

3. Program Spending Under CHIP

Spending in fiscal 1980 for the three major new programs set up by CHIP summarized in Table 4B.2. The cost of the benefits that employers are required to offer to employees is estimated to be $38.2 billion, $7.4 billion being paid by employees and $30.8 billion paid by employers.[9/] Of the total,

9/ Group insurance premiums are estimated to be substantially higher than required due to premiums for supplemental insurance to pay part of the cost sharing and to pay for other services.

TABLE 4B.2 PROGRAM EXPENDITURES UNDER CHIP IN FISCAL 1980 (Millions of Fiscal 1976 Dollars)

A. Private Employee Plans	
Income:	
Employee contributions	$ 7,400
Employer contributions	30,800
Total	$38,200
Disbursements:	
Benefits 1/	$31,000
Administration	4,500
Premiums paid to State Assisted Plans 2/	2,700
Total	$38,200
B. Federal Program for the Aged	
Income:	
Premiums	$ 1,000
Payroll taxes	18,000
General revenue contributions	10,000
Total	$29,000
Disbursements:	
Benefits 1/	$26,700
Administration	2,300
Total	$29,000
C. State Assisted Programs	
Income:	
Premium collections:	
Employers	$ 2,300
Employees	400
Direct enrollees	4,800
Federal government contributions	11,200
State government contributions	3,300
Total	$22,000
Disbursements:	
Benefits 1/	$19,400
Administration	2,600
Total	$22,000

1/ Includes uncollected amounts due under health credit card billings.
2/ Includes premiums paid by employers for low income employees electing coverage in an assisted plan and premiums paid by high cost groups.

$2.7 billion would be paid to state assisted plans. Employer plans would pay $31.0 billion for medical benefits and $4.5 billion for administrative expenses.

Spending under the Federal program for the aged is estimated at $29.0 billion in fiscal 1980, of which $26.7 billion are for benefits and $2.3 billion for administrative expenses. The program funding is estimated to be derived from $21.0 billion in payroll taxes, $1.0 billion of premiums, and $7.0 billion from general revenue contributions.

Total outlays through state assisted programs are estimated as $22.0 billion, of which $19.4 billion are for benefits and $2.6 billion for administrative expenses. The state program income is estimated to be derived from $2.3 billion of premiums collected from employers, $.4 billion of premiums collected from employees, $4.8 billion of premiums collected from other enrollees, state contributions of $3.3 billion, and Federal contributions of $11.2 billion.

4. Effect of Mandatory Coverage of Employees

The effects of requiring employers to offer standard benefits to employees, of the coverage of low income employees under state assisted plans, and of the option of employers to purchase their entire coverage from the state assisted plans are estimated as follows (billions of fiscal 1976 dollars):

	Mandated Coverage	Employee Option	Employer Option	Net Effect
Effect on Private Sector	+10.0	-1.2	-2.0	+6.8
Employee contributions	+1.0	-.3	-.4	+.3
Employer contributions	+9.0	-.9	-1.6	+6.5
Effect on Public Sector	0	+1.6	+2.0	+3.6
Premium payments to state assisted plans:				
by employees	0	*	+.4	+.4
by employers	0	+.9	+1.4	+2.3
Federal and state contributions	0	+.7	+.2	+.9

*Less than $50 million

Requiring employers to offer the employer plan benefits to employees is estimated to increase group health insurance premiums by $10.0 billion, of which $9.0 billion would be provided by employers and $1.0 billion by employees. The relatively larger increase of employer contributions is attributable to the requirements that employers pay at least 75% of premiums for employer plans.

The automatic coverage of all low income employees and families under state assisted plans with lower cost sharing and no premiums is estimated to result in a shift of $1.2 billion of premiums from employer plans to state assisted plans.[10/] Since no contribution is required from low income employees in the state assisted plans, employee contributions are virtually eliminated. This cost, $.3 billion, is picked up by Federal taxpayers as part of the Federal contribution to assisted plans. Federal taxpayers also absorb the cost of the lower cost sharing available to low income employees. This adds another $.4 billion to the Federal contribution, bringing the total Federal contribution to $.7 billion for these employees.

Employers with $2.0 billion of premiums for their employer plans are assumed to elect coverage in a state assisted plan. Such employers are assumed to require contributions from employees of $.4 billion. The rates paid to state assisted plans are assumed to be $.2 billion less than these employers would have had to pay to obtain private underwriting. The other $.2 billion would be met through the Federal and state contributions to the assisted plans.

The net effect is to increase private premiums for health insurance by $6.8 billion and to increase the public sector spending for employees by $3.6 billion. Of the total increase of $10.4 billion, employers would pay $8.8 billion, employees $.7 billion, and taxpayers $0.9 billion.

10/ This sum also includes those employees who pay a premium for assisted plan coverage.

TABLE 4B.3 AVERAGE PREMIUM RATES IN FISCAL 1980 UNDER EMPLOYEE PLANS 1/
(Fiscal 1976 Dollars)

	Single Employees	Employee & Family	Average Premium	Average Per Employee 2/
Institutional services	$152	$379	$303	$203
Ambulatory and professional services	117	293	234	157
Prescriptions and supplies	25	62	49	33
Administration	42	106	85	57
Total	$336	$840	$671	$450

1/ Includes premiums required for Employee Plan benefits for employees electing coverage in an Assisted Plan.

2/ Total premiums divided by the number of full time employees. Includes effects of employees who do not enroll, who are eligible for medical services as retired military personnel and dependents, or who are the spouse of an employee enrolled for family coverage.

The estimated average premium rates that would be paid in fiscal 1980 for the employee plans, and the average cost to employers for this coverage are shown in Table 4B.3. The average rate charged for a single employee is estimated to be $336 per year and the average rate charged for an employee with a family would be $840 annually. The average premium payment collected would be $671. The average cost of the insurance per full time employee would be somewhat less than this, $450 per year, since a number of families have two employees and since not all employees enroll in the employer plans. On the average, employers are required to pay at least $337 per employee (75% of $450) and are estimated to actually pay $474 per full time employee, when the cost of supplemental coverage is included.[11/]

5. Effect of Proposal on Spending for Personal Health Services

The effect of the proposal on spending for personal health services in fiscal 1980 is summarized in Table 4B.4. Direct spending out-of-pocket is estimated to decrease by $7.7 billion as a result of CHIP. Spending for individual policies is estimated to be reduced by $3.3 billion as employees not presently covered by an employer plan drop such policies and other persons enroll in state assisted plans at a more favorable rate. Employee contributions for private group insurance are estimated to be increased by $0.3 billion to $11.3 billion under the proposal and employer contributions are estimated to be increased by $6.5 billion to $38.5 billion.[12/] Total spending in the private sector is estimated to be reduced by $4.5 billion to $107.6 billion, or 57% of personal health services.

11/ An important element of these calculations is the prohibition of coverage under more than one policy. Under a coordination of benefits provision, the cost per employee would be substantially higher.

12/ These amounts do not include $2.7 billion of employer and employee contributions which are paid for coverage under state assisted plans.

TABLE 4B.4 EFFECT OF CHIP ON SPENDING FOR PERSONAL HEALTH SERVICES IN FISCAL 1980
(Billions of Fiscal 1976 Dollars)

	Present Law	Increase in Expenditures			Under Proposal
		Transferred	Induced	Total	
TOTAL U.S.	180.2	0	+9.1	+9.1	189.3
PRIVATE SECTOR	112.1	-8.1	+3.6	-4.5	107.6
Out-of-pocket	56.5	-7.6	-.1	-7.7	48.8
Through insurance:					
Individual policies	7.7	-3.2	-.1	-3.3	4.4
Employee contributions	11.0	-.2	+.5	+.3	11.3
Employer contributions	32.0	+3.5	+3.0	+6.5	38.5
Workmen's compensation & TDI	2.8	0	-.1	-.1	2.7
Other private	2.1	-.6	+.4	-.2	1.9
PUBLIC SECTOR	68.1	+8.1	+5,5	+13.6	81.7
Government insurance	3.0	+6.1	+.3	+6.4	9.4
Premiums for State Assisted Plans	0	+7.2	+.3	+7.5	7.5
Premiums for Federal Plan for Aged	0	+1.0	0	+1.0	1.0
Workmen's compensation & TDI	.9	0	0	0	.9
Medicare premiums	2.1	-2.1	0	-2.1	0
Federal taxpayers	47.8	+2.8	+4.8	+7.6	55.4
Through third parties:					
Federal contribution to State Assisted Plans		+8.0	+3.2	+11.2	11.2
Federal Health Plan for Aged		+26.8	+1.2	+28.0	28.0
Medicare	23.7	-23.7	0	-23.7	0
Medicaid	11.0	-5.4	*	-5.4	5.6
Other programs	2.5	-.3	*	-.3	2.2
Federal facilities and direct	10.6	-2.6	+.4	-2.2	8.4
State and local taxpayers	17.3	-.8	+.4	-.4	16.9
Through third parties:					
State Assisted Plans		+3.0	+.3	+3.3	3.3
Medicaid	8.7	-2.9	+.1	-2.8	5.9
Other programs	.4	-.1	*	-.1	.3
Direct payments	8.2	-.8	*	-.8	7.4

The $7.0 billion in premiums estimated to be collected by state assisted plans produces a large increase, $6.4 billion, in premiums for government sponsored insurance, raising the total from $3.0 billion to $9.4 billion. Medicare premiums are eliminated, being replaced by premiums for the Federal plan for the aged and the state assisted plan for disabled Medicare beneficiaries.

Spending supported by Federal taxpayers is estimated to be increased by $7.6 billion to $55.4 billion, largely as a result of the Federal contribution to the state assisted plans and additional spending for the aged. Federal spending for other programs is estimated to be reduced as the financing of such services is transferred to one of the new programs. The Medicaid program is estimated to be reduced approximately in half, by $5.4 billion to $5.6 billion and other indirect programs are estimated to be reduced by $.3 billion. Appropriations for care in Federal facilities are estimated to be reduced by $2.2 billion.[13/]

Spending supported by state and local taxpayers is estimated to be reduced by $.4 billion to $16.9 billion as a result of the proposal. Approximately $3.0 billion of spending is transferred from State Medicaid and other third party programs to contributions to the new assisted plans. Direct payments by state and local governments for care in institutions are estimated to be reduced by $.8 billion, largely as a result of payment through one of the new programs for state and local psychiatric hospital services for which charges are presently not collected.

13/ Spending for care in these facilities is estimated to be reduced by only $.4 billion. Federal facilities are eligible for payment under the programs set up by CHIP.

Total spending in the nation is estimated to be increased by $9.1 billion. This increase is attributable to the following factors:

Additional services performed	$4.8 billion
Payment of bad debts and unbilled charges	3.6
Full payment for Medicaid services	1.0
Full payment for Medicare services	.6
Increase in wages of institutional health employees (beyond that financed by windfall increases in revenue)	*
Utilization controls	-.8
Limits on increases in institutional spending	-2.7
Recovery of windfall increases in institutional spending	-.9
Limits on charges by professional providers	-1.0
Administration of new insurance	2.2
Additional administrative functions	3.0
Increase in planning, regulation, and evaluation	.1
Reduction in individual insurance expenses	-1.2
Reduced administration due to mandatory coverage and standardized policies	-.4
Maintain Federal facilities	.4
Diversion of philanthropic donations to other health purposes	.4
Total	$9.1 billion

Additional services performed as a result of the new insurance provided and payment for services that would have been uncollectable without national health insurance are estimated to increase spending for personal health services by $8.4 billion. Full payment for Medicaid and Medicare

services is estimated to add another $1.6 billion, bringing new payments to providers to $10.0 billion. Reductions in rates of payment to providers, mandatory assignments for the aged and enrollees in the assisted plans, and pre-admission certification and utilization review by PSRO's are estimated to reduce payments to providers by $5.4 billion, so that the net increase in payments to providers is estimated at $4.6 billion.

This relatively low increase in payments to providers results primarily from the assumed effectiveness of controls on rates of payment to hospitals. Controls are assumed to lower the increase in hospital costs by 2½% per year after 1978 and to recover a substantial portion of the windfall increases in hospital revenues that occur as a result of the payment of bad debts and full payment to all providers. If the proposal is not implemented in a way that these savings will in fact be realized, the additional spending in fiscal 1980 resulting from the proposal would be up to $3.6 billion higher.[14/]

The relatively large increases in third-party payments and administrative expenses are attributable primarily as a result of the processing of claims data for all covered services, billing and collections under the health credit card system, and the need to determine family income in order to calculate the cost sharing applicable to persons enrolled in the state assisted plans and Federal plan for the aged. The requirement of standardized policies and establishment of pools for employers with 50 or fewer employees is assumed to increase price competition among insurers and to reduce sales costs, since all employers must buy insurance.

14/ On the other hand, it has been assumed that only half of the potential reductions in hospitals and institutional spending obtainable through such controls will in fact be obtained. More effective implementation could reduce the cost of the proposal by up to $3.6 billion more than estimated.

The CHIP proposal results in net spending after taxes for personal health services of approximately equal amounts in the private and public sectors. Under the proposal approximately 24% of personal health services would continue to be paid for out-of-pocket, approximately 25% would be paid for by employers and employees through group insurance, another 4% would be paid for through premiums for government sponsored insurance. Federal taxpayers would pay for 36% of personal health services and state and local taxpayers would pay for 9%. Approximately 1% would also be paid through private philanthropy and employer health services.

6. Net fiscal impact of proposal on Federal budget

The estimated net fiscal impact of CHIP on the Federal budget is summarized in Table 4B.5. Deductions and exemptions for personal health services are estimated to reduce Federal tax income by $16.4 billion under the proposal, compared to $14.7 billion under present law. Thus in addition to the need to finance a net increase of $7.6 billion in Federal outlays, another $1.7 billion of new revenues would be needed to offset the reduction in income. A total of $9.3 billion of new Federal taxes would thus be required to maintain the same balance of income and outlays in the Federal budget.

TABLE 4B.5 NET FISCAL IMPACT OF CHIP PROPOSAL ON FEDERAL BUDGET IN FISCAL 1980
(Billions of 1976 Dollars)

	Present Law	Under Proposal	Effect of Proposal
Federal Outlays for Health Services	47.8	55.4	+7.6
Through third parties	37.2	47.0	+9.8
Direct payments	10.6	8.4	-2.2
Tax Subsidies for Health Services (by source)	14.7	16.4	+1.7
Out of pocket payments	3.1	2.6	-.5
Premiums paid by individuals	1.3	1.7	+.4
Employer contributions	9.8	11.7	+1.9
Other private spending	.5	.4	-.1
Total Budgetary Impact	62.5	71.8	+9.3

C. Health Insurance Association of America Proposal[1/]

1. Description[2/]

The proposal would establish a three-part program including: (1) a voluntary private health insurance plan for employees, (2) a private plan for individuals and (3) a state plan for the poor and uninsurable.

a. Benefits and cost sharing required of qualified plans[3/]

(1) Services

Each of the three programs would provide the following health insurance benefits for services necessary to diagnose or treat an injury, illness, or pregnancy and the preventive care specified.

- Inpatient hospital services (including private psychiatric)
- Post hospital skilled nursing facility services (180 days)
- Physicians' services
- Outpatient hospital and independent clinic services
- Laboratory and x-ray services
- Home health agency services (270 visits in a year)
- Outpatient mental health services (20 visits in a year)
- Well baby care (under age 5)
- Dental services for children (annual exam under age 13)
- Vision care services for children (annual exam under age 13)
- Family planning services
- Pap smear tests
- Prescription drugs
- Prosthetic devices
- Medical equipment and supplies

(2) Standard cost sharing

Except for low income persons, there would be an annual deductible of $100 per person and 20% coinsurance, with cost sharing for a family limited to $1,000 in a year. The deductible and maximum cost sharing

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1/ The H.I.A.A. proposal was introduced in the 94th Congress by Representative Burleson and Senator McIntyre.

2/ For a detailed description of this proposal, see Saul Waldman, "National Health Insurance Proposals: Provisions of Bills Introduced in the 94th Congress."

3/ The following describes the benefits that would be available during the first 7 years of the program, which were used as a basis of the cost estimates.

would be increased over time with inflation. Benefit payments could be reduced if payments from all policies covering a patient exceeded his covered medical expenses.

(3) Composition of a family

A family would consist of a head and either a spouse and/or dependent unmarried children who are either under age 19, full time students under age 25, and/or continuously disabled since reaching age 19.

b. Programs

(1) Employee plan

Employers must provide a qualified plan to all full time employees or lose all tax deductions for health insurance premiums.[4/] In addition to full time employees, employers must cover (a) disabled employees for 30 months (i.e., until eligible for Medicare), (b) employees laid off for 2 months, and (c) surviving families of employees dying in service for 2 months. The insurance would be purchased from private health insurance carriers, which are supervised by state and Federal governments. Specific regulatory requirements for qualified health insurance carriers are specified in the bill. Employers must allow all employees to join an HMO. Aged employees and aged spouses of employees are eligible for the excess of benefits in the qualified plan over those payable under Medicare.

Employees may be required to contribute up to a maximum that depends on monthly wages, as follows (applicable to fiscal 1978):

Individual	10% wages - $167
Family with one dependent	10% wages - $250
Family with two dependents	10% wages - $333

4/ All premiums paid for qualified insurance by individuals would be fully deductible under the proposal, however, so that discontinuing a plan, or requiring employees to pay the entire cost could be accomplished without sacrificing all of the present tax advantages of employer funded health insurance, other than avoiding social security taxes.

These amounts would be increased after the initial year at the rate of increase in the C.P.I. All employee contributions are fully deductible under the proposal.

(2) Individual plans and state individual plan pools

(a) Private policies

An individually underwritten policy which includes at least the qualified benefits and does not exceed the allowed cost sharing can be approved by state regulatory agencies as a qualified individual plan. Premiums for such plans are deductible in full on income tax returns.[5/] Rates and risk selection policies would be set through competition among insurers, as is the case under present law. Policies would be non-cancellable (unless all qualified policies were cancelled) and rates could be raised only on the entire class of policies.[6/]

(b) State individual plan pools

Each state is directed to organize a pool to provide coverage to all persons who cannot obtain a private qualified policy without restrictions at a reasonable cost (and who are not eligible for an employee plan or the state plan for the poor and uninsurable). Employers with less than 50 employees could also purchase their coverage from the pool. Expenses related to conditions diagnosed or treated within 6 months of application for coverage would be excluded from covered services. Pool deficits would be financed by assessments to health insurers in proportion to their total health

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5/ The deductibility of the full premium (rather than 50% premiums to a maximum of $150) is the only feature that could not be offered by insurers under present law.

6/ These provisions are incorporated already into the laws of most states. There are no restrictions as to pre-existing conditions, waiting periods, etc.

insurance premiums in the state.[7/]

(3) State plan for poor and uninsurable

All persons not eligible for a qualified employee plan may enroll in a state plan for the poor and uninsurable. The cost of the coverage for low income persons is subsidized by contributions from the Federal and state governments.

The persons eligible for coverage are as follows:

(a) Persons eligible for cash assistance supported by Federal funds (i.e., SSI and AFDC).

Eligibility would continue for 3 months after eligibility for cash assistance ended.

(b) Low income persons

Income limits, premium rates required, and applicable cost sharing eligibility as low income persons or families are as follows:

	Single	Family of 2	Family of 3 or More
Eligible if annual income[8/] less than:	\$5,000[9/]	\$7,500[9/]	\$10,000[9/]
Premium rate:	10% (Income -\$2000)	10% (Income -\$3000)	10% (Income -\$4000)
Annual deductible/person	2% (Income -\$500)[10/]	1½% (Income -\$750)[10/]	1% (Income -\$1000)[10/]
Annual cost-sharing maximum/family	20% (Income -\$500)[11/]	15% (Income -\$750)[11/]	10% (Income -\$1000)[11/]

7/ The pool could be organized as (a) a pool which issues policies to enrollees or (2) an assigned risk program, under which persons desiring coverage would obtain policies from a qualified insurer, who would administer the policy but share gains and losses on pool policies with other insurers.
8/ All income amounts refer to previous calendar year.
9/ Increased at the rate of increase of the C.P.I. after initial year.
10/ Rounded up to multiple of \$10
11/ Rounded up to multiple of \$100

Eligibility would continue until the end of the year in which enrolled regardless of income.12/

Persons may also enroll as low income persons if their income during the last two months is at an annual rate less than that required for eligibility on the basis of income in the prior year. Eligibility terminates at the end of the month following that in which a family becomes ineligible due to higher income.

(c) Special groups

The Federal or state government could purchase the entire coverage for any group (e.g., inmates of institutions, dependents of servicemen), and pay the entire premium.

(d) Aged persons

Persons over age 65 who are enrolled in Part B of Medicare may enroll and pay the balance of the premium that would be applicable over the Part B premium. If the applicable premium is less than that for Part B, the plan will pay for the excess as a benefit.

The state plan is funded through the applicable premium rates, and contributions from Federal and state governments.

c. Reimbursement

(1) Institutions

The proposal specifies detailed procedures through which states would exercise primary responsibility for controlling institutional costs. The state is required to designate a state agency to set reimbursement rates for each

12/ The bill permits a policy year different from a calendar year. Coverage continues to the end of the policy year.

institution that would be paid by or on behalf of all patients. In setting rates for each institution, the agency would take into consideration economic factors in the area, the cost of similar services in other institutions, the capital requirements of the institution, and the need for incentives to improve services.

The rates set for any class of institution would be reviewed by by H.E.W. If not approved, the Federal payment toward the cost of the state plan for the poor and uninsurable could be reduced to the level that would have been required had the rate for such institution been set at a level that H.E.W. would approve.

(2) Professional providers

Payment to professional providers is based on customary and prevailing charges as determined under the Social Security Act, i.e., limited to the lower of (a) the modal charge of the provider for the service during the base period, the calendar year preceding the beginning of the policy year, and (b) the 75th percentile of prevailing fees for such services among all physicians in the area during the base period.

(3) Prescriptions and medical supplies

Payments for prescriptions and medical equipment and supplies would be based on actual charges. Payments for equipment would be limited to the lower of purchase price or rental fees.

d. Additional provisions

(1) Primary responsibility for the regulation of all health insurance programs lies with state insurance departments and the state cost commission.

(2) As a condition for Federal funds to support state plans for the poor and uninsurable, states would have to levy equal taxes on all health insurers.[13/]

(3) Benefits would not be paid for services if the same benefits are payable under a no fault provision of a liability insurance policy.

(4) No damages for malpractice would be awarded to cover the cost of furnishing medical services that are paid for through the program.

(5) The proposal makes extensive provision for the improvement of resources for delivering health care (especially facilities for ambulatory patients), health planning, and health manpower.

(6) The bill provides financial assistance to develop a new type of provider, modeled on free standing hospital outpatient departments. These "comprehensive ambulatory health care centers" must provide services similar to those available in the outpatient departments of hospitals and provide for medical records, peer review, and transfer to a general hospital under unified supervision of hospital personnel.

2. Estimated health insurance coverage of population under proposal

The estimated health insurance coverage of the population in fiscal 1980 under the H.I.A.A. proposal is summarized in Table 4C.1. Approximately 57.5% of the population, including some 84.6 million adults and 48.2 million children, are estimated to be covered through health insurance plans provided by employers. Approximately 13% of the population, including 19.1 million adults and 10.5 million children, are covered under other privately administered

13/ This would require the states to tax Blue Cross and Blue Shield plans at the same rates as other insurers.

TABLE 4C.1 HEALTH INSURANCE COVERAGE OF POPULATION IN 1980 UNDER THE HEALTH INSURANCE ASSOCIATION OF AMERICA PROPOSAL
(Thousands)

	Enrolled As:		Population:			
	Singles	Families	Aged	Adults	Children 1/	Persons
TOTAL	54,160	55,020	25,000	131,000	75,000	231,000
Medicare	19,370	3,700	24,750	2,100	*	26,850
Employer Health Insurance Plans	17,160	35,170	150	84,470	48,240	132,860
Military servicemen and dependents 2/	1,300	1,800	0	4,770	2,330	7,100
Federal employees and dependents 3/	960	2,010	150	4,680	2,320	7,150
State and local government employees and dependents	2,810	5,670	0	13,200	7,630	20,830
Private employees and dependents	12,090	25,690	0	61,820	35,960	97,780
State Plan for the Poor and Uninsurable	9,860	7,230	100	20,610	14,630	35,340
Aged persons 4/	60	20	100	0	0	100
Employees and dependents	1,820	2,340	0	5,680	3,600	9,280
Other enrollees	7,980	4,870	0	14,930	11,030	25,960
State Individual Plan Pools	2,590	4,210	0	10,050	5,730	15,780
Employees and dependents	1,180	2,800	0	6,550	3,760	10,310
Others	1,410	1,410	0	3,500	1,970	5,470
Private Health Insurance Plans	2,630	3,420	*	9,000	4,740	13,740
Employees and dependents	820	1,960	0	4,600	2,640	7,240
Others	1,810	1,460	*	4,400	2,100	6,500
Not Insured 5/	2,550	1,290	*	4,770	1,660	6,430
Employees and dependents	1,330	850	0	2,970	1,050	4,020
Others	1,220	440	*	1,800	610	2,410

1/ Includes dependent, unmarried children under age 19 and through age 25 if in school.
2/ Includes retired servicemen, widows, and dependents eligible for CHAMPUS and care in service facilities.
3/ Includes retired Federal employees and dependents under age 65 enrolled in one of the Federal employee health insurance programs.
4/ Includes only those who rely on State Plan for basic hospital and medical coverage. A large proportion of aged persons are assumed to enroll in the State Plan for supplemental benefits.
5/ Uninsured persons are those who elect not to join a plan for which they are eligible.

insurance policies--either purchased directly from an insurance company or from the state sponsored pools. Nearly all of this insurance is through qualified policies.

Approximately 27% of the population, including nearly all aged persons, 22.7 million other adults, and 14.6 million children, are covered by Medicare and the new state plans for the poor and uninsurable. Primary coverage of medical services for the aged and disabled persons eligible for Social Security disability benefits for more than two years continues to be furnished through the Medicare program under the proposal. In addition, a large proportion of those covered by Medicare are assumed to enroll in the state plans in order to obtain supplemental benefits, and for low income beneficiaries, payment of the Part B premium.

Since employers are not required to offer qualified plans to employees, a substantial number of employees and their dependents are estimated to obtain coverage through private policies, the state pools, or the state plans. It is assumed in the estimates that all state and local governments and employers with 83.5% of private employees do offer qualified benefits to employees.[14/] Among those employees and their dependents who are not eligible for an employer plan, 11.2 million adults and 6.4 million children are estimated to obtain private policies and another 5.7 million adults and 3.6 million children are

14/ The offering of qualified benefits to employees would result in a substantial increase in premiums for the employers of over a third of full time employees. Allowing the entire employee contribution or premium to be included in itemized deductions substantially reduces the advantage of employer-funded health insurance to the higher paid managerial and entrepreneurial employees who would make the decisions for most firms. Further, employers with a high concentration of employees who would be eligible for the state plan for the poor and uninsurable could avoid funding the cost for these employees by converting their present coverage to a qualified association group plan (owned by an employee association). These factors lead to the estimated drop in health insurance coverage of private employees from an estimated 86.5% under present law to an estimated 83.5% under the proposal.

estimated to be eligible for and enroll in the state plans for the poor and uninsurable.

Approximately 2.8% of the population, including 4.8 million adults and 1.7 million children, are estimated not to be covered by any health insurance program providing basic hospital and medical benefits. Some of these persons rely on other government programs, such as the Veterans Administration hospitals and clinics, the Public Health Service hospitals and clinics, and the Indian Health programs.

3. Program spending under the H.I.A.A. proposal

The estimated spending in fiscal 1980 under each of the three major new programs set up by the proposal is outlined in Table 4C.2. Income and disbursements under the employee plans are estimated at $38.5 billion. This sum includes an estimated $34.5 billion in benefit payments, $3.5 billion in administrative costs and premium taxes, and $.5 billion in assessments by state pools. Income to the plans is estimated to be derived from approximately $29.0 billion in employer contributions and $9.5 billion in employee contributions.

Income and outlays under the state plans for the poor and uninsurable are estimated at $21.0 billion. Benefit payments are estimated at $18.0 billion and administrative costs at $3.0 billion.[15/] Income to the programs is estimated to be derived from $2.5 billion of enrollee premiums, a Federal contribution of $14.0 billion and a state contribution of $4.5 billion.

15/ A large part of the administration costs is estimated to be required to obtain and maintain income data concerning all enrollees. The exact income of each eligible enrollee is required to determine the premium rate payable to the state plans for the poor and uninsurable. A substantial portion of persons who will be required to pay premiums would not otherwise be required to file tax returns. Further, data on all persons would have to be obtained and stored in a format suitable for query operations.

TABLE 4C.2 PROGRAM EXPENDITURES UNDER H.I.A.A. PROPOSAL IN FISCAL 1980
(Millions of Fiscal 1976 Dollars)

A. Employee Plans	
Income:	
Employee contributions	$ 9,450
Employer contributions	29,000
Total	$38,450
Disbursements:	
Benefits	$34,500
Administration	3,500
Assessments by state pools	450
Total	$38,450
B. State Plan for Poor and Uninsurable	
Income:	
Premiums	$ 2,500
Federal contributions	14,000
State contributions	4,500
Total	$21,000
Disbursements:	
Benefits	$18,000
Administration	3,000
Total	$21,000
C. State Individual Plan Pools	
Income:	
Premiums	$ 6,500
Assessments to insurers	500
Total	$ 7,000
Disbursements:	
Benefits	$ 6,300
Administration	700
Total	$ 7,000

Income and outlays of the state individual plan pools are estimated to be $7.0 billion. Of this $6.3 billion is required to pay benefits and $.7 billion for administrative costs. Income to the pools is estimated to be derived from $6.5 billion of premiums and $.5 billion from assessments to insurers.[16/]

4. Average premium rates for employer plans

The estimated average premium rates for qualified plans offered by employers are summarized in Table 4C.3, broken down by major type of service. The average premium rate charged for single employees is estimated to be $375 and the estimated premium rate for families is estimated to be $975. The average premium rate charged employers is estimated to be $787. The average premium per full time employee of those employers offering employer plans is estimated to be $523. The average cost to employers for this coverage is estimated to be $395.[17/]

5. Effect of proposal on spending for personal health services

The effect of the proposal on spending for personal health services is summarized in Table 4C.4. Spending in the private sector is estimated

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16/ Such assessments for assigned risk policies or open enrollment pools that are made to all insurers on the basis of total premiums are in effect premium taxes used for a particular social purpose, i.e., subsidizing health insurance for persons who would otherwise be uninsurable, be able to obtain only limited insurance or with restrictions on conditions insured, or who would have to pay a very high rate. Note that of the $500 million in assessments estimated to be required for the state individual plan pools to maintain a rate approximately 25% higher than the average rates in group insurance, $450 million is estimated to be paid by insurers providing the employee plans. The other $50 million would be derived from private individual policies and association group policies.

17/ All of these amounts include the assessments made by state individual plan pools on the basis of total health insurance premiums.

TABLE 4C.3 AVERAGE PREMIUM RATES IN FISCAL 1980 UNDER EMPLOYEE PLANS
(Fiscal 1976 Dollars)

	Single Employees	Employee & Family	Average Premium	Average Per Employee[1/]
Institutional services	$157	$405	$327	$218
Ambulatory and professional services	146	382	308	205
Prescriptions and supplies	34	88	71	47
Administration	34	88	71	47
Assessments by state individual plan pools	4	12	10	6
Total	$375	$975	$787	$523

1/ Total premiums divided by the number of full time employees. Includes effects of employees who do not enroll and who are eligible for medical services as retired military personnel and dependents.

TABLE 4C.4 EFFECT OF THE H.I.A.A. PROPOSAL ON SPENDING FOR PERSONAL HEALTH SERVICES IN FISCAL 1980
(Billions of Fiscal 1976 Dollars)

	Present Law	Increase in Expenditures			Under Proposal
		Transferred	Induced	Total	
TOTAL U.S.	180.2	0	+8.9	+8.9	189.1
PRIVATE SECTOR	112.1	-8.1	+2.1	-6.0	106.1
Out-of-pocket	56.5	-9.8	*	-9.8	46.7
Through insurance:					
Individual policies	7.7	-2.0	-.2	-2.2	5.5
Employee contributions	11.0	+1.5	+.7	+2.2	13.2
Employer contributions	32.0	+2.7	+1.3	+4.0	36.0
Workmen's compensation & TDI	2.8	0	-.1	-.1	2.7
Other private	2.1	-.5	+.4	-.1	2.0
PUBLIC SECTOR	68.1	+8.1	+6.8	+14.9	83.0
Government insurance premiums	3.0	+7.0	+2.0	+9.0	12.0
State plans for poor and uninsurable		+2.5	*	+2.5	2.5
State individual plan pools		+4.5	+2.0	+6.5	6.5
Workmen's compensation & TDI	.9	0	*	*	.9
Medicare	2.1	*	*	*	2.1
Federal taxpayers	47.8	+2.8	+3.4	+6.2	54.0
Through third parties:					
Federal contributions to state plans		+9.9	+4.1	+14.0	14.0
Medicare	23.7	+.1	-1.3	-1.2	22.5
Medicaid	11.0	-5.8	*	-5.8	5.2
Other programs	2.5	-.3	*	-.3	2.2
Federal facilities and direct	10.6	-1.1	+.6	-.5	10.1
State and local taxpayers	17.3	-1.7	+1.4	-.3	17.0
Through third parties:					
State plans for poor and uninsurable		+3.1	+1.4	+4.5	4.5
Medicaid	8.7	-3.0	*	-3.0	5.7
Other programs	.4	-.1	*	-.1	.3
Direct payments	8.2	-1.7	*	-1.7	6.5

to be reduced by $6.0 billion or 5.4% by the proposal despite the substantial increases in private insurance. Direct payments out-of-pocket are estimated to be reduced by $9.8 billion or 17.3% and group insurance is estimated to be increased by $6.2 billion or 14.4%. Spending for individual policies is estimated to be reduced by $2.2 billion or 29%.

Spending through the public sector is estimated to be increased by $14.9 billion or 22%, which would increase the share of total spending for personal health services through the public sector from $68.1 billion, or 38%, to $83.0 billion, or 44%. A substantial part of the increase is in premiums for government-sponsored insurance. This is estimated to be due to an estimated $2.5 billion in premiums for the state plans for the poor and uninsurable and $6.5 billion in premiums for state individual plan pools.

Spending by Federal taxpayers for personal health services is estimated to be increased by $6.2 billion by the proposal.[18/] This increase results from the excess of the Federal contributions to state plans of $14.0 billion over the reductions in the Federal contributions to state Medicaid plans (reduced by $5.8 billion) and other programs (reduced by $.8 billion).

Spending by state and local taxpayers is estimated to be reduced slightly by $.3 billion under the proposal. The state share of the cost of the state plans for the poor and uninsurable is approximately offset by the reduction in state spending through Medicaid and other programs.

18/ This sum excludes additional spending for health resources provided for by the proposal.

Thus the overall effect of the proposal is to increase group insurance premiums paid by employers and employees moderately and to substantially increase Federal and state funding for personal health services for low income persons and persons who would otherwise not be able to obtain qualified programs at reasonable costs. The proposal substantially reduces the proportion of services paid for directly out-of-pocket.

Overall spending to the nation is estimated to be increased by $8.9 billion. This increase is attributable to the following factors:

Additional services performed	$6.1 billion
New services created	.1
Payment of bad debts and unbilled charges	2.8
Full payment for Medicaid services	1.1
Full payment for Medicare services	.6
Utilization controls	-.5
Limits on increases in institutional spending	-4.5
Recovery of windfall increases in institutional spending	-1.2
Administration of new insurance	2.6
Additional administrative functions	1.8
Increase in planning, regulation and evaluation	.1
Reduction in individual insurance expenses	-.6
Reduced administration due to standardized policies	-.4
Maintain Federal facilities	.5
Diversion of philanthropic donations to other purposes	.4
Total	$8.9 billion

Additional services performed as a result of the new insurance provided and the payment for services that would not have been paid for under current law are estimated to increase overall spending by $9.0 billion. Full payment for Medicare and Medicaid services are estimated to increase spending by $1.7 billion. Preadmission certification and utilization review are estimated to reduce such additional services by $.5 billion and limits on rates charged by hospitals and other institutions are estimated to reduce spending by $5.7 billion. Total payments for services are thus estimated to be increased on balance by $4.5 billion.

Spending related to administration and regulation is estimated to be increased by $3.5 billion by the proposal. The diversion of philanthropic donations to other health related purposes and the continued funding of Federal facilities despite reduction in services is estimated to increase spending by $.9 billion.

The H.I.A.A. proposal would have been estimated to be substantially more expensive in the absence of the provisions to reduce the rate of increase in hospital costs and to force hospitals to use windfall increases in revenues to defer future rate increases rather than to improve services and increase wages. On the other hand the cost of the proposal would have been estimated to be somewhat lower if it were not necessary to determine the income of each enrollee in the state plan for the poor and uninsurable.

6. Net fiscal impact of proposal on Federal budget

The net fiscal impact of the H.I.A.A. proposal on the Federal budget for fiscal 1980 is summarized in Table 4C.5. Exemptions from taxation for personal health services are estimated to reduce tax income to the Federal government by $18.8 billion under the proposal, compared to $14.7 billion under present law. A major part of the increase, $2.8 billion, is estimated to occur as a result of the changes in the tax treatment of premiums specified in the proposal. The balance, $1.3 billion, is relatively low compared to the overall increase in insurance estimated to take place under the proposal due to the assumed decrease in the number of employer funded health insurance programs and to the assumed effectiveness of the price controls on hospitals, which reduce to premiums that must be paid for health insurance. The $4.1 billion loss in revenue and the $6.2 billion increase in Federal spending would require $10.3 billion in new Federal taxes to maintain the same balance of income and outlays in the Federal budget.[19/]

19/ These sums do not include the effect of new Federal spending for health resources specified in the proposal.

TABLE 4C.5 NET FISCAL IMPACT OF H.I.A.A. PROPOSAL ON FEDERAL BUDGET IN FISCAL 1980
(Billions of 1976 Dollars)

	Present Law	Under Proposal	Effect of Proposal
Federal Outlays for Health Services	47.8	54.0	+6.2
Through third parties	37.2	43.9	+6.7
Direct payments	10.6	10.1	-.5
Tax Subsidies for Health Services (by source)	14.7	18.8	+4.1
Out of pocket payments	3.1	2.5	-.6
Premium paid by individuals	1.3	4.9	+3.6
Employer contributions	9.8	11.0	+1.2
Other private spending	.5	.4	-.1
Total Budgetary Impact	62.5	72.8	+10.3

D. American Medical Association Proposal[1/]

1. Description[2/]

The American Medical Association proposal would establish a three-part program which (1) would require employers to offer a qualified plan to all full time employees, (2) would provide Federally funded insurance for unemployed persons and families, and (3) would provide tax credits against personal income taxes to offset part or all of the premium cost of premiums for qualified health insurance.

a. Benefits and cost sharing required for qualified plans

(1) Services

These include:

- Inpatient hospital services (including private psychiatric)
- Skilled nursing facility services (100 day limit)
- Physicians' services
- Outpatient hospital and independent clinic services
- Laboratory and x-ray services
- Home health agency services
- Outpatient mental health services (supervised by physicians)
- Preventive care and examinations (when performed or supervised by a physician)
- Dental services for children (under age 18)[3/]
- Emergency dental services for adults
- Ambulance services
- Prosthetic devices
- Medical equipment and supplies
- Family planning services (supervised by physicians)

Preventive and routine services are covered on the same basis as services to diagnose or treat an injury or illness. Benefits for mental illness, alcoholism, and drug abuse would be covered on the same basis as

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1/ The American Medical Association proposal, "Medicredit", was introduced in the 94th Congress by Representative Fulton.

2/ For a detailed description, see Saul Waldman, "National Health Insurance Proposals: Provisions of Bills Introduced in the 94th Congress."

3/ Coverage would be provided in the initial year of the program for children under age 6. This age limit would be increased by one year each year until all children under age 18 were covered. It is assumed in the cost estimates that coverage is available for all children under age 18 in fiscal 1980.

other forms of illness. Only services directly performed, supervised or ordered by physicians are covered.

Persons eligible for Medicare benefits are eligible on the same conditions as other persons but coverage would be limited to services not covered by the Medicare program. Thus services for persons eligible for Medicare are limited to preventive services not necessary to diagnose or treat an injury or illness, emergency dental care, and skilled nursing care not preceded by a hospital stay.

(2) Cost sharing

All qualified plans would pay at least 80% of the reasonable cost or usual and customary charges for the services itemized above. Total annual cost sharing for any family would be limited to 10% of the excess of family income over the following amounts:[4/]

Family size	Family Income
One	$1,500
Two	3,000
Three	3,600
Four	4,200
Five or more	4,800

Cost sharing for higher income persons would be further limited by an overall maximum of $1,500 for an individual and $2,000 for a family.

(3) Composition of a family

A family would consist of a head and either a spouse and/or dependent unmarried children either under age 19 or full time students through age 23.

4/ Families with income less than these amounts would have no cost sharing.

b. Programs

(1) Private plan for employees

Employers are required to provide qualified policies to all full time employees and pay at least 65% of premiums. If the cost to any employer exceeded 3% of total payroll, a Federal subsidy would be payable, based on a proportion of the excess of the cost of insurance over 3% of payroll. The proportions for the first few years are specified in this bill, but the ultimate level would be based on studies to be conducted by H.E.W. as to the effect of the cost of the employer plans on employment.[5/]

The maximum premium rate that can be charged for a qualified plan to an employer with 100 or fewer employees would be 125% of the average premium rate for all employment groups with more than 100 employees in the same state. Further, all carriers would be required to participate in an assigned risk pool if established by the state.

Any employee whose contribution is greater than the premium he would pay if he purchased a private policy less his employer's Federal subsidy would be eligible for a Federal subsidy for the amount of the difference.

(2) Federal program for unemployed

Persons eligible for unemployment insurance would continue to be insured for the benefits provided by the last employer, either as a member of that group or directly by the insurance carrier for that group. The premium would be paid by the Federal government. Coverage is available only if no other family member is eligible for family coverage under an employee plan.

5/ The cost estimates are based on the assumption that the Federal government would pay for 50% of the excess of the cost of employer plans over 3% of payroll.

Workers who have exhausted eligibility for unemployment insurance are eligible to join the program for the non-employed and self-employed. The Federal government would pay the full premium for such coverage until the end of the calendar year in which eligibility for unemployment insurance terminated. Such unemployed persons and their dependents would have no cost sharing.

(3) Plan for non-employed and self-employed

All persons not eligible to join an employee plan (or exhausting unemployment insurance benefits) may purchase a qualified private plan for the non-employed and self-employed. Premiums for such policies are subsidized through tax credits or direct Federal subsidies that vary with an individual or family's income tax liability. All policies would be issued and administered by private insurance carriers.

The maximum premium rate that can be charged by any insurance carrier for a qualified policy is 125% of the average rate for employers with more than 100 employees in the same state. All carriers underwriting employee plans would be required to offer a qualified plan during two 30 day open enrollment periods each year and at all times to persons first becoming eligible.[6/] Qualified plans must be renewable and payment may not be restricted for conditions diagnosed prior to enrollment. Coverage could be offered directly or through a pool formed of several or all insurers in a state. Carriers could also be required to participate in an assigned risk

6/ The bill does not specify whether insurers may or may not underwrite policies (i.e., require evidence of health condition) issued during open enrollments. Since the concept of underwriting appears to be inconsistent with that of open enrollment, it is assumed in the policy assumptions that underwriting is prohibited.

pool, or share the losses of a multi-carrier pool established to provide insurance to risks refused coverage at standard rates.

The amount of tax credit is equal to a percentage of premiums paid for qualified coverage. This percentage ranges from 100% for persons with no income tax liability down to 10% for persons with tax liability of $891 or more. These amounts would be increased at the rate of increase of the C.P.I. after the initial year of the program.

Individuals or families with no income tax liability and unemployed persons enrolled during the calendar year in which their eligibility for unemployment insurance expired would have no cost sharing.[7/]

c. Reimbursement

(1) Rates of payment for hospital services would be determined by a designated state agency, under "acceptable" methods of reimbursement including "appropriate prospective rate determination systems", which would include budget review, negotiated rates, target rates, or formula negotiation.

(2) Professional providers

Payments to professional providers would be made on the basis of "usual and customary" charges.[8/]

7/ The bill does not specify how insurance carriers would set premium rates for benefits that vary with income or whether the maximum premium for a policy with no cost sharing would also be limited to 125% of the average premium rate in the larger employee plans. In the policy assumptions, it is assumed that insurers establish rates for plans according to the maximum cost sharing provided and that any policy holder who wishes to obtain a policy with different cost sharing must apply for a revised policy if the cost sharing limit is to be changed. It is also assumed that the limit on premiums applies to policies with the same cost sharing maximums. It is further assumed that all insurers participate in pools which offer insurance policies with lower than the maximum cost sharing and do not offer policies competing with such pools.

8/ "Usual and customary" charges are terms in general use by Blue Shield plans to determine the level of payment to physicians. The "usual" charge for any service by any physician is typically whatever the physician informs the insurer is his usual charge. The "customary" charge for any service may be based on a percentile (85% to 95% typically) of the usual charges of all physicians for that service in a past period, or may be negotiated between the plan and physicians. Customary charges are thus typically less than the actual charges of some physicians.

(3) Other services

Other services are reimbursed on a reasonable cost or "reasonable charge" basis, as appropriate.

d. Additional provisions

(1) Primary responsibility for the regulation of all health insurance programs would lie with state governments. The Federal government is expressly prohibited from supervising or controlling the practice of medicine, the manner in which services are provided, the operations of providers, or the level of compensation.

(2) No damages for malpractice would be awarded to cover the cost of furnishing medical services that are paid for through the program.

(3) Payments under qualified policies are reduced to prevent a patient from having a lower level of cost sharing than included in a qualified policy for the services covered.

(4) State insurance departments could require carriers to participate in assigned risk pools if necessary to assure coverage for everyone.[9/]

2. Estimated health insurance coverage of population under proposal

The estimated health insurance coverage of the population in fiscal 1980 under the A.M.A. proposal is summarized in Table 4D.1. Approximately 69% of the population, including 101.8 million adults and 57.7 million children, are estimated to be covered by qualified group insurance policies purchased by employers. Another 14% of the population, including 22.0 million adults and 15.1 million children, are estimated to be covered by private individual qualified policies. Approximately two-thirds of these are assumed to be enrolled in pools

9/ Since carriers who underwrite qualified group health insurance plans must offer qualified insurance without underwriting at a rate no higher than 125% of the average rate in the state for groups of 100 employees or more, there is no need for an assigned risk pool except for employers with more than 100 employees.

TABLE 4D.1 HEALTH INSURANCE COVERAGE OF POPULATION IN 1980 UNDER THE AMERICAN MEDICAL ASSOCIATION PROPOSAL
(Thousands)

	Enrolled As:		Population:			
	Singles	Families	Aged	Adults	Children 1/	Persons
TOTAL	54,470	55,020	25,000	131,400	74,600	231,000
Federal Medicare Program	19,370	3,700	24,750	2,100	*	26,850
Employee Health Insurance Plans	21,190	42,160	150	101,650	57,660	159,460
Military servicemen and dependents 2/	1,300	1,800	*	4,770	2,330	7,100
Federal employees and dependents 3/	860	1,990	150	4,680	2,330	7,160
State and local government employees and dependents	2,760	5,610	*	13,400	7,500	20,900
Private employees and dependents 4/	16,270	32,760	*	78,800	45,500	124,300
Federal Program for Unemployed	1,990	660	*	3,200	870	4,070
Covered through employee plans	1,810	600	*	2,920	770	3,690
Covered through qualified policy pools	180	60	*	280	100	380
Individual Qualified Policy Pools 4/	9,000	5,440	100	16,220	12,030	28,350
Private Health Insurance	1,900	2,200	*	5,700	3,100	8,800
Not Insured 5/	1,020	860	*	2,530	940	3,470
Employees and dependents	590	580	*	1,610	640	2,250
Others	430	280	*	920	300	1,220

1/ Includes dependent, unmarried children under age 19 and through age 23 if in school.
2/ Includes retired servicemen, widows, and dependents eligible for CHAMPUS and care in service facilities.
3/ Includes retired Federal employees and dependents under age 65 enrolled in one of the Federal employee health insurance programs.
4/ Excludes persons funded through Federal program for the uninsured.
5/ Uninsured persons are those who elect not to join a plan for which they are eligible.

formed by insurance companies to issue qualified insurance to low income persons and persons who cannot be insured at the maximum rate allowed for qualified plans (the average rate in employer plans with more than 100 employees). Approximately 2% of the population, including 3.2 million adults and .9 million children, are estimated to be insured through qualified private insurance policies with the entire premium paid through the Federal program for the unemployed.

Approximately 1.5% of the population, including 2.5 million adults and .9 million children, are estimated not to be covered by any insurance program which includes basic hospital and medical benefits. Some of these persons rely on other government programs, such as the Veterans Administration hospitals and clinics, the Public Health Service hospitals and clinics, and the Indian Health programs.

3. Program spending under the A.M.A. proposal

The estimated spending in fiscal 1980 under each of the major programs set up by the proposal is outlined in Table 4D.2. Income and disbursements under the employee plans are estimated to be $55.0 billion. Of this, $47.0 billion is estimated to be required for benefit payments and $5.5 billion for administration. All insurers who issue qualified policies to employment groups are required under the proposal to issue qualified policies on an open enrollment basis without underwriting restrictions at a rate no greater than 125% of the average premium for larger employment groups. All insurers are assumed to discharge this obligation through participation in a state-wide pool. Since the pool would enroll nearly all disabled persons not currently eligible for Medicare, most retired persons under age 65, and a large proportion of uninsurable persons not eligible for an employee plan -- such a pool can only be operated at a loss. The loss is assumed to be assessed to each insurer on the basis of total qualified policies (which give rise to the obligation to participate in the pool). The

TABLE 4D.2 PROGRAM EXPENDITURES UNDER AMERICAN MEDICAL ASSOCIATION PROPOSAL IN FISCAL 1980
(Millions of Fiscal 1976 Dollars)

A. Employee Plans 1/	
Income:	
Employee contributions	$10,400
Federal subsidy to low income employees 2/	1,100
Federal subsidy to premiums for unemployed	1,500
Employer contributions	38,000
Federal subsidy to employers	4,000
Total 3/	55,000
Disbursements:	
Benefits	$47,000
Administration 3/	5,500
Assessments by individual qualified policy pools	2,500
Total 3/	$55,000
B. Private Qualified Policies 4/	
Income:	
Premiums	$ 3,300
Federal subsidy to premiums 2/	500
Total 5/	$ 3,800
Disbursements:	
Benefits	$ 3,100
Administration 5/	500
Assessments by individual qualified policy pools	200
Total 5/	$ 3,800
C. Individual Qualified Policy Pools 6/	
Income:	
Premiums to enrollees	$ 500
Federal subsidy to premiums for unemployed	200
Federal subsidy to premiums for others 2/	12,600
Assessments to qualified carriers	2,700
Total 7/	$16,000
Disbursements:	
Benefits	$14,500
Administration 7/	1,500
Total 7/	$16,000
D. Federal Program for Unemployed	
Income (all Federal subsidies)	$ 1,700
Disbursements:	
Payments to employee plans and carriers	$ 1,500
Payments to individual qualified policy pools	200
Total	$ 1,700

1/ Includes groups underwritten as assigned risks and unemployed whose coverage is continued through Federal subsidies.
2/ Includes certificates of entitlement and tax credits.
3/ Excludes an estimated $300 million of expense to Federal government to make income determinations and issue certificates of entitlement.
4/ Includes qualified association group insurance policies.
5/ Excludes expenses of Federal government in connection with handling of certificates of entitlement and collection of data.
6/ Includes income and outlays related to persons eligible for Federal program for uninsured.
7/ Excludes an estimated $500 million of expenses to Federal government to make income determinations and issue certificates of entitlement.

insurance companies must in turn recover these assessments by raising premiums on qualified policies. The share of the pool losses assumed to be assessed to employee plans is $2.5 billion. Thus total disbursements from the employee plans are $55.0 billion.

Income to the employee plans is derived from several sources. The share of contributions is estimated to be $11.5 billion. Low income employees, however, are entitled to obtain $1.1 billion in certificates of entitlement (or equivalently in tax credits) from the Federal government, reducing the net employee contribution to $10.4 billion. The employer share of contributions is estimated to be $42.0 billion. Employers are eligible for premium subsidies from the Federal government estimated at $4.0 billion, reducing the net employer contributions to $38.0 billion. Finally, $1.5 billion of premiums is estimated to be paid from the Federal program for the uninsured to continue coverage for persons receiving unemployment insurance and their dependents.

Disbursements under privately underwritten qualified policies are estimated to be $3.8 billion. Benefit payments are estimated to be $3.1 billion, and administrative costs to be $.5 billion, and assessments by individual qualified policy pools are estimated to be $.2 billion. The funds used to pay these disbursements are estimated to be derived from $3.3 billion of premiums and $.5 million of Federal subsidies.[10/]

The income and outlays of the individual qualified policy pools are estimated to be $16.0 billion in fiscal 1980. Benefit payments are estimated to be $14.5 billion and administrative costs to be $1.5 billion.[11/] Income to the program is estimated to be derived by $.5 billion of premiums paid by enrollees, $.2 billion of Federal payments for premiums of unemployed

10/ Premiums for privately underwritten qualified policies would differ from disbursements by the allowance in the premiums for building reserves on level premium policies and by any underwriting gains or losses.

11/ The allowance for administration does not the cost to the Federal government to determine an individual or family's income in order to issue an appropriate certificate of entitlement.

persons, $12.6 billion in Federal premium subsidies, and $2.7 billion of assessments to carriers of qualified policies.

The Federal program for uninsured persons and their dependents is estimated to disburse $1.7 billion in subsidies in fiscal 1980. Of these, payments to employee plans and carriers are estimated to be $1.5 billion and payments to individual qualified policy pools are estimated to be $.2 billion.

4. Average premium rates for employer plans

The estimated average premium rates for qualified plans offered by employers are summarized in Table 4D.3, broken down by major type of service. The average premium rate charged for single employees is estimated to be $453 and the estimated premium rate for families is estimated to be $1210. The average premium rate charged is estimated to be $960. The average premium per full time employee is estimated to be $640, of which the minimum employer share would be $460.[12/]

5. Effect of proposal on spending for personal health services

The estimated effect of the A.M.A. proposal on spending for personal health services in fiscal 1980 is summarized in Table 4D.4. Spending in the private sector is estimated to be increased by $3.7 billion or 3% by the proposal. Spending directly out-of-pocket is estimated to be reduced by $8.5 billion or 15%. Premiums paid by individuals for private health insurance policies are estimated to be decreased by $2.2 billion or 29%, and employer and employee contributions to group health insurance are estimated to be increased by $14.6 billion, or 34%

Spending through the public sector is estimated to be increased by $12.7 billion or 19%. Spending by Federal taxpayers is estimated to be increased by $18.3 billion, or 38%. The major part of this increase is due to

12/ These amounts exclude the effect of Federal subsidies for low income employees and for employers whose premiums for qualified insurance exceed 3% of payroll.

TABLE 4D.3 AVERAGE PREMIUM RATES IN FISCAL 1980 UNDER EMPLOYEE PLANS
(Fiscal 1976 Dollars)

	Single Employees	Employee & Family	Average Premium	Average Per Employee[1/]
Institutional services	$199	$533	$422	$282
Ambulatory and professional services	188	501	398	265
Administration	45	121	96	64
Assessment by individual qualified policy pools	21	55	44	29
Total	$453	$1210	$960	$640

1/ Total premiums divided by the number of full time employees. Includes effects of employees who do not enroll, who are eligible for medical services as retired military personnel and dependents, or who are the spouse of an employee enrolled for family coverage.

TABLE 4D.4 EFFECT OF AMERICAN MEDICAL ASSOCIATION PROPOSAL ON SPENDING FOR PERSONAL HEALTH SERVICES IN FISCAL 1980
(Billions of Fiscal 1976 Dollars)

	Present Law	Increase in Expenditures			Under Proposal
		Transferred	Induced	Total	
TOTAL U.S.	180.2	0	+16.4	+16.4	196.6
PRIVATE SECTOR	112.1	-4.6	+8.3	+3.7	115.8
Out-of-pocket	56.5	-9.5	+1.0	-8.5	48.0
Through insurance					
Individual policies and pools	7.7	-2.8	+.6	-2.2	5.5
Employee contributions	11.0	+1.5	+1.0	+2.5	13.5
Employer contributions	32.0	+6.7	+5.4	+12.1	44.1
Workmen's compensation & TDI	2.8	0	*	*	2.8
Other private	2.1	-.5	+.3	-.2	1.9
PUBLIC SECTOR	68.1	+4.6	+8.1	+12.7	80.8
Government insurance premiums	3.0	0	0	0	3.0
Workmen's compensation & TDI	.9	0	*	*	.9
Medicare	2.1	*	*	*	2.1
Federal taxpayers	47.8	+10.2	+8.1	+18.3	66.1
Through third parties:					
Federal premium subsidies		+10.0	+5.0	+15.0	15.0
Federal employer subsidies		+3.0	+1.0	+4.0	4.0
Federal program for uninsured		+1.2	+.5	+1.7	1.7
Medicare	23.7	+2.5	+1.0	+3.5	27.2
Medicaid	11.0	-5.2	*	-5.2	5.8
Other programs	2.5	-.3	*	-.3	2.2
Federal facilities and direct	10.6	-1.0	+.6	-.4	10.2
State and local taxpayers	17.3	-5.6	0	-5.6	11.7
Through third parties:					
Medicaid	8.7	-3.8	*	-3.8	4.9
Other programs	.4	-.1	*	-.1	.3
Direct payments	8.2	-1.7	*	-1.7	6.5

Federal subsidies to private insurance policies. Federal premium subsidies are estimated to be $15.0 billion, Federal subsidies to employers are estimated to be $4.0 billion, and Federal payments for premiums for uninsured persons and their families are estimated to be $1.7 billion. Spending for the Federal Medicare program is estimated to be increased by $3.5 billion.[13/] Federal contributions to state Medicaid programs are estimated to be reduced by $5.2 billion and Federal spending for other programs is estimated to be reduced by $.7 billion.

Spending by state and local taxpayers is estimated to be reduced by $5.6 billion or 32% by the proposal. The largest part of this reduction, $3.8 billion, is estimated to result from reductions from spending in state Medicaid programs. Direct payments to institutions are estimated to be reduced by $1.7 billion and spending for other programs by $.1 billion.

Thus the overall effect of the proposal is to substantially increase spending for privately administered qualified policies, and to reduce out-of-pocket spending and payments through Medicaid programs. A large part of the increase in insurance premiums is paid for through Federal contributions, so that most of the increase in spending occurs through the public sector.

Overall spending to the nation is estimated to be increased by $16.4 billion. This increase is attributable to the following factors:

Additional services performed	$ 7.4 billion
Payment of bad debts and unbilled charges	3.5
Full payment for Medicaid services	1.1
Increase in professional fees	1.3

13/ This increase in spending under Medicare depends on the policy assumption of how the supplemental benefits would be furnished to persons over age 65. (See Appendix A, section E).

Utilization controls	-.3
Limits on increases in institutional spending	-.6
Recovery of windfall increases in institutional spending	-.1
Administration of new insurance	2.4
Additional administrative functions	1.2
Increase in planning, regulation, and evaluation	.1
Reduced administration due to standardized policies	-.4
Maintain Federal facilities	.5
Diversion of philanthropic donations to other health purposes	.3
Total	$16.4 billion

Additional services performed as the result of the new insurance provided and the payment for services that would not have been paid for under current law are estimated to increase overall spending by $10.9 billion. Full payment for Medicaid services is estimated to increase spending by $1.1 billion. A more rapid rise in professional fees than would occur under present law is estimated to increase spending by $1.3 billion. Utilization controls and utilization review are estimated to reduce additional hospital services by $.3 billion and limits on rates charged by hospitals and other institutions are estimated to reduce spending by $.7 billion. Total payments for services are thus estimated to be increased by $12.3 billion.

Spending related to administration and regulation is estimated to be increased by $3.3 billion by the proposal. The diversion of philanthropic donations to other health related purposes and the continued funding of Federal facilities despite reductions in services is estimated to increase spending by $.8 billion.

6. Net fiscal impact of proposal on Federal budget

The estimated net fiscal impact of the A.M.A. proposal on the Federal budget for fiscal 1980 is summarized in Table 4D.5. Exemptions from taxation are estimated to reduce Federal tax income by $17.9 billion under the proposal, compared to $14.7 billion under present law. Thus Federal tax revenues are estimated to be reduced by $3.2 billion by the proposal. Consequently $21.5 billion in Federal taxes would be required to maintain the same balance of income and outgo in the Federal budget.

TABLE 4D.5 NET FISCAL IMPACT OF
AMERICAN MEDICAL ASSOCIATION PROPOSAL ON FEDERAL BUDGET IN FISCAL 1980
(Billions of 1976 Dollars)

	Present Law	Under Proposal	Effect of Proposal
Federal Outlays for Health Services	47.8	66.1	+18.3
Through third parties	37.2	55.9	+18.7
Direct payments	10.6	10.2	-.4
Tax Subsidies for Health Services (by source)	14.7	17.9	+3.2
Out of pocket payments	3.1	2.6	-.5
Premiums paid by individuals	1.3	1.4	+.1
Employer contributions	9.8	13.5	+3.7
Other private spending	.5	.4	-.1
Total Budgetary Impact	62.5	84.0	+21.5

E. American Hospital Association Proposal[1/]

1. Description[2/]

The American Hospital Association proposal would establish a three-part program including (1) a mandatory private health insurance plan for employees, (2) a Federal program for the poor and aged, and (3) a plan for individuals.

a. Benefits and Cost Sharing

All three plans would provide the same benefits. These include basic hospital, medical, psychiatric, drug and long term care benefits, and supplementary "catastrophic" benefits. The basic benefits provide payment for the following services, subject to the copayments noted:

Type of Service	Number of Services/ Benefit Period	Copayment Required[3/]
Inpatient hospital	90 days	$5 per day
Post hospital skilled nursing facility	30 days	$2.50 per day
Nursing home (homebound patients)	90 days	$2.50 per day
Outpatient mental health facilities	3/unused hosp. days	$2 per day
Inpatient physician services	Unlimited	$2 per visit
Outpatient physician and hospital	10 visits	$2 per visit
Diagnostic services	Unlimited	20% cost or fee
Health examinations	By regulation	None
Immunizations	Unlimited	None
Well baby care	By regulation	None
Home health services	200 visits	$2 per visit
Dental services for children under 12	1 visit & routine care	20% routine care
Vision services for children under 12	1 visit and eyeglasses	20% eyeglasses
Prescription drugs and insulin	Specified conditions	$1 per prescription
Devices and equipment	By regulation	20% cost or fee
Ambulance	Unlimited	20% cost or fee

Preventative services and services to treat pregnant women are covered on the same basis as services to diagnose or treat any injury or illness.

1/ The American Hospital Association proposal was introduced in the 94th Congress by Representative Ullman.

2/ For detailed description, see Saul Waldman, "National Health Insurance Proposals: Provisions of Bills Introduced in the 94th Congress."

3/ The copayment amounts would be increased after the initial year at the rate of the Consumer Price Index, whenever the increase in the latter exceeds 3% in a year.

The catastrophic benefits provide payment for additional unlimited services, when a family's out-of-pocket spending for insurance premiums, copayments, and for care beyond that covered by the basic plan exceeds an expense limit, that depends on family size and income. Services fully covered are: inpatient hospital, outpatient mental health facilities, physicians and outpatient hospital services, and home health services. The catastrophic plan would also pay the copayments for other services covered by the basic plan.

Mental illness, alcoholism, and drug abuse would be covered on the same basis as other forms of illness. Psychoanalysis is covered under basic benefits and under the catastrophic coverage as specified in regulations.

b. Programs

(1) Private Plan for Employees

The employee plan would require employers who are subject to the Social Security tax to offer the standard benefits and cost sharing to their employees and their families. No person could be covered under more than one policy. The insurance would be provided through private health insurance carriers, supervised by the states under Federal guidelines. Federal subsidies are provided for low-income workers, small employers for whom the cost of providing the benefits exceeds 4% of wages, and enrollees in health care corporations.

Employers would be required to pay at least 75 percent of the premiums. The maximum premium rates and expense limits for low income employees vary by family size and income as follows:

Class	Family Size and Income 1	2	3	4	Maximum Premium Single	Family	Catastrophic Expense Limit
1	$ 0-2000	$ 0-3000	$ 0-4500	$ 0-6000	0	0	0
2	2001-3000	3001-4500	4501-6000	6001-7500	$ 50	$125	$ 250
3	3001-4500	4501-6000	6001-7500	7501-9000	100	250	500
4	4501-6000	6001-7500	7501-9000	9001-10,500	150	375	750
5	6001+	7501+	9001+	10,501+	25% group rate		10% income

(All amounts are increased at the rate of the CPI after the initial year, if such increase exceeds 3% in a year).

The excess of 25% of the group insurance premiums over the maximum premium rates for low income employees would be paid by the Federal government. Also, the entire employee contribution could be included in itemized deductions on income tax returns.[4/]

(2) Federal Plan for Poor and Aged

The Federal plan combines programs for low income families and persons over age 65.

(a) Low Income Persons and Families

Low income persons are those in classes 1-4 (as described above) who are not eligible for an employer plan. They may join the Federal plan by enrolling and paying the applicable premium. The premium rates and the catastrophic expense limits are the same as for the maximums for the employer plans. Premiums can also be included in itemized deductions on income tax returns.

(b) Aged Persons

All aged persons are covered without premium payments. Catastrophic expense limits are half those for low income families of the same income class and number of members.

4/ Currently, deductions are limited to 50% of premiums up to a maximum of $150.

(3) Individual Plans

Persons not eligible for an employer plan or the Federal plan may enroll in an individual plan which includes the standard benefits. Catastrophic expense limits for the individual plans are the same as for the employer plans. Premium payments by enrollees with incomes less than $22,500 are limited to the sum of 4% of income plus 10% of the premium charged by the plan. The subsidy is available as a tax credit if claimed on income tax returns by eligible enrollees or persons purchasing other qualified policies. The premium less the tax credit can be included in itemized deductions on income tax returns.

States are responsible for making an individual plan available at reasonable group rates, in accordance with Federal regulation. States may require participation by private insurers in a pool for this purpose.[5/]

c. Federal Subsidy for Members of Health Care Corporations

The proposal creates a new health care organization to be known as "health care corporations." These organizations would include all types of providers eligible for payment under the proposal and some additional services, such as health education, unified medical records for all services received by enrollees, and may include medical social services, psychiatric counseling, and counseling

5/ For such coverage to be made available, a substantial subsidy is required. The policy assumption is adopted that this is accomplished by requiring all insurance companies to participate in the pool, which is equivalent to an increase in premium taxes on health insurance. Since private health insurers could not compete with a subsidized government program without underwriting or varying the premium rate by age, sex, etc., there would be no private individual plans eligible for the tax credits.

for drug addiction and alcoholism. The organizations must allow all licensed practitioners in their service areas to participate if they meet criteria related to professional ability, and may make their own financial arrangements to pay practitioners (e.g., fee for service, capitation rates, salary, etc.). Institutions must be reimbursed according to the formula in the bill (which ensures full payment of all costs and a return on capital for those which operate within predetermined budgets). Health care corporations would hold periodic open enrollment periods.

Health care corporations would be regulated by state authorities under general guidelines set by the Federal government. All persons enrolled in health care corporations would receive a subsidy from the Federal government equal to 10% of the enrollment charge.6/

d. Reimbursement

Reimbursement rates would be established by the states acting under general Federal guidelines. The overall responsibility for reimbursement would lie with the state health commissions, which would develop the state health care plan and have broad authority to regulate health care in the state.

Institutions would be paid according to a form of rate of return regulation, similar to that used in setting rates for public utility services. The state health commissions would establish payment rates for each institution in advance on the basis of projections of budgetary requirements. The basis for payment would include all direct and indirect costs, including

6/ For purposes of estimating the cost of the proposal, the policy assumption was adopted that individuals will not be allowed to receive subsidies in excess of actual outlays for premiums.

all approved education and research programs, the expense of obtaining and maintaining working capital and a return on total assets (i.e., profit). Depreciation allowances would include adjustments for the effect of inflation on replacement rates. In addition to reimbursing institutions for all costs, including capital and inflation related costs, the cost of any approved construction or modernization projects in excess of depreciation accumulations would also be paid. Also, certain charitable contributions would be excluded from consideration in setting rates.

The rates of payment would be settled in negotiations between institutions and the commission. After rates had been negotiated and approved, changes could be made only to reflect events which could not be foreseen at the time the rates were approved, and if continued use of the rates would result in severe financial hardship for the provider.

Payments for non-institutional providers would be based on reasonable fees, salaries, or other compensation.[7]

e. Additional Provisions

(1) State health care commissions would have broad authority for regulating the quality of health care within a state, establishing rules and procedures for determining the scope of services that should be provided and establishing the level of compensation received by each type of institution and class of professional provider. They would also provide the primary focus for evaluation of health care within the state and be responsible for the collection of health statistics and information. The commissions are appointed by the governors of the states for staggered six-year terms. They would thus be a semi-autonomous government body, and independent of day-to-day management of state governments.

7/ The bill is ambiguous with respect to professional providers who charge patients a fee in excess of the copayment and the allowance agreed upon with the state health commission (or health care corporation). The policy assumption was adopted that such excess charges are prohibited.

(2) The Medicare program would be abolished and only those services not eligible for payment through the new programs would be retained in state Medicaid programs. Other Federal programs would be limited to non-covered services. The payroll tax, however, would continue.

(3) To be eligible for reimbursement through the program, skilled nursing facilities would need to be physically a part of or in the immediate proximity to a hospital and must be under the supervision of the professional staff of the hospital, or have an organized medical staff.

(4) Services of radiologists and pathologists would be covered only as a hospital service.

(5) All copayments and other covered services not paid for directly could be charged under a health credit card program. No provision is made to facilitate collections of overdue accounts.

(6) All providers are subject to systems of peer review and medical audit, under the general supervision of the state health care commission.

2. Estimated health insurance coverage of population under proposal

The estimated health insurance coverage of the population in fiscal 1980 under the American Hospital Association proposal is summarized in Table 4E.1. Approximately two-thirds of the population, 154.5 million persons, are covered under employer-sponsored health insurance plans. These include 97.5% eligible single adults and 99% of families with a full time employee, including 100.0 million adults and 54.9 children. Of these, approximately 140 million are covered under the plans that employers are required to offer employees under the proposal, and another 14 million are covered by Federal programs for employees and military servicemen. Twenty-five million persons over age 65 and some 33.7 million persons under age 65 would be covered by the new Federal plan

TABLE 4E.1 HEALTH INSURANCE COVERAGE OF POPULATION IN 1980 UNDER THE AMERICAN HOSPITAL ASSOCIATION PROPOSAL
(Thousands)

	Enrolled As:		Population:			
	Singles	Families	Aged	Adults	Children 1/	Persons
TOTAL	58,265	55,020	25,000	135,200	70,800	231,000
Federal Plan for Poor and Aged	33,000	8,500	25,000	23,540	10,110	58,650
Low income persons	14,000	5,500	0	23,540	10,110	33,650
Aged persons	19,000	3,000	25,000	0	0	25,000
Employer Health Insurance Plans	21,245	42,240	0	99,670	54,850	154,520
Military servicemen and dependents 2/	1,300	1,800	0	4,770	2,330	7,100
Federal employees and dependents 3/	865	1,985	0	4,680	2,325	7,005
State and local government employees and dependents	2,765	5,625	0	13,170	7,095	20,265
Private employees and dependents	16,315	32,830	0	77,050	43,100	120,150
State Individual Plan Pools	2,170	2,510	0	6,950	3,500	10,450
Private Health Insurance Plans 4/	450	1,050	0	2,400	1,540	3,940
Not Insured 5/	1,400	720	0	2,640	800	3,440
Employees and dependents	530	500	0	1,410	560	1,970
Others	870	220	0	1,230	240	1,470

1/ Includes dependent, unmarried children under age 19.
2/ Includes retired servicemen, widows, and dependents eligible for CHAMPUS and care in service facilities.
3/ Includes retired Federal employees and dependents under age 65 enrolled in one of the Federal employee health insurance programs.
4/ Primary coverage only; excludes persons insured only by "dread disease" policies, income per day of hospitalization policies, etc.
5/ Uninsured persons who elect not to pay the premium required for a plan for which they are eligible.

for the poor and aged. Another 10.5 million are estimated to be enrolled in state individual plan pools and another 3.9 million are estimated to be covered under private health insurance policies providing basic hospital and medical benefits. Only 3.4 million persons, one and one half percent of the population, are estimated not to be covered by either the standard benefits or a private health insurance policy providing basic hospital and medical benefits. These include an estimated 2.6 million adults and .8 million children. Some rely on other Federal programs, such as the Veterans Administration hospitals and clinics, the Public Health Service hospitals and clinics, and the Indian Health programs.

The total number of persons classified as children under the American Hospital Association proposal is somewhat lower than under the other proposals analyzed in this report. Typically, children over age 19 are covered in family health insurance policies as long as they are dependent, unmarried, and full time students up to an age limit ranging from 22 to 25. Such children in school would be eligible for coverage as low income adults under the Federal plan for the poor and aged, however, with little or no premium payment. Consequently, virtually all other insurance policies would exclude all children over age 19 from coverage. The number of persons covered as adults is correspondingly increased by this transfer of children in school, and the number of persons considered single individuals is also increased.

3. Program spending under the American Hospital Association proposal

Spending in fiscal 1980 under the three major new programs set up by the proposal is outlined in Table 4E.2. Income and disbursements under employer plans are estimated to be $58.5 billion. Included in this sum are an estimated $.5 billion in assessments by the state individual plan pools to

TABLE 4E.2 PROGRAM EXPENDITURES UNDER AMERICAN HOSPITAL ASSOCIATION PROPOSAL IN FISCAL 1980 (Millions of 1976 Dollars)

A. Employer Plans	
Income	
Employee contributions (net of subsidies)	$10,100
Premium subsidies (low income employees)	500
Health care corporation subsidies	900
Employer contributions (net of subsidies)	44,500
Tax credits to small employers	2,500
Total	$58,500
Disbursements	
Benefits 1/	$51,500
Administration	6,500
Assessments by state individual plan pools	500
Total	$58,500
B. Federal Plan for Poor and Aged	
Income	
Premiums (net of subsidies	$ 1,700
Health care corporation subsidies	300
Payroll taxes	18,000
General revenue contributions	35,500
Total	$55,500
Disbursements	
Benefits for low income persons 1/	$19,200
Benefits for aged persons 1/	31,150
Administration	5,150
Total	$55,500
C. State Individual Plans Pools	
Income	
Premiums (net of subsidies	$ 2,700
Premium subsidies	2,700
Health care corporation subsidies	100
Assessments to insurers	500
Total	$ 6,000
Disbursements	
Benefits 1/	$ 5,300
Administration	700
Total	$ 6,000

1/ Includes uncollected amounts due under health credit card billings.

cover the estimated losses of those programs. Of the $58 billion related to health coverage for employees, benefits are estimated to be $51.5 billion and administrative expenses to be $6.5 billion.

Income to the program is derived from several sources. The employee share of the total is estimated to be $11.5 billion. Employees are estimated to receive $.5 billion in premium subsidies (for low income employees) and $.9 billion in subsidy payments for joining health care corporations, however, reducing their share of the cost to an estimated $10.1 billion. The employer share is estimated to be $47.0 billion. Employers are eligible for a tax credit from the Federal government equal to any excess of the cost of their share of the program over 4% of payroll for the first ten employees. This subsidy is estimated to be $2.5 billion, so that outlays by employers are estimated to be $45.3 billion.

Spending under the Federal plan for the poor and aged is estimated to be $55.5 billion. Of this, $19.2 billion is for benefits for low income persons, $31.2 billion is for benefits for aged persons, and $5.1 billion is for administration.

Funding of the program consists of an estimated $1.7 billion in premiums collected directly from low income enrollees, $.3 billion in health care corporation subsidy payments, $21.0 billion through continuing the Medicare payroll taxes, and $32.5 billion from general revenue contributions.

Spending by the state individual plan pools is estimated to be $6.0 billion, $5.3 billion for benefits and $.7 billion for administration. Income to the pools is estimated to consist of $2.7 billion in premium collections,

$2.7 billion in Federal premium subsidies, $.1 billion in health care corporation subsidy payments, and $.5 billion in assessments to health insurers.[8/]

4. Average premium rates under proposal for Employer Plans

The average premium rates for the standard benefits that employers are required to offer employees are summarized in Table 4E.3, broken down by major type of service.

The average premium rate in employer plans for single employees is estimated to be $486 and for employees with families to be $1280. The average premium rate charged employees is estimated to be $1017. The average premium for full time employee is estimated to be $680. The average cost of the insurance to employers would be approximately $517 per full time employee, after taking into account the proportion paid by employers, and the subsidy available to small employers.

5. Effect of proposal on spending for personal health services

The effect of the proposal on spending for personal health services is summarized in Table 4E.4. Spending in the private sector is estimated to be reduced by $4.2 billion or 4%. Direct spending out of pocket is estimated to be reduced by $16.1 billion, or 29%. Spending through individual insurance policies is estimated to be reduced by $5.9 billion, or 77%. Employee contributions and premiums for association group policies are estimated to be increased moderately by $1.4 billion to $12.4 billion, an increase of 13%. Employer contributions are estimated to be increased substantially from $32.0 billion to

8/ This distribution of funding for the state individual plan pools depends importantly on the assumption that the pool rate is maintained at a level higher than the average premium for the employer plans. Since a large proportion of the income to the pools is derived from subsidies, a self-supporting rate for the pool would be feasible that required no assessment to employer plans. (All persons with incomes less than $22,500 would be eligible for some premium subsidy.) The premium rates for the pool would be quite high, however, and consequently a larger proportion of higher income persons would continue private policies (without tax advantages) rather than enroll in the pools. Overall spending under the proposal would not be materially changed.

TABLE 4E.3 AVERAGE PREMIUM RATES IN FISCAL 1980 UNDER EMPLOYEE PLANS[1/]
(Fiscal 1976 Dollars)

	Single Employees	Employee & Family	Average Premium	Average Per Employee[2/]
Institutional services	$208	$546	$433	$290
Ambulatory and professional services	202	532	423	283
Prescriptions and supplies	17	45	36	24
Long term care	2	6	5	3
Administration	53	140	111	74
Assessments by state individual plan pools	4	11	9	6
Total	$486	$1280	$1017	$680

1/ Total outlay for insurance, including the higher cost for low income employees and assessments by the state individual plan pools, and before the effect of premium subsidies.

2/ Total premiums divided by the number of full time employees. Includes effects of employees who do not enroll, who are eligible for medical services as retired military personnel and dependents, or who are the spouse of another employee who is enrolled for family coverage.

TABLE 4E.4 EFFECT OF THE AMERICAN HOSPITAL ASSOCIATION PROPOSAL ON SPENDING FOR PERSONAL HEALTH SERVICES IN FISCAL 1980
(Billions of Fiscal 1976 Dollars)

	Present Law	Increase in Expenditures			Under Proposal
		Transferred	Induced	Total	
TOTAL U.S.	180.2	0	+20.2	+20.2	200.4
PRIVATE SECTOR	112.1	-13.0	+8.8	-4.2	107.9
Out-of-pocket	56.5	-16.7	+.6	-16.1	40.4
Through insurance:					
Individual policies	7.7	-5.9	*	-5.9	1.8
Employee contributions 1/	11.0	+.8	+.6	+1.4	12.4
Employer contributions 1/	32.0	+10.0	+7.0	+17.0	49.0
Workmen's compensation & TDI	2.8	0	-.1	-.1	2.7
Other private	2.1	-1.2	+.7	-.5	1.6
PUBLIC SECTOR	68.1	+13.0	+11.4	+24.4	92.5
Government insurance	3.0	+2.0	+.3	+2.3	5.3
Federal plan for poor and aged	0	+1.7	0	+1.7	1.7
State individual plan pools 2/	0	+2.4	+.3	+2.7	2.7
Workmen's compensation & TDI	.9	0	*	*	.9
Medicare premiums	2.1	-2.1	0	-2.1	0
Federal taxpayers	47.8	+18.3	+11.1	+29.4	77.2
Through third parties:					
Federal plan for poor and aged	0	+45.5	+8.0	+53.5	53.5
Premium subsidies	0	+3.6	+2.1	+5.7	5.7
Health care corporation subsidies	0	+.9	+.4	+1.3	1.3
Medicare	23.7	-23.7	0	-23.7	0
Medicaid	11.0	-6.6	*	-6.6	4.4
Other programs	2.5	-.3	*	-.3	2.2
Federal facilities and direct payments	10.6	-1.1	+.6	-.5	10.1
State and local taxpayers	17.3	-7.3	*	-7.3	10.0
Through third parties:					
Medicaid	8.7	-4.4	*	-4.4	4.3
Other programs	.4	-.1	*	-.1	.3
Direct payments	8.2	-2.8	*	-2.8	5.4

1/ Includes assessments for state individual plan pools, and excludes Federal subsidies to low income employee contributions, small employers, and health care corporations.
2/ Excludes assessments to private health insurers for pool losses.

$49.0 billion, an increase of $17.4 billion, or 54%. Other private spending is estimated to be reduced by $.5 billion.

The public sector is estimated to be increased by $24.4 billion or 36%. Premiums for government sponsored insurance are estimated to be increased by $2.3 billion. Medicare premiums are eliminated, but $1.7 billion of premiums are required for the new Federal plan for the poor and aged and $2.7 billion of premiums for state individual plan pools.

Spending for the new Federal plan for the poor and aged and for the premium and health care corporation subsidies is estimated to increase Federal spending sharply, by $29.4 billion, an increase of 62%. Spending through the Medicare program is eliminated and spending through the Medicaid program, direct Federal facilities and other Federal programs is estimated to be reduced sharply.

Spending by state and local taxpayers is estimated to be reduced by 42% by the proposal from $17.3 billion to $10.0 billion. Spending through state Medicaid programs is estimated to be reduced by approximately half and spending to cover deficits of state owned and operated facilities and other direct payments are assumed to be reduced by $2.8 billion or 34%.

Thus the overall effect of the American Hospital Association proposal is to shift spending for personal health services from out-of-pocket payments and the present Medicare and Medicaid programs into the three major new programs set up under the proposal. Total spending is estimated to be increased by $20.2 billion. This increase is attributable to the following factors:

Additional services performed	$11.8 billion
New services created	.5
Payment of bad debts and unbilled charges	4.8
Full payment for Medicaid services	1.5
Full payment for Medicare services	1.0
Utilization controls	-.8
Limits on increases in institutional spending	-.6
Recovery of windfall increases in institutional spending	-.2
Limits on charges by professional providers	-3.6
Administration of new insurance	4.6
Additional administrative functions	1.9
Increase in planning, regulation, and evaluation	.2
Reduction in individual insurance expenses	-1.8
Reduced administration due to mandatory coverage and standardized policies	-.4
Maintain Federal facilities	.6
Diversion of philanthropic donations to other health purposes	.7
Total	$20.2 billion

Additional services performed as a result of the new insurance provided and the payment for services that would not have been paid for without national health insurance are estimated to increase spending for personal health services by $17.1 billion. Full payment for Medicare and Medicaid services is estimated to add another $2.5 billion. Reductions in rates of payment to providers, the maximum fees that can be charged for services covered

by the proposal are estimated to reduce payments by $4.4 billion and pre-admission certification and utilization review is estimated to reduce payments by $.8 billion. Thus total spending for services is estimated to be increased by $11.9 billion.

Spending related to administration and regulation is estimated to be increased by $4.5 billion by the proposal and diversion of philanthropic donations to other purposes and continued funding of Federal facilities is assumed to result in a net $1.3 billion increase in spending.

6. Net fiscal impact of proposal on Federal budget

The estimated net fiscal impact of the American Hospital Association proposal on the Federal budget for fiscal 1980 is summarized in Table 4E.5. Exemptions from taxation for personal health services are estimated to reduce Federal taxes by $20.7 billion, resulting in an additional loss of $6.0 billion in revenues compared to present law. Part of this revenue loss, $1.7 billion, is estimated to occur as a result of the changes in the tax treatment of premiums specified in the proposal. The rest is due to the very large increase in the premiums that employers are required to pay for health insurance, which are estimated to reduce taxable incomes of employees by some $17.5 billion, and income and payroll taxes by $5.3 billion.[9/] Deductions for out-of-pocket expenditures are estimated to be substantially reduced, however, offsetting some of the revenue loss. The overall additional Federal taxes that would be required to maintain the same balance of income and outlays in the Federal budget are estimated to be $35.4 billion.

9/ The crucial assumption underlying this calculation is that a new payroll tax or health insurance premium paid by an employer results eventually in an equivalent drop in wages or salary - either through lower pay increases or more rapid inflation, if employers increase prices to offset the effect of higher payroll taxes. (To the extent that the payroll taxes result in lower profits, income taxes would be reduced at a more rapid rate.)

TABLE 4E.5 NET FISCAL IMPACT OF
AMERICAN HOSPITAL ASSOCIATION PROPOSAL ON FEDERAL BUDGET IN FISCAL 1980
(Billions of 1976 Dollars)

	Present Law	Under Proposal	Effect of Proposal
Federal Outlays for Health Services	47.8	77.2	+29.4
Through third parties	37.2	67.1	+29.9
Direct payments	10.6	10.1	-.5
Tax Subsidies for Health Services (by source)	14.7	20.7	+6.0
Out of pocket payments	3.1	2.2	-.9
Premium paid by individuals	1.3	3.0	+1.7
Employer contributions	9.8	15.1	+5.3
Other private spending	.5	.4	-.1
Total Budgetary Impact	62.5	97.9	+35.4

F. The Health Security Proposal[1/]

1. Description[2/]

The Health Security proposal would provide a Federally administered and financed program to furnish comprehensive medical services for all U.S. residents.

a. Benefits[3/]

The program would cover unlimited hospital care, skilled nursing facility care, physicians' services including preventive care and routine examinations, dental care,[4/] home health services, laboratory and x-ray, medical supplies and appliances, prescription drugs for chronic illnesses, eye examination, eyeglasses, and certain other health services when furnished through health maintenance organizations or other approved institutions. There would be no cost sharing provisions. Institutional services for psychiatric diagnoses would be limited to 45 days during an illness, and outpatient psychiatric treatment would be restricted to 20 visits in a year unless furnished through a health maintenance organization or outpatient mental health facility.

b. Financing

The program would be financed 50% by payroll taxes and 50% by Federal general revenues. The payroll taxes would be levied on 150% of the

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1/ The Health Security proposal is sponsored by the AFL-CIO and major independent unions. It was introduced in the 94th Congress by Senator Kennedy and Representative Corman.

2/ For a detailed description of this proposal, see Saul Waldman, "National Health Insurance Proposals: Provisions of Bills Introduced in the 94th Congress."

3/ The Health Security Board has broad latitude in determining the services that would be covered. For this reason the cost estimate for this bill must be regarded as illustrative of the cost that could occur if a particular set of policies is followed. See Section G of Appendix A for details as to the specific policies assumed to be followed in preparing the estimates in this report.

4/ Dental services are to be phased in over a period of years. A schedule is provided in the bill for persons under age 25. The cost estimates include dental services for all persons under age 25.

earnings base under Social Security as follows: 1% for employees, 3.5% for employers, and 2.5% for self-employment and unearned income. The taxes would apply to all earned and unearned income, including that of state and local government employees.

c. Reimbursement

A national health budget would be established and allocated to regions and localities, by type of medical service. Hospitals and skilled nursing facilities would be paid according to an annual predetermined budget. Practitioners could select fee-for-service according to a fee schedule, capitation, or salary. Rates of payment would be negotiated with the Health Security Board.

d. Other Provisions

(1) The program would be administered through a Health Security Board that would determine standards of eligibility for all providers, determine rates of payment for all services, reach agreements with all providers, and regulate use and quality of services.

(2) Institutional providers could be ordered to add or reduce service, and to relocate.

(3) Major surgery could be performed only by qualified specialists, after an independent consultation and approval by another specialist.

(4) The Medicare program would be abolished and Medicaid limited to services not covered by the Health Security program.

(5) A health resources development fund would ultimately receive 5% of the income of the program.

2. Population Covered by the Health Security Program

Since virtually the entire population is covered under the bill, an estimated 231 million persons will be eligible during fiscal 1980. Military personnel and their families, and some veterans eligible for VA services would, however, continue to receive most of their care through Federal hospitals and clinics.

3. Program Spending Under Health Security

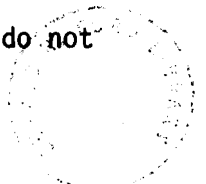
Spending in fiscal 1980 under the Health Security program is estimated as follows:

Personal health services	$127.3 billion
Administration and planning	10.2
Health Resources development fund 5/	7.0
	$144.5 billion

Nearly all spending for services covered by the proposal would be transferred to the Health Security program. The principal exceptions are the workmen's compensation program and services furnished through Federal hospitals and clinics. Also a number of providers are assumed not to participate in the program, either because they cannot meet the standards set by the Health Security Board for participation or because they refuse to accept the level of compensation offered by the Health Security Board. 6/

Spending under present law for those services which would be transferred to the Health Security program is estimated as $112.1 billion. Another $8.3 billion is spent for administration related to these services. The Health Security proposal is estimated to result in substantial increases in the use

5/ These appropriations are beyond the scope of this report and are not included elsewhere in the estimates.
6/ In the estimates it is assumed that 5% of physicians and dentists do not participate in the program.



and cost of the services covered and related administration. Such induced spending for personal health services is estimated as follows:

Additional services performed	$16.5 billion
New services created	.4
Payment of bad debts and unbilled charges	4.8
Full payment for Medicaid services	1.5
Full payment for Medicare services	1.0
Increase in wages of institutional health employees (beyond that financed by windfall increases in revenue not recovered)	1.1
Utilization controls	-1.4
Limits on increases in institutional spending	-2.7
Recovery of windfall increases in institutional spending (from recovery of bad debts, etc.)	-1.1
Limits on charges by professional providers	-3.6
Administration of new insurance	5.9
Reduced administrative functions	-2.3
Increase in planning, regulation, and evaluation	.2
Reduction in individual insurance expenses	-1.9
Maintain Federal facilities	.7
Diversion of philanthropic donations to other purposes	.9
TOTAL	$20.0 billion

Of the estimated $20.0 billion net induced services, $17.1 billion would be paid directly by the Health Security program. Of this amount, $15.2 billion is for medical services and $1.9 billion is for administration and planning. Another $1.4 billion of induced services would be paid out-of-pocket or through prepaid prescription programs. Diversion of philanthropic spending to other health related activities and failure to reduce the staffing of Federal health

facilities in proportion to the decrease in patient loads is estimated to increase spending by $1.6 billion. Budgetary restraint on increases in hospital spending would reduce workmen's compensation costs by $.1 billion.

The $112.1 billion of spending under present law for services transferred to the Health Security program plus the $15.2 billion of induced costs for medical services would produce a total program outlay for medical services of $127.3 billion. The $8.3 billion of present law spending for administrative expenses related to covered services absorbed by the Health Security program and the $1.9 billion of induced administrative and planning expenses resulting from the proposal would produce a total administration and planning outlay for Health Security of $10.2 billion. Thus total spending for personal health services through the Health Security program is estimated at $137.5 billion in fiscal 1980.

4. Effect of Proposal on Spending for Personal Health Services

The estimated effect of the Health Security proposal on overall spending for personal health services in fiscal 1980 is summarized in Table 4F.1. The principal effect of the Health Security proposal is to shift most of the spending for personal health services from the private sector to the public sector and to concentrate such spending in the Federal Health Security Program. As a result, Federal spending for personal health services would be more than tripled from $47.8 billion under present law to $152.7 billion under the proposal. Over 90% of such Federal spending would be channeled through the Health Security Program. Federal matching of state Medicaid programs and other Federal spending through third parties for personal health services would be reduced by more than half. Funding of Federal facilities would be reduced by 18% pending further legislation to incorporate such facilities into the Health Security program.

TABLE 4F.1 EFFECT OF HEALTH SECURITY PROPOSAL ON SPENDING FOR PERSONAL HEALTH SERVICES IN FISCAL 1980
(Billions of Fiscal 1976 Dollars)

	Present Law	Increase in Expenditure			Under Proposal
		Transferred	Induced	Total	
TOTAL U.S.	180.2	0	+20.0	+20.0	200.2
PRIVATE SECTOR	112.1	-76.1	+2.2	-73.9	38.2
Out-of-pocket	56.5	-26.9	+1.2	-25.7	30.8
Through insurance:					
Individual policies	7.7	-6.7	*	-6.7	1.0
Employee contributions	11.0	-10.6	*	-10.6	.4
Employer contributions	32.0	-30.2	+.2	-30.0	2.0
Workmen's compensation & TDI	2.8	0	-.1	-.1	2.7
Other private	2.1	-1.7	+.9	-.8	1.3
PUBLIC SECTOR	68.1	+76.1	+17.8	+93.9	162.0
Government insurance	3.0	-2.1	*	-2.1	.9
Workmen's compensation & TDI	.9	0	*	*	.9
Medicare premiums	2.1	-2.1	0	-2.1	0
Federal taxpayers	47.8	+87.1	+17.8	+104.9	152.7
Through third parties:					
Health Security Program 1/	0	+120.4	+17.1	+137.5	137.5
Medicare	23.7	-23.7	0	-23.7	0
Medicaid	11.0	-6.0	*	-6.0	5.0
Other programs	2.5	-1.7	*	-1.7	.8
Federal facilities and direct	10.6	-1.9	+.7	-1.2	9.4
State and local taxpayers	17.3	-8.9	*	-8.9	8.4
Through third parties:					
Medicaid	8.7	-4.7	*	-4.7	4.0
Other programs	.4	-.4	0	-.4	0
Direct payments	8.2	-3.8	*	-3.8	4.4

*Less than $50 million

1/ Excludes $7.0 billion in spending for development of health resources.

Spending in the private sector would be greatly reduced by the proposal. Direct spending out-of-pocket would be reduced by 45% from $56.5 billion under present law to $30.8 billion. Spending for insurance policies other than workmen's compensation would be reduced by 94% from $51.1 billion to $3.4 billion.[7/] Spending for premiums for government sponsored insurance would be eliminated except for workmen's compensation programs. Spending by state and local taxpayers would be cut approximately in half and would be directed principally to long term care and rehabilitative services. Total spending in the nation is estimated to increase by $20 billion.

5. Net Fiscal impact of proposal on Federal budget

The estimated net fiscal impact of the Health Security proposal on the Federal budget for fiscal 1980 is summarized in Table 4F.2. Exemptions from taxation for spending out-of-pocket and through insurance premiums for personal health services are estimated to be substantially reduced by the proposal. Deductions for health insurance premiums are estimated to be virtually eliminated, reducing the tax reductions from $11.1 billion to $.6 billion. Approximately $30.2 billion of employer contributions for health insurance, however, are replaced by an estimated $40.5 billion of new employer payroll taxes (in addition to the $9.0 billion paid under present law for Medicare).[8/]

7/ Approximately $.7 billion of this is estimated to result from failure to cancel individual policies covering benefits payable through the Health Security program or converting such policies to income per day of hospitalization (which encourages use of hospitals).

8/ The estimated payroll taxes are based on the assumption that half of the Health Security program is financed through payroll taxes and taxes on unearned income with a base equal to 150% of that for Social Security taxes. Estimated tax rates required for personal health services are 5.8% for employers, 4.1% for self-employed and unearned income, and 1.7% for employees. (These rates include the 5% of program revenues specified as earmarked for a health resources development fund but exclude any extra taxes needed to build or maintain a trust fund equal to one year's benefits. The lag between income to the program and payments to providers would produce a cash surplus in the trust fund if sources of financing are adequate.)

TABLE 4F.2 NET FISCAL IMPACT OF HEALTH SECURITY PROPOSAL ON FEDERAL BUDGET IN FISCAL 1980
(Billions of 1976 Dollars)

	Present Law	Under Proposal	Effect of Proposal
Federal Outlays for Health Services	47.8	152.7	+104.9
Through third parties	37.2	143.3	106.1
Direct payments	10.6	9.4	-1.2
Tax Subsidies for Health Services (by source)	14.7	15.1	+.4
Out of pocket payments	3.1	1.7	-1.4
Premium paid by individuals	1.3	.1	-1.2
Employer contributions	9.8	13.0	+3.2
Other private spending	.5	.3	-.2
Total Budgetary Impact	62.5	167.8	+105.3

Thus employee taxable incomes would be reduced by up to $10.3 billion by the proposal, resulting in income tax collections that are $3.2 billion lower than under present law.[9/] Taxes of employees (and other persons paying premiums) would also be increased since employee payroll taxes are not deductible, while employee premiums for health insurance are. The net effect would be a decrease of $.4 billion in Federal taxes without any change to Federal tax laws. This would increase the net fiscal impact of the proposal on the Federal budget to $105.3 billion of additional taxes that would be required to maintain the same balance of income and outlays in the Federal budget. Of these, new payroll taxes would raise $53.3 billion (assuming the tax rates are increased by enough to raise half of the cost of the program), leaving a need for another $53.0 billion in Federal general taxes exclusive of any additional spending for health resources.

9/ The crucial assumption underlying this calculation, is that a new payroll tax or health insurance premium paid by an employer results eventually in an equivalent drop in wages or salary - either through lower pay increases or more rapid inflation if employers increase prices to offset the effect of higher payroll taxes. (To the extent that the payroll taxes result in lower profits, income taxes would be reduced at a more rapid rate.)

V. Comparative Cost of Major National Health Insurance Proposals

The estimated relative cost of the major national health insurance proposals analyzed are summarized in Tables 5.1 through 5.8 according to the definitions of costs set forth in the Chapter on methodology.

A. Increase in national spending for personal health services

The estimates of national spending for personal health services and the increases over present law are shown in Table 5.1. These increases are the broadest measure of the cost of national health insurance and as such indicate the extent to which the nation as a whole would sacrifice other goods and services in order to spend more on health care. The estimates of total spending in fiscal year 1980 range from $188.1 billion for the Long-Ribicoff Bill to $200.4 billion for the American Hospital Association proposal. The increases in spending range from $7.9 billion, or 4.4%, to $20.2 billion, or 11.2%.

The increases in spending estimated for the proposals analyzed fall into two groups:

1. The increases in spending estimated for the Long-Ribicoff, CHIP, and H.I.A.A. proposals fall into the range of $7.9 to $9.1 billion. Each of these proposals would change only moderately the way in which households pay for health services and would require most small bills to be paid directly out-of-pocket. Each also concentrates most new dollars spent on health care on services for low income persons and those who cannot purchase unrestricted coverage at reasonable rates. This group of proposals also tends to cover preventive services only for children while restricting benefits for adults to those services necessary to diagnose or treat an injury, illness or pregnancy.

2. The increases in spending estimated for the A.M.A., A.H.A., and Health Security proposals fall in the range of $16.4 to $20.2 billion. These proposals have no deductibles that must be met before payment

TABLE 5.1 PERSONAL HEALTH CARE EXPENDITURES UNDER MAJOR NATIONAL HEALTH INSURANCE PROPOSALS IN FISCAL 1980
(Billions of Fiscal 1976 Dollars)

Proposal	Spending	Increase	Percent
Present Law	180.2		
Long-Ribicoff	188.1	7.9	4.4%
CHIP	189.3	9.1	5.0%
Health Insurance Association of America	189.1	8.9	4.9%
American Medical Association	196.6	16.4	9.1%
American Hospital Association	200.4	20.2	11.2%
Health Security (AFL-CIO)	200.2	20.0	11.1%

would be made and limit all cost sharing to relatively modest amounts. The Health Security Proposal would eliminate all cost sharing. This group of proposals covers most preventive and routine services on the same basis as care required for an injury, illness, or pregnancy. Further, each provides extensive coverage of services needed in connection with mental illness, drug abuse, and alcoholism. For all of these reasons, these proposals are estimated to result in substantially higher spending.

The estimated increase in spending depends on the treatment under a proposal of a number of complex fundamental issues as to the regulation of medical services and how they are paid for. The principal causes of the increases in spending estimated for each proposal are summarized in Table 5.2. The extent and type of the services covered and the cost sharing required are the most important elements in the estimated increases. Many other important factors, however, are also estimated to influence the level of spending under a proposal. Rates of payment to providers, price and utilization controls, the extensiveness of claim administration and data processing required all are very important factors contributing to the cost of a proposal.

The estimates of additional services performed range from $2.9 billion for the Long-Ribicoff Bill to $16.9 billion for the Health Security proposal. These estimates primarily reflect the scope of services covered under the proposals and the amount of cost sharing required from patients. Estimated payments for bad debts and unbilled charges range from $2.1 billion under the Long-Ribicoff Bill to $4.8 billion under the A.H.A. and Health Security proposals. These estimates are roughly proportional to those for additional services performed, except for the CHIP and A.H.A. proposals, which are estimated to pay for a large number of additional bad debts through health credit card programs. The estimated cost to pay for Medicaid services at the same rates as paid by other users range from $1.0 billion for CHIP to $1.8 billion for the Long-Ribicoff proposal. The

TABLE 5.2 COMPONENTS OF INCREASE IN SPENDING FOR PERSONAL HEALTH SERVICES UNDER MAJOR NATIONAL HEALTH INSURANCE PROPOSALS

(Billions of Fiscal 1976 Dollars)

	Long-Ribicoff	CHIP	H.I.A.A.	A.M.A.	A.H.A.	Health Security
Additional services performed	+2.9	+4.8	+6.1	+7.4	+12.3	+16.9
Payment for bad debts and unbilled charges	+2.1	+3.6	+2.9	+3.5	+4.8	+4.8
Full payment for Medicaid services	+1.8	+1.0	+1.1	+1.1	+1.5	+1.5
Full payment for Medicare services	0	+.6	+.6	0	+1.0	+1.0
Inflation in fees or wages	*	*	*	+1.3	*	+1.1
Utilization controls	-.5	-.8	-.5	-.3	-.8	-1.4
Limits on institutional spending	*	-3.6	-5.7	-.7	-.8	-3.8
Limits on professional fees	-.3	-1.0	0	0	-3.6	-3.6
Administrative cost of new insurance	+1.1	+2.2	+2.6	+2.4	+4.6	+5.9
Change in administrative functions and type of insurance	+.5	+1.4	+.8	+.8	-.3	-4.2
Federal spending for planning, regulation, and evaluation	*	+.1	+.1	+.1	+.2	+.2
Maintenance of appropriations for Federal facilities	+.1	+.4	+.5	+.5	+.6	+.7
Diversion of philanthropic donations	+.2	+.4	+.4	+.3	+.7	+.9
	+7.9	+9.1	+8.9	+16.4	+20.2	+20.0

* Less than $.05 billion

high cost estimated for the latter results from the coverage of long term care services currently provided for through Medicaid. Federal standards for long term care facilities are assumed to result in a major upgrading of the level of care provided to indigent institutionalized persons. (Only a few highly restricted long term care services are covered under the other proposals analyzed.) The estimated cost to pay for Medicare services at the same rates as paid by other users range from zero (for proposals that do not change the Medicare program) up to $1.0 billion.

The factors used to estimate increases in services performed also provide some allowance for increases in wages for types of institutional employees in short supply. To the extent that services are not available, it is assumed that wages will increase at a more rapid rate, so that cost increases are substituted for the services not available. Two proposals, the A.M.A. and Health Security, however, were estimated to produce more inflationary conditions. The payment of full "usual and customary" charges under the A.M.A. bill and the very large increase in physician services paid for through insurance are estimated to result in an increase in physician fees of 1% per year beyond that which would have occured under present law. Similarly, wages of institutional personnel are estimated to increase at a rate of 1% per year faster under the Health Security proposal than would otherwise occur, reducing the impact of budget controls.

Utilization controls are estimated to reduce the additional services performed by amounts ranging from $.3 billion under the A.M.A. proposal to $1.4 billion under the Health Security proposal. Price controls or limits on spending by institutions are estimated to reduce spending by amounts ranging from $0.7 billion under the A.M.A. proposal to $5.7 billion under the H.I.A.A. proposal. Limits on professional fees are estimated to decrease spending under some of the proposals by amounts ranging up to $3.6 billion under the A.H.A. and

Health Security proposals.[1/]

Payment through a third party for services that under present law would be paid for directly by patients (or not paid for at all in the case of bad debts) are estimated to increase spending for claim administration by amounts ranging from $1.1 billion under the Long-Ribicoff Bill to $5.9 billion under the Health Security proposal. Changes in administrative functions and type of insurance (e.g., individual vs. group) are estimated to change spending for administration by amounts ranging from a reduction of $4.2 billion under the Health Security proposal to an increase of $1.4 billion under CHIP. These estimates are influenced primarily by the extent of processing of data required, the extent and frequency with which an individual or family's income must be determined in order to determine the appropriate premium rate or to pay claims, the underwriting and sales expense of health insurance policies, and the processing required in connection with health credit card programs. Federal spending for the planning, regulation and evaluation component of administrative costs is estimated to increase by amounts ranging up to $.2 billion.

Finally, spending for personal health services is assumed to be increased under each proposal by a failure to reduce appropriations for Federal facilities in proportion to the services diverted to other providers, and the diversion of philanthropic donations to other purposes. The increase in spending estimated to result from these factors range from $.3 billion for the Long-Ribicoff Bill to $1.6 billion under the Health Security proposal.

1/ Such decreases stem from a requirement that physicians accept payment by the national health insurance plan as full compensation for their services.

B. Changes in how households pay for personal health services

The estimated changes in how households pay for personal health services brought about by the proposals are summarized and compared in Table 5.3. The proportions of spending estimated to be made through the private and public sectors fall into two relative size groups, the Health Security proposal and all of the other proposals analyzed. Spending through the private sector under the Health Security proposal is estimated to be $38.2 billion, while that for the other proposals range from $106.1 billion under the H.I.A.A. proposal to $115.8 billion under the A.M.A. proposal. Spending through the public sector under the Health Security bill is estimated to be $162.0 billion, and that for the other bills analyzed to range from $78.8 billion for the Long-Ribicoff Bill to $92.5 billion for the A.H.A. proposal.

The estimates of direct spending out-of-pocket for personal health services are estimated to vary inversely with the increase in overall spending under the proposals. The estimates range from $53.2 billion under the Long-Ribicoff Bill to $30.8 billion under the Health Security proposal.2/ Estimates of spending through insurance range from only $6.1 billion under the Health Security proposal to $65.9 billion under the A.M.A. and A.H.A. proposals.

Estimates of premiums for government insurance range from $.9 billion under the Health Security proposal (where they are limited to payments for workmen's compensations funds by employers) to $12.0 billion under the H.I.A.A. proposal, which creates state pools and a contributory state program to provide insurance to low income and uninsurable persons. Payment by federal taxpayers is estimated to range from $54.0 billion under the H.I.A.A. proposal to $152.7 billion under the Health Security proposal. Spending by local and

2/ In the case of the latter proposal, such spending is entirely for services not covered.

TABLE 5.3 SPENDING FOR PERSONAL HEALTH SERVICES BY CHANNEL OF PAYMENT

UNDER PRESENT LAW AND MAJOR NATIONAL HEALTH INSURANCE PROPOSALS IN FISCAL 1980
(Billions of Fiscal 1976 Dollars)

	Present Law	Long-Ribicoff	CHIP	H.I.A.A.	A.M.A.	A.H.A.	Health Security
TOTAL U.S.	180.2	188.1	189.3	189.1	196.6	200.4	200.2
PRIVATE SECTOR	112.1	109.3	107.6	106.1	115.8	107.9	38.2
Out-of-pocket	56.5	53.2	48.8	46.7	48.0	40.4	30.8
Through insurance	53.5	54.1	56.9	57.4	65.9	65.9	6.1
Other Private	2.1	2.0	1.9	2.0	1.9	1.6	1.3
PUBLIC SECTOR	68.1	78.8	81.7	83.0	80.8	92.5	162.0
Government insurance premiums	3.0	3.0	9.4	12.0	3.0	5.3	.9
Federal taxpayers	47.8	60.4	55.4	54.0	66.1	77.2	152.7
State and local taxpayers	17.3	15.4	16.9	17.0	11.7	10.0	8.4

state taxpayers is estimated to range from $8.4 billion under the Health Security bill to $17.0 billion under the H.I.A.A. proposal. In each case, spending by state and local taxpayers would be lower than estimated under present law and spending by federal taxpayers would be substantially higher. The estimated increases in Federal spending range from 13% under the H.I.A.A. proposal to more than three times under the Health Security proposal.

C. National health insurance program spending by channel of payment

The estimated spending for personal health services through each channel under the new programs set up or those directly modified by each proposal is summarized in Table 5.4. Some proposals replace the Medicare program while others retain it and incorporate it into the national health insurance plans. Also, all of the proposals replace a major part of the state Medicaid programs with new programs for low income persons, while retaining at least that part of the Medicaid programs which pay for services not covered by the new plans. To obtain comparable overall program totals, spending for Medicare and Medicaid is included in national health insurance program spending.

Spending through private insurance is estimated to range from none under the Health Security proposal to $54.6 billion under the A.H.A. proposal. Spending for government insurance premiums is estimated to range from none under Health Security to $11.1 billion under the H.I.A.A. proposal. Spending by Federal taxpayers through national health insurance programs and Medicaid is estimated to be $142.5 billion. Such spending under the other proposals is estimated to range from $41.7 billion under the H.I.A.A. proposal to $64.9 billion under the A.H.A. proposal.

State and local government spending for national health insurance programs and Medicaid is estimated to be in the range of $4.0 to $4.9 billion

TABLE 5.4 PROGRAM SPENDING FOR PERSONAL HEALTH SERVICES UNDER MAJOR NATIONAL HEALTH INSURANCE PROGRAMS IN FISCAL 1980 BY CHANNEL OF PAYMENT[1/]

(Billions of Fiscal 1976 Dollars)

	Long Ribicoff	CHIP	H.I.A.A.	A.M.A.	A.H.A.	Health Security
TOTAL U.S.	64.8	98.0	101.5	112.9	128.2	146.5
PRIVATE SECTOR	5.5	35.5	38.5	52.2	54.6	0
Through insurance	5.5	35.5	38.5	52.2	54.6	0
PUBLIC SECTOR	59.3	62.5	63.0	60.7	73.6	146.5
Government insurance premiums	2.1	8.5	11.1	2.1	4.4	0
Federal taxpayers	47.5	44.8	41.7	53.7	64.9	142.5
State and local taxpayers	9.7	9.2	10.2	4.9	4.3	4.0

1/ Includes insurance programs set up or altered as a result of a national health insurance proposal, including Medicare and Medicaid.

under the A.M.A., A.H.A., and Health Security proposals, in all cases entirely for residual Medicaid for non-covered services. For the other bills, such spending is estimated to range from $9.2 to $10.2 billion. Each of these bills requires some state and local government expenditure for covered services.

D. Changes in administrative responsibility for the financing of personal health services

The estimated changes in administrative responsibility for the financing of personal health services brought about by the proposals are summarized in Table 5.5. Amounts paid out-of-pocket, donated to charity, paid for by private workmen's compensation programs are administered by those who pay them. Services underwritten by private insurers (excluding any administered in the role of agents for government programs) differ from those paid for by households or employers for private insurance by any direct subsidies available from new programs, and by any assessments by government pools. The amounts underwritten range from $6.1 billion under Health Security to $87.0 billion for the A.M.A. proposal.

The amounts administered by the Federal or state and local governments include the insurance programs for which premiums are collected directly from the public.

The amounts estimated to be administered by the Federal government range from $36.6 billion for the H.I.A.A. proposal to $147.7 billion for the Health Security proposal. The amounts estimated to be administered by state and local governments range from $14.3 billion for Health Security to $46.9 billion for the H.I.A.A. proposal.

E. National health insurance programs by administrative responsibility

The estimated spending for personal health services under new programs,

TABLE 5.5 SPENDING FOR PERSONAL HEALTH SERVICES ACCORDING TO ADMINISTRATIVE RESPONSIBILITY

UNDER PRESENT LAW AND MAJOR NATIONAL HEALTH INSURANCE PROPOSALS IN FISCAL 1980
(Billions of Fiscal 1976 Dollars)

	Present Law	Long Ribicoff	CHIP	H.I.A.A.	A.M.A.	A.H.A.	Health Security
TOTAL U.S.	180.2	188.1	189.3	189.1	196.6	200.4	200.2
PRIVATE SECTOR	112.1	109.3	107.6	105.6	135.7	111.3	38.2
Paid directly by individuals	56.5	53.2	48.8	46.7	46.7	40.4	30.8
Private insurers	53.5	54.1	56.9	56.9	87.0	69.3	6.1
Other private	2.1	2.0	1.9	2.0	2.0	1.6	1.3
PUBLIC SECTOR	68.1	78.8	81.7	83.5	60.9	89.1	162.0
Federal government	38.4	62.8	39.3	36.6	42.2	67.5	147.7
State and local government	29.7	16.0	42.4	46.9	18.7	21.6	14.3

Medicare, and Medicaid are summarized in Table 5.6 by administrative responsibility. The amounts administered by private insurers range up to $72.1 billion under the A.M.A. proposal. The programs administered by the Federal government range from $24.6 billion under the H.I.A.A. proposal to $137.5 billion under the Health Security proposal. Those administered by state and local governments range from $9.0 billion under the Long-Ribicoff and Health Security proposals to $38.9 billion under the H.I.A.A. proposal.

F. Average premium rates for employee plans and average cost per full time employee

The estimated average premium rates that would be charged for employee plans and the average per full time employee of employee plan premiums and payroll taxes (including Medicare) are summarized in Table 5.7. The average premium rate for an enrolled single employee and the average for employees who enroll with families are shown for those proposals with employee plans. Also shown are the average premium rates for all enrollees, whether single or with families. The average rates for single employees range from $366 for CHIP to $486 for the A.H.A. proposal. Average family rates range from $671 for CHIP to $1017 for the A.H.A. proposal.

The estimated average payment per full time employee of employee plan premiums and payroll taxes for national health insurance programs and Medicare ranges from $270 for the Long-Ribicoff proposal to $880 for the A.H.A. proposal. Except in the case of the Health Security proposal, for which half of the cost would be raised through general taxes, these amounts show the average cost of coverage of full time employees. Part is actually paid through direct Federal premium subsidies or tax credits. The employer shares range from $170 for the

TABLE 5.6 PROGRAM SPENDING FOR PERSONAL HEALTH SERVICES UNDER MAJOR NATIONAL HEALTH INSURANCE PROGRAMS IN FISCAL 1980 ACCORDING TO ADMINISTRATIVE RESPONSIBILITY[1/]
(Billions of Fiscal 1976 Dollars)

	Long Ribicoff	CHIP	H.I.A.A.	A.M.A.	A.H.A.	Health Security
TOTAL U.S.	64.8	98.0	101.5	112.9	128.2	146.5
PRIVATE SECTOR	5.5	35.5	38.0	72.1	58.0	0
Private insurers	5.5	35.5	38.0	72.1	58.0	0
PUBLIC SECTOR	59.3	62.5	63.5	40.8	70.2	146.5
Federal government	50.3	29.0	24.6	30.1	55.5	137.5
State and local government	9.0	33.5	38.9	10.7	14.7	9.0

1/ Includes insurance programs set up or altered as a result of a national health insurance proposal, including Medicare and Medicaid.

TABLE 5.7 AVERAGE PREMIUMS AND COST OF NATIONAL HEALTH INSURANCE

PER FULL TIME EMPLOYEE IN FISCAL 1980
(Fiscal 1976 Dollars)

Proposal	Premium Rates			Average per Full Time Employee 1/			
	Single Employee	Employee With Family	Average Premium	Total	Employer Share 2/	Employee Share 3/	Federal Share
Long-Ribicoff	-	-	-	$270	$170	$100	$ 19 4/
CHIP	$366	$840	$671	650	464	187	0
H.I.A.A.	375	975	787	723	494	220	0
A.M.A.	453	1210	960	840	542	221	77
A.H.A.	486	1280	1017	880	617	217	46
Health Security	-	-	-	725 5/	564 5/	161 5/	0

1/ Premiums and payroll taxes for national health programs and Medicare. Shows financing for only part of proposals. (All shares will be increased by taxes required to pay for public programs.)
2/ Based on estimated employer contributions made, and may exceed share required. Includes $100 of payroll taxes for Medicare, except in case of Health Security proposal.
3/ Includes $100 of payroll taxes for Medicare, except in case of Health Security proposal.
4/ Estimated excess of value of tax credits over value of deductions to employers.
5/ Includes only part of cost of financing benefits for full time employees. Rest of cost would be raised through general taxation.

Long-Ribicoff proposal to $617 for the A.H.A. proposal and the employee shares from $100 (all for Medicare) under the Long-Ribicoff proposal to $221 under the A.M.A. proposal.

These amounts reflect only that part of the cost of national health insurance raised by payroll taxes and mandating insurance plans covering full time employees. Additional funds must be raised under all proposals to fund new programs for low income persons and for those who have difficulty obtaining insurance. Since the principal source of taxes is income earned by employed persons, the average full cost to employees of national health insurance will be substantially higher in all cases (especially for the Health Security proposal since the payroll taxes raise only part of the revenues needed to pay for the insurance for full time employees).

G. Effect of proposals on Federal Budget

The estimated effects of the proposals analyzed on the Federal unified budget are summarized in Table 5.8. The total budgetary effect of a proposal is obtained by adding the increase in Federal spending required by a proposal to any reduction in Federal revenues produced by the proposal. The changes in tax revenues would occur either directly as a result of changes in the tax laws or as a result of changing taxable incomes. Taxable incomes may be reduced by increasing spending for those types of health services that are deductible or by imposing payroll taxes or mandatory health insurance premiums on employers.[3/]

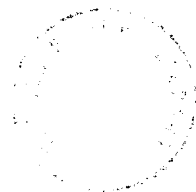
3/ A crucial assumption followed in the estimates is that payroll taxes and mandatory insurance premiums paid by employers lead to equivalent decreases in the taxable incomes of employees. A payroll tax or head tax (i.e., a mandatory insurance premium) imposed on an employer must result (at least in the short run) in increased prices, reduced profits, or reduced wages. A general price increase by nearly all employers and self employed persons would reduce real wages through inflation, and thus have a similar effect to a reduction in wages. A decrease in profits would produce a greater relative reduction in taxes than the case if wages were reduced. Thus for a relatively short span of time (in this case three years), the effect of payroll and head tax can be approximated by the assumption of an equivalent drop in employee incomes.

TABLE 5.8 NET FISCAL IMPACT OF MAJOR NATIONAL HEALTH INSURANCE PROPOSALS

ON FEDERAL SPENDING AND BUDGET
(Billions of Fiscal 1976 Dollars)

	Outlays		Tax Expenditures		Total Expenditures	
	Total	Increase	Total	Increase	Total	Increase
Present Law	47.8		14.7		62.5	
Long-Ribicoff	60.4	12.6	16.1	1.4	76.5	14.0
CHIP	55.4	7.6	16.4	1.7	71.8	9.3
Health Insurance Association of America	54.0	6.2	18.8	4.1	72.8	10.3
American Medical Association	66.1	18.3	17.9	3.2	84.0	21.5
American Hospital Association	77.2	29.4	20.7	6.0	97.9	35.4
Health Security (AFL-CIO)	152.7	104.9	15.1	.4	167.8	105.3

The increases in Federal spending estimated to occur under the proposals range from $6.2 billion under the H.I.A.A. proposal to $104.9 billion under the Health Security proposal. The changes in revenue estimated to occur as a result of the proposal range from an increase of $2.4 billion under the Health Security proposal to a loss of $6.0 billion under the A.H.A. proposal. The total new taxes that would have to be raised to maintain the same balance of income and outgo in Federal spending are estimated to range from $9.3 billion under CHIP to $102.5 billion under the Health Security proposal. The very large increase in taxes estimated to be required for the Health Security proposal stem from both the assumption by the Federal government of the responsibility for paying for a very large proportion of personal health services in full and from the $20 billion increase in total spending estimated under the proposal. The other proposals require substantial increases in spending in the private sector or for government insurance to pay for the estimated increases in national spending, in addition to increased Federal spending.



APPENDIX A

PRINCIPAL POLICY ASSUMPTIONS

A. General Policy Assumptions Applicable to All Proposals[1/]

1. Assumptions as to the effective date of implementation

To obtain valid cost comparisons among the bills, certain timing assumptions are necessary. The estimates in this study are based on the following:

a. All benefit provisions of each proposal are assumed to be effective in July 1977 (whether or not this is in accordance with the proposal itself).

b. Any provision that changes over time according to a schedule in a bill is assumed to be in the last stage of implementation in fiscal 1980.[2/]

c. Any provision of a bill that would require Congressional or Presidential approval or further legislation to become effective is assumed not to be in effect in fiscal 1980.[3/]

d. Changes in the structure of the health delivery system and the creation of health resources are assumed to have a relatively minor impact by 1980.[4/]

1/ Additional policy assumptions common to the estimates for all proposals are described in Section II.G on estimating transferred costs and in Section II.H on estimating induced costs.

2/ Thus for example, the employer contribution rate in CHIP is assumed to be 75% (although the bill specifies 65% for the first 3 years), and the subsidy to small employers to help pay the premiums for the employer plan is assumed to have been phased out. The Ullman bill is assumed to provide the comprehensive benefits by fiscal 1980, rather than stage them in over several years. Similarly, the Health Security bill is assumed to provide dental benefits for all persons under age 25.

3/ Thus for example, dental benefits for persons over age 25 are not assumed to be included in the Health Security proposal.

4/ Changes in the structure of the delivery systems and the creation of new resources are important features of many proposals. Such changes necessarily take place slowly, however, and their impact on the cost of health services will emerge only over a long period of time. Attempts were made to identify the structural changes which could be effective in the first few years, and the estimated cost impact on those changes are included in the estimates.

2. Definitions of eligible providers and conditions under which services are reimbursable

Unless explicitly stated otherwise (in the bill or in special policy assumptions relating to that bill, regulations are assumed to define covered services as follows:

a. For services furnished through a government program, definitions of covered services are assumed to be the same as in the Medicare program.[5/]

b. For services furnished through private programs, the definition of services is assumed to be that typically used in private insurance policies providing comparable benefits.

c. The following definitions were assumed for services not covered by Medicare and not generally covered by private insurance (unless otherwise specified).

(1) Vision care services:

(a) Annual examination by an optometrist or ophthalmologist. For children in school with no prior history of vision problems, the annual examination is assumed to be a professionally supervised screening.

(b) A pair of corrective lenses whenever a change in prescription is recommended.

5/ Payment for services through Medicare requires that three conditions be met:
- The provider must meet explicit standards for eligible providers (e.g., licensed as a nursing home, maintains 24-hour nursing services under the supervision of a registered nurse, etc.).
- The medical service actually performed must meet standards for services (e.g., skilled nursing, physical therapy, etc.) for which the provider may be reimbursed.
- The patient's condition must be such as to require the service (e.g., payment of skilled nursing facility charges by Medicare requires that skilled services be needed on a continuing basis and at least one skilled service is in fact performed each day.)

Some of the proposals explicitly specify a different level of coverage than provided through the Medicare program. For example, the AMA bill, the Ullman bill, and the Health Security bill would all pay for routine and preventive services. Services are not eligible for payment by the Medicare program unless there is a diagnosis of an accident or an illness.

(2) Hearing benefits:

(a) For children with no prior history of hearing problems, an examination by an audiologist whenever recommended by a general practitioner or nurse employed by a school health program.

(b) For children with a previous history of hearing problems, annual examination by an audiologist.

(c) A new hearing aid upon initial diagnosis of a hearing problem and replacement whenever needed as a result of a change in the condition of the ears.

(3) Well child visits:

(a) For children from birth to six months: examination at birth and a visit each six weeks until six months old.

(b) For children from six months to two years old: two visits annually.

(c) For children from two to five years old: annual examination.

(4) Family planning services:

(a) Covered family planning services will include visits to family planning clinics; the services of home health aides, nurses, and health social workers skilled in birth control techniques and counseling; abortions; and all sundries used in connection with family planning.

(5) Preventive services:

Preventive services for the general population are assumed to include immunization, routine examinations, chest x-rays, etc. The only physician services assumed to be excluded are examinations in connection with applications for insurance or employment and for plastic surgery not required as a result of an accident or illness.

3. Rate of payment for institutional services

Unless specified otherwise, payment through a public program for institutional services is assumed to be made on the same basis as in the Medicare program. Under programs which require that hospitals and other institutions charge the same rates to all users, charges are assumed to be set at a level which would reproduce the current net revenues of hospitals if received from all non-government payers. The overall level of reimbursement to institutions assumed depends on the peculiar circumstances of each bill.[6/]

4. Level of payment to professional providers

a. Payments to physicians, clinical psychologists, optometrists (for eye examinations), and dentists are assumed to be made as noted in Section II. H.2.i.

b. Payments for prescription drugs, sundries, and medical supplies:

(1) Under programs that process all covered services (i.e., a health credit card program or no deductible), payment is assumed to be made on the basis of a fee schedule. For multiple source drugs the fee is assumed to be based on an allowance for acquisition cost plus a pharmacist fee.

(a) If pharmacists must accept the schedule fee as full compensation, the allowance for acquisition cost is assumed to be equal to the median among the current average wholesale prices of nationally available products. The pharmacist fee is assumed to be based on the 75% percentile among the average costs of pharmacies of similar size and volume of sales.

(b) If pharmacists may collect the excess of their prices over program reimbursements, the schedule fee is assumed to be based on the lowest estimated acquisition cost among equivalent products and a uniform pharmacist fee, set to reflect the lowest price outlets within an area.

6/ See Section II.H for the assumptions with regard to the effect of budgetary controls on hospital spending. The specific changes in payment rates assumed to estimate the cost of any bill are stated in the special policy assumptions related to that proposal.

(2) Under programs that do not process all covered services (e.g., a deductible applicable to prescription benefits and no health credit card program), reimbursement is assumed to be based on actual charges.

c. Transplants, dialysis, open-heart surgery and other highly specialized/expensive procedures

Regulations are assumed to be similar to those for kidney disease patients under Medicare.

d. Payments for other services

Payments for all other services are assumed to be based on a fee schedule. If the fee constitutes full compensation, it is assumed to be set so as to reflect the 75th percentile of charges by providers of the same class in an area. If the fee does not constitute full compensation, it is assumed to be set at the lowest level at which the service is generally available in an area.

5. Definition of income

Where eligibility, premiums, or benefits depend on family or personal income, the operational definition of income is assumed to be as follows:

a. For persons receiving Supplemental Security Income (SSI), income will be the definition used in the SSI program, exclusive of any "disregards,"[7/] plus all SSI payments.

b. For persons receiving welfare payments, income will be the standard used as a base for determining the welfare payments (i.e., the sum of welfare payments and any income counted as an offset in determining such payments) excluding any "disregards".

7/ Disregards are amounts of income not counted in determining income; e.g., an exclusion of 50% of the first $100 of earned income in previous month.

c. For other persons who file income taxes or have income tax withheld, adjusted gross income plus any untaxed government transfer payments (e.g., Social Security or Railroad Retirement benefits, etc.) will apply.

d. For other persons, all earned and unearned income considered in determining SSI payments.

In other words, for each class of person for whom an "income" is currently determined by a government agency as a basis for taxation or transfer payments, the amount so determined is assumed to be the basis of any eligibility or other income classification for purposes of national health insurance.[8/] For other persons (presumably lower income), the procedures to determine income will be similar to those followed by the largest Federal program that currently has a similar responsibility.

6. Enrollment procedures

a. Where employers are required to offer coverage to employees in a group insurance plan, enrollment is assumed to be permitted within 30 days of initial hiring as a full time employee and during annual enrollment periods thereafter.

b. Where participation in a program is voluntary, enrollment is assumed to be permitted only on the following occasions:

(1) When eligibility is lost under another program (e.g., an employee plan),

(2) When forming a new household,

8/ There are three principal reasons for adopting this assumption:
(i) Economy in administering national health insurance,
(ii) Simplification of complex eligibility provisions for government programs, and
(iii) The best estimate of what procedures will be adopted for a new program is provided by those adopted previously in similar situations.

(3) When moving between states or entering the U.S. from abroad, or

(4) During annual open enrollment period. In this case, coverage is assumed to be effective three months after application and payment of initial premium.

c. If employers are permitted to obtain coverage for all employees through a public program, enrollment is assumed to be permitted only on the following occasions:

(1) When first incorporated,

(2) When there has been a change in ownership or control,

(3) When there has been a substantial drop in the number of employees, or

(4) During open enrollment periods once every two years. In this case, coverage is effective at the end of three months.

7. Participation rates

a. Voluntary participation in insurance programs offered as a result of a national health insurance program is assumed to depend primarily on the actuarial cost of the group to which a family or individual belongs and rate at which coverage is offered. The variables considered in estimating the probable participation rates are age, sex, income, size of group (or family), and disability status.

Nearly all severely disabled persons,most occupationally disabled persons, and half of early retirees without other coverage are assumed to enroll in any pool or public program offered at an average rate as low as 125% of the average cost of group insurance in an area. Thus no

pool or public program with open enrollment could survive without a subsidy at least equal to the excess morbidity of these groups.[9/]

Participation rates among other persons in a voluntary insurance program were assumed to vary by income and the ratio of the contribution to the average group insurance premium that would be required to furnish comparable benefits to all employees as follows:

Income	Ratio of Contribution to Average Employer Premium						
Fiscal 1976 Dollars	0	25%	50%	75%	100%	125%	150%
0 - 2,500	1.000	.850	.700	.550	.400	.150	.075
2,500 - 5,000	"	.900	.800	.600	.450	.200	.100
5,000 - 7,500	"	.950	.900	.810	.720	.300	.150
7,500 - 10,000	"	.965	.930	.890	.850	.400	.200
10,000- 15,000	"	.980	.960	.930	.900	.450	.250
15,000 and over	"	.990	.975	.960	.940	.500	.300

The total number of persons insured, if a program is available that subsidizes a maximum rate on an open enrollment basis is assumed to be as follows (includes persons purchasing private policies at lower rates than the contribution required for the pool).

Income	Ratio of Contribution in Pool to Average Employer Premium						
Fiscal 1976 Dollars	0	25%	50%	75%	100%	125%	150%
0 - 2,500	1.000	.850	.700	.550	.400	.300	.200
2,500 - 5,000	"	.900	.800	.600	.450	.350	.250
5,000 - 7,500	"	.950	.900	.810	.720	.610	.500
7,500 - 10,000	"	.965	.930	.890	.850	.800	.700
10,000- 15,000	"	.980	.960	.930	.900	.860	.800
15,000 and over	"	.990	.975	.960	.940	.920	.900

The average morbidity among those participating was assumed to be up to 5% higher than the proportion of persons.

9/ The excess morbidity has been found to range from 33% to 67% higher than average in such situations.

b. Where private insurance is permitted to compete with a public program or pool, private carriers will offer coverage at a slightly lower rate and use underwriting techniques to obtain a set of risks that can be insured profitably at that rate.

c. Proposals which have a clear intent to make coverage at average rates available to non-insured persons on an open enrollment basis are assumed to provide whatever subsidy is required to achieve this objective.

d. Where there are two employees in a family each eligible for an employer plan, each is assumed to enroll if this practice is permitted and if the actuarial value of the second policy, net of reductions due to coordination of benefits, exceeds the employee contribution required.

8. Administration of public programs

It is assumed that wherever possible administration will be carried out by insurance companies acting as carriers (as is presently done in the Medicare program). All income determinations, however, will be made by civil servants working in cooperation with private carriers.

9. Level of maintained data

Unless additional functions are required (or deleted), the level of data collected and processed for public programs is assumed to be the same as in the Medicare program.

10. Level of processing for health credit card claims

The level of data collected and processed for health credit card billings is assumed to consist only of items necessary to establish the amount due; i.e., name, identification number, provider name and identification number, date, and amount due. It is assumed that the only processing done is that which is required to maintain accurate accounts and collect receivables.

Billings are assumed to be monthly, at an interest rate 2% higher than the prime rate to be charged on the unpaid balance. Credit would be denied to anyone with a balance past due more than 3 months (under the current or any previous private or public health insurance program).

B. Special Policy Assumptions for Long-Ribicoff Proposal

1. Reimbursement policies

All reimbursement amounts are assumed to be set according to the procedures established by the Medicare program.[1/]

2. Participation

The Federal government is assumed to provide the catastrophic benefits for all Federal employees and for all military servicemen and their families through their present health insurance plans. Other employers are assumed to establish private plans furnishing catastrophic benefits for 75% of non-Federal employees. Half of self-employed persons are assumed to purchase the catastrophic insurance through individual policies or association group insurance.

3. Effect of participation on average morbidity

The average morbidity of employees covered by private plans is assumed to be 10% less than the average morbidity of persons covered under the Federal program. The average morbidity of persons electing coverage through individual policies is assumed to be 20% lower than the average morbidity of persons covered by the Federal program.

4. Administration of private catastrophic plans

Administration for private catastrophic plans is assumed to be fully integrated with other health insurance benefits. It is assumed that no additional data will be requested by the Federal government other than an expansion

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1/ The Long-Ribicoff proposal does not introduce any new procedures to control institutional costs. Institutional services paid for through the catastrophic program would however become subject to certain provisions of the Social Security Act designed to reduce institutional costs. These provisions are estimated to have a relatively minor impact on total spending for institutional services.

of disclosure forms filed with the Department of Labor to show compliance.

5. Administration of the Federal Catastrophic Health Insurance Program

It is assumed that there will be no processing of data concerning any family until services in excess of one of the catastrophic deductibles have been accumulated. Subsequent processing is assumed to parallel that in the Medicare program.

6. Administration of the Federal Medical Assistance Program

It is assumed that cash assistance recipients will be issued eligibility cards when their income is determined for purposes of establishing entitlement to cash assistance benefits. The eligibility card would show the amount of family deductible if any. Income would be established for other persons only after medical expenses have been accumulated in excess of the deductible. Eligibility for further benefits would not be redetermined during the rest of the year, except for a relatively small sample of persons studied for purposes of program evaluation and management.

7. Treatment of existing programs

a. Continuation of state Medicaid programs and supplementation of the Federal Medical Assistance Program are assumed to follow the policy assumptions noted in Section II.G (on transfers). Thus it is assumed that (1) states will maintain the level of funding for all services not included in the Federal program for which Federal matching continues to be available, and that (2) for services not eligible for reimbursement under the Federal Medical Assistance program which would have been eligible for reimbursement under a state Medicaid program, 85% of services for cash assistance recipients and 67% of services for other persons will be maintained by the states, and

that (3) half of the amounts that would have been paid through Medicaid under present law but are not paid under any insurance program under the proposal are discontinued or become bad debts.

8. State pools to provide certified policies

It is assumed that all states establish pools to provide certified policies at rates between 125% and 150% of the average rate for small groups in the state.2/ All applications to the pool are assumed to be underwritten with standards at least as rigorous as used by the insurers participating in the pools.3/ Health insurers are assumed to issue competing policies at rates lower than the pool rates, using more rigorous underwriting standards to obtain a set of risks that can be profitably underwritten at such rates.

9. Services covered by both Medicare and the Catastrophic Health Insurance program

All services for which payment would be made under both the Medicare

2/ The Federal government could issue its own policies in any state that did not form such a pool.

3/ This assumption is crucial to the interpretation of the Long-Ribicoff bill. If it had been assumed that the Federal government could require open enrollment or restrict underwriting in the pools -- the overall impact of the Long-Ribicoff bill would have been estimated to be substantially different. The enrollment in the pools would have been estimated to be similar to that for the state individual plan pools in the H.I.A.A. proposal. Further, losses in the pools comparable to those in the H.I.A.A. estimates are assumed to be assessed to all health insurers in proportion to health premiums. Overall spending for personal health services would have been estimated to be somewhat higher and services paid for out-of-pocket somewhat lower.
The estimates were not based on an assumption of open enrollment as the language of the bill clearly would not support such a Federal requirement. Since open enrollment periods are specifically required for certified group policies, the omission of such a requirement for certified individual policies (or pools) in effect prohibits one.

and the Catastrophic Health Insurance program are assumed to be paid for only through the Medicare program.[4/]

4/ The proposal states that such services will be paid for only through the catastrophic program. This would result in redundant income to the Medicare program and further underfinancing of the catastrophic program; hence the policy assumption.

C. Special Policy Assumptions for CHIP

1. Limitations on coverage

Independent practitioners other than physicians, dentists, optometrists, audiologists, podiatrists, and Christian Science practitioners are assumed to be covered only in institutional settings. Other definitions of covered services are assumed to be as stated in Section A of this Appendix.

2. Reimbursement policies

Rates of payment for services reimbursed by the program or paid for through the health credit card system are assumed to be set by a state rate setting commission independent of the department of health, acting under specific regulations promulgated by the Secretary of H.E.W. It is assumed that on the average the effect of state decisions will be as follows:

a. Hospitals, Skilled Nursing Facilities, and Home Health Agencies

The overall rate of increase in hospital spending for inpatient services is assumed to be reduced by 2.5% per year after 1978 by actions of state rate setting commissions. The commissions are also assumed to increase the proportion of windfall increases in revenues that are used to defer future rate increases from 50% to 75%.1/

1/ The proposal does not specify how institutional rates would be set. Approximately 71% of the cost of institutional care would be raised locally (through employer and employee contributions and the state share of the cost of assisted plans), about the same as under present law. Due to the increases in institutional spending estimated to occur as a result of the proposal, however, total dollars raised locally would be increased. State appropriations for institutional care would be reduced slightly. On balance, there is a strong incentive for states to implement effective controls. On the other hand, conditions are not significantly changed from present law, under which states may implement similar measures. The Federal government has strong incentives to require effective procedures before approving state programs, since the Federal government pays for a substantial share of the cost of local health care programs. (The Federal government would not, however, be able to provide significant pressure on states to implement control procedures effectively, since the only Federal option is to withdraw approval entirely.)

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b. Physician Services

Payments are assumed to be paid according to a uniform fee schedule for each area. The initial fees for any area are assumed to be based on a relative value scale, with the value of a unit determined by the average of reasonable charges that would have been recognized by Medicare in that area. The overall level of fees, however, is assumed to be raised in proportion to the increase in the proportion of fees that physicians are required to accept as full compensation for their services. In fiscal 1978, the fee schedule is estimated to average 81.5% of the fees that would be charged under present law.

c. Other Professional Practitioners

Other professional practitioners are assumed to be reimbursed by fee schedules paying approximately the same proportion of billed charges as for physicians.

3. Assisted plan premium rates

Each employer is assumed to file a disclosure form showing the average enrollment and the net cost of the mandated benefits and related administrative costs (net of any dividends, rate credits, etc.) for the previous calendar year. These would be summarized for each state and projected to the following calendar year by standard actuarial techniques. Federal government actuaries would review the projections of the states.

(continuation of footnote #1)
Although states are unambiguously directed to set rates, presumably on the basis of prospective budgets, and are very likely to be directed by the Federal government to implement effective programs, no specific procedures or methods are specified in the bill. It is thus possible that the programs actually implemented could range from those as effective as the Maryland and Connecticut rate setting commissions, to programs that have little impact on costs. Due to the wide range of possible effectiveness of institutional cost controls, cost controls were estimated to have half of the estimated maximum impact.

4. Administration of income-related cost sharing

Persons receiving welfare or Supplemental Security Income payments would be enrolled automatically. They would be issued special credit cards showing the income class indicated by their payment determination. Other persons wishing to establish that their premiums or cost sharing are lower than in the standard plan would file an application with state authorities.[2/] Further processing during that calendar year would be based on such applications unless amended by further applications. A copy of each declaration would be forwarded to state income tax authorities. A settlement would be made with a sample of persons who benefited from reduced cost sharing or premiums after the end of each calendar year, using the income reported for the year. State income tax forms would have provisions to claim refunds related to health insurance.

5. Level of statistical data collected

The administrative cost included in the estimates allows for the level of statistical data currently collected under Medicare, increased by the processing required to obtain profiles by practitioners and patients for PSRO review. Data for each PSRO area is assumed to be maintained by a lead carrier and shared with other insurers. Only summary statistics would be forwarded to H.E.W. for national compilation. Publication and research activities would be comparable to those carried out at present by the Social Security Administration.

2/ Normally these applications would be taken by providers and forwarded to state authorities.

D. Special Policy Assumptions for Health Insurance Association of America Proposal

1. Limitations on coverage

a. The initial benefits specified in the bill to be required in qualified policies are assumed to be in effect in fiscal 1980.[1/]

b. Independent practitioners other than physicians, dentists, optometrists, audiologists, podiatrists, and Christian Science practitioners are assumed to be covered only in institutional settings.

c. Eye examinations are assumed to be provided by an optometrist or an ophthalmologist.

d. Payment for eyeglasses is assumed to be limited to the cost of a set of plain plastic frames and to lenses dispensed under new prescriptions. Any excess of charges over the cost of a pair of plain frames could be charged to the patient.

2. Reimbursement rates

a. Payments to institutions

The increase in hospital spending after 1978 is assumed to be reduced by 4.2% per year through limits on the rates that hospitals and other institutions may charge for their services. It is also assumed that the proportion of windfall revenues that are used to defer future rate increases is raised from 50% to 90%.[2/]

1/ The bill provides for the extension of the services required for qualified policies and the elimination of cost sharing on certain preventive benefits --to be effective in 1985. The date for this extension was so far into the future and so long after the estimation date of 1980, that an exception was made to stated rules. Estimates were prepared on the basis of the benefits that would be in effect from 1978 to 1984.

2/ The H.I.A.A. proposal specifies the most effective and detailed procedures of any proposal analyzed for limiting increases in institutional costs. The provisions resemble the laws in the States of Maryland and Connecticut

(continued on next page)

b. The average of customary and prevailing charges as determined as a basis for payment for qualified plans is estimated to be 82.5% of actual charges.[3/]

3. New services created by the proposal

The proposal provides for substantial financial support for "comprehensive ambulatory health care centers," a type of provider that is not currently generally available other than through the outpatient departments of hospitals and some independent clinics. To a large extent these facilities would provide services in lieu of visits to physicians and hospitals. An additional allowance of $100 million was added in the cost estimates for services would not have occurred in the absence of the creation of this new type of provider.

4. Adjustments for dynamic limits for eligibility determinations, deductibles, and dollar maximums

The H.I.A.A. proposal would adjust all dollar amounts used to determine eligibility and cost sharing by the ratio of the C.P.I. for the prior calendar

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(continuation of footnote #2)
(enacted with H.I.A.A. support). The experience of the Maryland commission was used as the basis for estimating the potential effect of such rate setting commissions.

Total local spending for institutional care and state and local government appropriations for institutional care are about the same as under present law, so that the incentives for the states to implement effective controls are similar to the situation in Maryland and Connecticut. The provisions for Federal review and reduction of payments to states which do not implement effective controls provide a practical mechanism for the Federal government to exert pressure on states in which institutional care costs are higher than average. The factors used in estimating cost of the H.I.A.A. proposal assume that the controls will have 85% of the maximum effect estimated to be feasible.

3/ This payment rate is estimated to result from the procedures specified in the bill. If the general policy assumptions stated in Section A had been followed, a rate of payment of 78.5% would have been assumed. Since physicians are allowed to collect any excess of charges over customary and prevailing charges, however, in either event private policies are assumed to base payment on a higher proportion of actual physician charges. Consequently, the overall costs of the proposal are not greatly changed by the assumed payment rate.

year to that for 1976. Thus in fiscal 1980, the applicable income limits would on the average be increased by the ratio of the C.P.I. for July 1979 to the C.P.I. for July 1976. It is assumed that the base for this calculation would be the C.P.I. for July 1977, since it is also assumed that the bill is not implemented until October 1977. This assumption results in adjustments to eligibility and cost sharing limits for the H.I.A.A. proposal consistent with those assumed for other proposals.

5. Operation of state individual plan pools

It is assumed in the cost estimates that each state establishes an independent pool, operated by a carrier, which issues its own insurance policies or certificates. The cost of operating centralized pools is estimated to be substantially less than for individual policies. Arrangements to pool losses on assigned risk policies would add further to the higher cost of assigned risk arrangements.

6. Premium rates in the Federal plan for the poor and uninsurable

The premium rates in the state plans for the poor and uninsurable are assumed to break even on average in fiscal 1980.

7. Premium rates in state individual plan pools

The premium rates in state individual plan pools are assumed to average 125% of the average premium rate in employee plans.

8. Participation rates in voluntary programs

a. Employee plans are assumed to be available to 83% of employees of private employers. Such programs are assumed to cover 30% of employees who would be eligible for the Federal program for the poor and uninsurable if not

covered by an employer plan.[4/]

9. Duplicate coverage

Seven percent of families in which both spouses are eligible for an employer plan are assumed to both enroll for family coverage. This is estimated to produce a 6% increase in services covered and a 3% increase in spending through these programs after the effect of the coordination of benefits provision.[5/]

10. Administration of income related cost sharing

An income determination must be made to determine the applicable premium rate and deductible for all persons enrolled in the state plans for the poor and uninsurable.[6/] It is assumed that policy years are set to be the same as the Federal fiscal year and that all persons eligible on the basis of income tax returns filed the preceding April are automatically enrolled and billed for any applicable premium. All persons enrolled are assumed to be required to file income tax returns the next April to be used to determine continued eligibility. The special eligibility provisions based on current income are assumed to be made on the basis of income declarations, with any difference in payment settled on the basis of the income tax return required in the succeeding year.

4/ A substantial increase in premium rates is required of employers to retain the present tax advantages of employer funded health insurance. Further, as a result of the legislation, equivalent tax benefits are available under private policies or association group policies (group policies covering all employees which are not sponsored by the employer). Further, lower cost sharing is available to low income employees with no increase in required contribution through the Federal plan for the poor and uninsurable --provided there is no employer coverage. Consequently, employers with a large proportion of low income employees are assumed to drop their health insurance coverage or convert it to an association group policy held by an employee association.

5/ The standard coordination of benefits provision prohibits payments under group insurance policies which exceed covered medical expenses.

6/ Although income determinations must also be made to determine the maximum contribution for low income employees, such maximum depends only on the wages paid by that employer so that the information is available at the source to make the appropriate determination at little cost.

All payments under the program are assumed to be made on the basis of the maximum deductible and family cost sharing ($100 and $1000 in fiscal 1978 respectively). Credits for lower cost sharing amounts are assumed to be made on the basis of separate applications, which are assumed to be assignable to providers.[7/]

11. Level of statistical data collected

a. Private policies

It is assumed that no data is collected under private policies other than that which is now required under present law in connection with disclosure of benefits to the Department of Labor.

b. State individual plan pools

It is assumed that no statistical data other than that typically accumulated by the larger health insurers is maintained for the state individual plan pools, other than that which is required to provide the necessary data related to assessments.

c. State plans for the poor and uninsurable are assumed to maintain a level of statistical data comparable to that of Medicare under the present law.

d. Pre-admission and certification and utilization review of all institutional admissions is assumed to require the same level of data as maintained for this purpose under present law. Such data would be used by all insurers offering qualified policies.

7/ Under the procedures specified above, it is not necessary to determine a patient's income in order to determine the applicable cost sharing. Providers that do not feel able to collect any cost sharing due may accept the income declared by a patient and accept assignment of any additional benefits payable as a result. The program would have to maintain a complete file on persons enrolled designating an income for each family. A high error rate is likely to occur with consequent difficulties in over and under payments, disputes, hearings and appeals, etc.

E. Special Policy Assumptions for the American Medical Association Proposal

1. Limitations on coverage

a. Routine diagnostic and treatment services by dentists are assumed to be available to all children under age 18.[1/]

b. Services of independent practitioners other than physicians and dentists are assumed to be covered only in institutional settings or through direct employment by a physician or an organization supervised by a physician.

c. Services provided by outpatient mental health facilities that are supervised by a physician are assumed to be covered under the proposal.

d. Services of family planning clinics operating under the supervision of a physician are assumed to be covered by the proposal.

2. Coverage of the aged

Supplemental insurance for Medicare beneficiaries is assumed to be furnished through an extension of services covered by the Medicare program. Specifically, the requirements for three days of hospitalization prior to payment for skilled nursing facility services and the limits on psychiatric hospital care are assumed to be eliminated from Part A of Medicare and the services covered under Part B are assumed to be extended to include routine and preventive services and emergency dental care.[2/]

1/ The bill provides for initial coverage of children under age 6 with this age limit increased by a year each year until all children under age 18 are covered. Thus only children under age 9 would be covered in the third year.

2/ The AMA proposal specifies that these benefits will be furnished through separate individual policies. Not only would such an arrangement result in excessive administrative cost but would be impractical to administer. Physician services covered under the proposal are those found not to be eligible for payment under Medicare. Further, the supplemental policy is prohibited by law from paying for services eligible for payment through Medicare. The carrier for the supplemental policy would thus have to obtain the claim processing information used by the Medicare carrier. The only practical arrangement is for the same carrier to administer both the basic and the supplemental coverages--as has been assumed in the estimates.

3. Reimbursement rates

a. Payments to institutions

The rate of increase in hospital spending after 1978 is assumed to be reduced by 0.5% per year through limits on hospital budgets. It is also assumed that the proportion of windfall revenues that are used to defer future rate increases is raised from 50% to 55%.[3/]

b. Payments to physicians and dentists

Reasonable charges as determined by insurers for qualified policies are assumed to be 95% of actual fees by physicians and dentists.[4/] Reasonable charges as determined by Medicare carriers are assumed to be unaffected by the proposal.

3/ The only additional requirement over present law in the proposal is that each state must designate an agency to review institutional budgets. The methods that may be used to review such budgets are restricted from those that could be used by state governments under present law, and the Federal government is prohibited from exercising any review. Further, the state agency is directed to use "acceptable methods of reimbursement" determined after consultation with providers and their organizations and must offer several different methods of reimbursements from which institutions may choose. Incentives to states to implement this authority effectively are strengthened by increasing the proportion of the funding of the cost of institutional care that is raised locally. State and local direct appropriations for institutional care would be reduced, however, as funding for low income persons is shifted to the Federal government. On balance, the bill appears to moderately increase incentives to control local institutional costs. States are directed to implement such controls. The provisions of the bill relating to the procedures to be followed, however, weaken current local options to control costs. In view of these circumstances, the factors used in estimating the cost of the AMA proposal assume that controls will have 10% of the maximum effect assumed to be feasible.

4/ Payments to physicians and dentists are assumed to be based on "usual and customary charges" as typically determined by Blue Shield plans. Usual charges are assumed to be whatever physicians currently state is their charge for any particular type of service. Customary charges are assumed to be based on the 90th percentile of the "usual charges" as determined at the beginning of any calendar year.

c. Other medical supplies

Payment for other medical services covered is assumed to be made on the basis of actual charges.

4. Assignments

a. It is assumed that physicians may accept assignments for qualified policy benefits without agreement to limit collections to usual and customary charges.[5/]

b. The present Medicare assignment policy is assumed to be continued.[6/]

5. Rates for qualified policies

a. Premium rates for qualified individual policies are assumed to vary with the amount of maximum family cost sharing provided under the policy. Individuals or families who become eligible for a lower (or higher) maximum cost sharing amount would thus have to obtain a revised policy, with a higher (or lower) rate.

b. The limit on the premium rate that can be charged for individual qualified policies or those covering groups with less than 100 employees is assumed to be based on the average cost of covering employees in groups larger than 100 under policies with the maximum cost sharing limit ($1,500 for an individual and $2,000 for a family), adjusted for the actuarial value of the lower cost sharing amount designated by a particular policy.

6. Open enrollment procedures and underwriting

Open enrollment procedures are assumed to be as specified in the general policy assumptions in Section A of this Appendix, rather than twice

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5/ This matter is not specifically covered in the proposal. Since usual and customary charges are estimated to be 95% of actual charges, the assumption has only a very small impact on the estimates.

6/ The Federal government is prohibited by the proposal from setting rates of payment for any class of medical personnel. Acceptance of assignments is voluntary, however, and physicians are able to charge and collect their full fees. Thus the Federal government would not appear to be setting compensation for physicians.

a year as specified in the bill. Insurers are assumed to be required to advertise the coverage widely and accept all applicants.

7. Formation of pools by carriers

All carriers are assumed to discharge their obligations to offer qualified policies without underwriting during open enrollment periods through participation in a state-wide insurance pool.

8. Underwriting of private policies

Each carrier is required to participate in at least one pool which offers qualified individual policies during open enrollment periods. Carriers are assumed to be permitted to offer other policies which include the qualified benefits but also include other benefits (e.g., prescription drugs, adult dental care, vision care services, etc.) and to be permitted to underwrite such coverage in competition with the open enrollment pools in which they participate.

Insurance carriers are assumed not to offer individual policies with maximum cost sharing amounts less than $1,000 per individual or family, except indirectly by participating in a pool which offers such coverage.[7/]

9. Assigned risk pools

Each state is assumed to establish an assigned risk arrangement to pool losses on policies for employers with more than 100 employees who have been refused insurance coverage by two or more carriers. Premium rates for assigned risk policies are assumed to be limited by state insurance departments.

7/ The administrative expense of underwriting, issuing, and revising policies for low income persons each year to reflect current income would be prohibitive. The effect of this policy assumption and the preceding is that all families currently covered under Medicaid and other low income persons eligible for reduced cost sharing will be covered through insurance pools. If this population group were assumed to be covered under individually issued insurance policies, the estimated administrative cost of the proposal would be very substantially higher.

10. Administration of income related premiums and cost sharing

a. Employee plan

All responsibility for obtaining a certificate of entitlement (i.e., Federal vouchers to pay for part of premiums for qualified policies) is assumed to be with employees eligible.[8/] Employers are assumed to routinely aid employees to apply each year for certificates.

Maximum cost sharing amounts are assumed to be determined on the basis of the lower of actual income in the previous year and estimated income for the current year. Each enrollee entitled to a premium subsidy is assumed to be issued an enrollment card designating the maximum cost sharing. Maximum cost sharing for other enrollees and for those with lower current year income is assumed to be based on an income declaration. Copies of the income declarations are assumed to be sent to Federal tax authorities and to the employer. All persons eligible for reduced cost sharing must file an income tax return (except those who have previously obtained a Federal certificate and have a higher income in the current year). Any income declaration questioned by an employer is assumed to be checked against the tax return.

b. Recipients of state or Federal cash assistance payments

Government agencies that establish income in order to determine eligibility for cash assistance payments are assumed to process certificates of entitlement and applications for coverage in the state-wide pools (assumed to be established by carriers to underwrite persons eligible for income related cost sharing) and issue eligibility cards which show the maximum cost sharing

8/ This policy assumption follows as a corollary to the more general principal that only government officials supervised by elected representatives may have access to the personal data necessary to determine income.

applicable. Any premium due (in addition to the Federal subsidy) is assumed to be withheld from cash payments.[9/]

c. Persons whose eligibility for unemployment insurance is expiring

State unemployment insurance officials are assumed to be responsible for processing applications for certificates of entitlement (for the full premium amount) and for coverage in the state-wide pools. Eligibility cards are assumed to be issued which show the maximum cost sharing applicable.

d. Other qualified policies

The principal responsibility for obtaining a certificate of entitlement to subsidize the premiums of others is assumed to lie with the individual or family eligible. Income determinations are assumed to be made by the Internal Revenue Service. This agency is also assumed to be responsible to check for fraud in the system of Federal subsidies.

11. Base for calculation of maximum cost sharing amounts and tax credits

The amounts used to determine the maximum amount of cost sharing per family and the amounts of tax liability used to determine the percentage of premium subsidized are assumed to be increased at the rate of increase of the C.P.I. after the initial year (assumed to be fiscal 1978).

12. Subsidy to employers

The estimates are based on a Federal subsidy to employers for 50% of the excess of the cost of a qualified policy over 3% of payroll.[10/]

9/ These policy assumptions ensure that all cash assistance recipients are enrolled, that income is established by public officials, and that duplicate processing is avoided as much as possible. They also ensure that the error rates in determining eligibility for public programs are carried over to the health insurance program, but this is inevitable. (The cost estimates in this report assume error rates in determining income similar to those found in current cash assistance programs.)

10/ According to the proposal such subsidy in the third year of the program would be 60%, falling to 50% in the fourth year and to 40% the fifth year. The level of subsidy thereafter would be based on a study by H.E.W.

13. Tax credits and certificates of entitlement

Certificates of entitlement and tax credits are both treated as a direct Federal payment for medical care.

14. Level of statistical data collected and processed

The administrative cost included in the estimates allows for the level of statistical data currently collected under Medicare, increased for the processing required to obtain profiles by practitioners and patients for PSRO review. Data for each PSRO area is assumed to be maintained by a lead carrier and shared with other insurers. Only summary statistics are assumed to be forwarded to H.E.W. for national compilation. Publication and research activities are assumed to be comparable to those currently carried out by the Social Security Administration.

F. Special Policy Assumptions for the American Hospital Association Proposal[1/]

1. Services covered by the proposal

a. The ultimate benefits to be offered by the proposal are assumed to be implemented in fiscal 1977 without a transition period. Thus comprehensive and catastrophic expense benefits are thus assumed to be available to all persons eligible for coverage. Similarly, all children under age 12 are assumed to be eligible for dental services (rather than the phasing in during the first five years of the program).

1/ The American Hospital Association proposal could involve a major departure from the current financing of medical care in the United States. The proposal would make extensive changes in the financial incentives of both providers and patients. This could in turn have a major impact on the medical services provided and the level of compensation received by health personnel. Medical services could become closely regulated by semi-independent state health care commissions, operating under general regulations and guidelines issued by a Federal department of health. These commissions would have comprehensive powers in regulating and evaluating health care within the state.

Payments to institutions would
health care commissions and health care corporations, hospitals, etc. Payments would be based on a form of rate of reutrn regulation similar to that used in setting rates for utility services in the U.S. Strong financial incentives are provided for regrouping health services into new organizations called health care corporations.

Further, the proposal tends to state general objectives rather than to provide detailed specifications. As a result there is a wide range of ways in which the bill could be implemented. The cost will depend on the policies actually followed and the level of compensation negotiated between health care corporations and providers.

In view of the extensiveness of the changes to be made, and the wide range of policies that could be adopted, realistic policy assumptions are very difficult to select. The resulting cost estimates cannot be regarded as forecasts of definite future events. They are rather illustrative of one of the many possible paths that might be followed should the American Hospital Association proposal be adopted.

b. Home health agency services are assumed to be covered if provided through agencies that meet the current standards of the Medicare program.

c. Approximately 40% of prescription drugs are assumed to be determined as required for the specific conditions requiring expensive therapy or especially important to public health.

d. Copayments are assumed to be waived for persons receiving treatment for alcoholism or drug abuse.

e. The schedule for well child visits and the periodic health examinations are assumed to be implemented as suggested in the bill.

f. For children with no diagnosed visual problem, the eye examinations are assumed to be provided through professionally supervised school screening programs. Children with a diagnosed visual problem are assumed to be examined annually by an optometrist or an ophthalmologist.

g. Payment for eyeglasses is assumed to be limited to the cost of a set of plain plastic frames and lenses dispensed under new prescriptions.

h. Payment for audiologists exams and hearing aids are assumed to be limited as noted in Section A of this Appendix.

i. The outpatient institutional care benefit is assumed to include all care provided by outpatient mental health facilities for persons suffering from alcoholism, drug abuse, or mental problems.

2. Reimbursement rates

a. The increase in hospital costs after 1978 is assumed to be reduced by 0.4% per year through limits on hospital and other institutional budgets. It is also assumed that the proportion of windfall revenues that are used to

defer rate increases is increased from 50% to 54%.[2/]

b. Payments to independent physicians are assumed to be made according to fee schedules set for the initial year, 1978, at the level of prevailing charges that would have been recognized by the Medicare program in fiscal 1978,[3/]

2/ Semi-autonomous state health care commissions would have sole responsibility for regulating and evaluating all aspects of medical care, including negotiating prospective payment rates to institutions. In determining rates, the law specifies that certain factors should be taken into consideration which would tend to increase payments to institutions as well as some that could result in reductions. For example, reimbursements must include price level depreciation, an allowance for working capital expenses, and an allowance for profit to investor-owned institutions or a similar contribution to the surplus of non-profit organizations. Further, the commissions are directed to ignore gifts, grants, etc. in determining prospective budgets. There is no Federal review of rates set at the state level or any provision for a reduction in Federal payment should officials of the Federal government find the rate of payments in any state to be high relative to other areas of the country.

In view of the broad responsibilities for the general level of health care that is vested in state health commissions it is very probable that the commissioners would be primarily interested in assuring the quality of care. The independence of the commissioners, once appointed, would tend to insulate the commissioners from day to day budget pressures to control costs. Further, although employers and employees would have to pay for a large proportion of local institutional care, state and local appropriations for hospital care would be virtually eliminated. Thus it appears likely that the semi-autonomous state commissions would become dominated by health professionals or other persons predominantly interested in the status of public health. For this reason, the cost control procedures were not estimated to have more than a minor impact, estimated as 7.5% of the maximum allowances.

3/ Prevailing fees as defined in the Medicare program are estimated to be approximately 80% of actual charges by physicians in 1980. (Reasonable charges, which involve both customary and prevailing limitations, are estimated to be 78.5% of actual charges by physicians in 1980.)

increased by an economic index to reflect current costs.[4/]

After 1978 increases are assumed to be limited to the economic index used to determine the maximum prevailing charges permitted under the Medicare program. The net income of physicians and other primary care professionals is assumed to be reduced by 2% per year after 1978 relative to the net income that would have been earned without any national health insurance proposal. The ratio of the average schedule fee to the fees that would be charged under present law is estimated to be 87% in fiscal 1980.

Physicians and other practitioners are assumed to be required to accept the fee schedule payments as full compensation for their services (in addition to the copayments specified in the bill).

c. Payments rates by health care corporations to providers are assumed to be at the same rates as occur for independent providers.

d. The increases in wages and salaries of all classes of health personnel other than physicians and dentists are assumed to increase at the same rate that would have occurred in the absence of any national health insurance plan.

3. Regulation of providers

For the purposes of preparing cost estimates, the regulatory effect of the health care commission is not estimated to have a substantial effect on the cost of services in fiscal 1980, other than the effects on reimbursement rates noted above.

4. Health care corporations

a. Health care corporations are assumed to be organized in all parts

4/ Prevailing charges in the Medicare program are derived from data that is a year and a half old. It is assumed that when physicians are required to accept the prevailing charges as full compensation for their services, that an adjustment will be made to eliminate the effect of this lag in data.

of the country and to enroll 15% of the population by fiscal 1980.

b. The cost per service to health care corporations is assumed to be the same as for care provided directly to consumers.

c. Health care corporations are assumed to be authorized to limit open enrollments to 10% of total membership. The remaining enrollees are assumed to be obtained by underwriting groups and by using underwriting procedures similar to those used in issuing private insurance policies.[5/]

d. All group practice plans are assumed to be eligible for the 10% subsidy to enrollees in health care corporations, provided they meet the requirements as to open enrollments.

e. Capitation rates charged by health care corporations are assumed to be allowed to vary by age, sex, and number of family members.[6/]

5. Participation by professional providers

Approximately 95% of physicians and dentists and virtually all other professional health personnel are assumed to participate in the program, either by joining a health care corporation or agreeing to accept the fees and co-payments offered under the insurance policies as full compensation.

5/ The average morbidity of persons joining group practice plans during open enrollment periods has been found to be 30% to 60% higher than the average morbidity of persons enrolled otherwise. If the proportion of total enrollment that enrolls during open enrollment periods exceeds 10%, a larger subsidy than the 10% provided to members of health care corporations would be required for these organizations to be viable. Alternatively it might have been assumed that there is an additional Federal or state subsidy to health care corporations to offset the effect of anti-selection.

6/ The bill restricts the variation in premium rates to the number of family members. If that policy were followed, health care corporations with facilities in areas where the average age of the population was low would have lower rates than those in areas where older residents resided. Competition would force health care corporations to avoid facilities in those areas where the average age of the population is high, would have ready access to facilities, etc. This would not appear to conform to the intent of the legislation. Consequently, it is assumed that health care corporations can vary their premium rates by age, sex, and location.

6. Establishment of state individual plans

Each state is assumed to establish an individual plan. In order to provide coverage at reasonable group rates, each state is also assumed to require a contribution to subsidize the individual plan from each qualified carrier in the state in proportion to their share of total premiums for health insurance. The subsidy is assumed to be sufficient for the average rate charged by the state individual plans to be 125% of the average premium rate in the employer plans.

7. Administration of income related premiums and cost sharing

All copayment amounts and income brackets to determine eligibility for health insurance are assumed to be increased at the rate of the C.P.I.

Tax credits to lower the effective rate paid by low income employees and by self employed persons with incomes less than $22,500 are assumed to be paid in connection with filing income taxes and based on the income reported. Income for purposes of establishing eligibility for the Federal program for the poor and aged and the expense limit for catastrophic insurance are assumed to be determined on the basis of current income as declared in income declarations. A small sample of such declarations is assumed to be checked by state tax authorities. Persons receiving catastrophic benefits are assumed to file income tax returns for the year in which benefits were received to settle any differences between actual and declared income. Tax refunds based on such settlements are assumed to be assignable to providers.

8. Level of statistical data collected and processed

The administrative cost included in the estimates allows for the level of statistical data currently collected under Medicare, increased by the processing required to obtain profiles by practitioners and patients for PSRO review. Data for each PSRO area is assumed to be maintained by a lead

carrier and shared with other insurers. Only summary statistics would be forwarded to H.E.W. for national compilation. Publication and research activities would be comparable to those carried out at present by the Social Security Administration.

G. Special Policy Assumptions for the Health Security Proposal[1/]

1. Services covered by the proposal

a. Dental care is assumed to be provided to all persons under age 25. The bill specifies that the entire population will be phased into participation over a number of years, or sooner at the discretion of the Health Security Board. The estimates thus do not fully reflect the cost of all services that would ultimately be provided by the proposal.

b. The Health Security Board may cover any drug found to be "costly" to those who needed to use that drug on a continuing basis. It is assumed that all drugs for which the average cost for those using it averages $50 or more per year will be included. Approximately 25% of legend drugs and all insulin would be paid for through the program.

All drugs may be covered if furnished to persons enrolled in HMO's or foundation plans. The cost estimates are based on the assumption that

1/ The Health Security bill could involve the greatest departure of any bill analyzed in this report from the current practice in financing of medical care in the United States. The proposal would make extensive changes in the financial incentives of both providers and patients. This in turn could have a major impact on the nature of medical services provided and the level of compensation received by health personnel. Medical services could become closely regulated by the Federal government through the reimbursement mechanism. Payment rates in practice would be negotiated between the government and health institutions, independent professionals, and their organizations--and between the latter and their employees and organizations. The present system of financing medical services in the U.S. would largely be replaced. An additional problem in estimating the cost of the proposal is that the bill tends to state general objectives rather than to provide detailed specifications. As a result, there is a wide range of ways in which the bill could be implemented. The cost will depend on the policies actually followed and the level of compensation negotiated with organizations of medical personnel and their institutions. Further, some provisions of the bill are in direct conflict with others. A policy assumption must be adopted in such situations as to which provision will prevail. For these reasons, realistic policy assumptions are very difficult to select. The resulting cost estimates therefore cannot be regarded as forecasts of definite future events. They are rather illustrative of one of the many possible paths that might be followed should the Health Security proposal be adopted.

drugs furnished through group prepayment practice plans and other health maintenance organizations are fully covered.

c. Payment for eye exams is assumed to be limited to one exam per year for persons under age 21 and to one exam every two years for older persons. For children with no diagnosed visual problem, the examinations are assumed to be provided through professionally supervised school screening programs.

d. Payment for eyeglasses is assumed to be limited to purchase of an initial set of plain frames and for lenses dispensed under a new prescription. Payment for contact lenses is assumed to be made only in connection with ophthalmic surgery.

e. All skilled nursing home care meeting the definitions of the Medicare program is assumed to be covered.[2/]

2. Spending under present law for covered services

Spending under present law for the services covered by the Health Security proposal are summarized in Table A.1. All of these services are transferred to the Health Security program except those funded through workmen's compensation, provided by Federal facilities, and those excluded by regulation of non-participating providers.

3. Effect of limiting budget to designated sources of income

The budgeting process is assumed to reduce the rate of increase in the cost of the program after the initial year. The budget is assumed to be particularly effective in controlling the rate of construction of new

2/ The Health Security Board may waive the 120-day limit for skilled nursing care facilities. It is assumed that it will do so based on similar decisions made in the implementation of Medicare.

TABLE A.1 ESTIMATED SPENDING UNDER PRESENT LAW IN FISCAL 1980 FOR SERVICES COVERED BY HEALTH SECURITY PROGRAM
(Billions of Fiscal 1976 Dollars)

	INPATIENT INSTITUTIONAL			AMBULATORY INSTITUTIONAL			PROFESSIONAL AND OTHER SERVICES						
	General Hospital	Long Term & Psych.	Nursing Homes	General Hospital	Mental Health	Home Health	Physicians	Dentists	Other Professionals	Drugs & Sundries	Other Services	Administration & Planning	Total
TOTAL U.S.	53,962	2,353	2,329	8,882	3,298	771	32,484	4,396	5,442	2,674	4,278	9,383	130,252
PRIVATE SECTOR	27,019	848	885	5,924	860	319	25,173	4,061	4,220	2,479	959	7,324	80,071
Out-of-pocket	2,823	149	710	2,581	269	235	11,044	3,251	3,832	2,157	241		27,292
Through insurance:													
Individual policies	3,024	33	76	355		4	1,216		37	6		2,677	7,428
Employee contributions	5,074	162	22	702	67	10	3,056	206	66	79	10	971	10,425
Employer contributions	14,822	472	63	2,051	198	28	8,930	604	193	229	28	2,838	30,456
Workmen's compensation & TDI	1,010	26		174			913		92	8	14	558	2,795
Other private	266	6	14	61	326	42	14				666	280	1,675
PUBLIC SECTOR	26,943	1,505	1,444	2,958	2,438	452	7,311	335	1,222	195	3,319	2,059	50,181
Government insurance:	336	8		493		35	1,707		31	2	12	352	2,976
Workmen's compensation & TDI	336	8		57			304		30	2	4	186	927
Medicare premiums				436		35	1,403		1		8	166	2,049
Federal taxpayers	24,029	971	1,015	1,900	803	417	4,891	204	692	110	1,707	1,506	38,245
Through third parties:													
Medicare	16,488	146	435	1,376	23	417	3,618	32	40		10	1,075	23,660
Medicaid	2,837	316	546	364	29		840	155	579	103	12	236	6,017
Other programs	674	8	34	160	33		433	17	73	7	176	85	1,700
Federal facilities & Direct	4,030	501			718						1,509	110	6,368
State and local taxpayers	2,578	526	429	565	1,635		713	131	499	83	1,600	201	8,960
Through third parties:													
Medicaid	2,229	250	429	286	28		659	121	456	82	10	185	4,735
Other programs				80			54	10	43	1	170	16	374
Direct payments	349	276		199	1,607						1,420		3,851

facilities and the rate of increase in professional fees. It is assumed not to be effective in controlling the rate of increase in take-home pay of medical personnel other than physicians and dentists or in the extent of medical services provided to the public.

4. Level of income to the Health Security program

It is assumed that the financing provisions are revised to provide income adequate to support the program, including such additional amounts as are necessary to build and maintain a trust fund equal to one year's disbursements.

5. Reimbursement rates

a. During the first year of the program, all health workers are assumed to earn the same income as they would have earned under present law for the same volume of services. To the extent that there are not enough trained specialists available at these rates, however, increases in compensation are assumed to be required to attract additional manpower to that specialty field.[3/]

3/ The Health Security proposal entitiles the entire population of the United States to a broad range of medical services for the prevention, diagnosis and treatment of accidents and disease. In order to furnish the services promised, the Board would have to obtain the services of most health institutions and workers, including nearly all physicians. If the level of compensation offered by the board to any class of providers were significantly lower than could be earned under present law for the same level of services, it would appear highly unlikely that a majority of those affected would participate. It is thus assumed in the estimates that in the initial year of the program, the fees paid to professional providers would produce the same level of compensation that would have been earned under present law, after considering any windfall income that occurred as a result of payment of bad debts, full payment for Medicare and Medicaid services, etc. Similarly, it is assumed that the program will pay the full costs of institutions, including their capital related costs, and that budget restrictions do not result in any significant decreases in the wages of employees or the number employed. Further, the wage rates for any types of health technician in short supply are assumed to be raised enough to attract an adequate number.

b. Institutions are assumed to be paid for their full cost of operation in fiscal 1978. The increase in hospital costs after fiscal 1978 is assumed to be reduced by 2.5% per year through limits on hospital and other institutional budgets. Similarly, the proportion of windfall increases in revenues that are used to defer future rate increases is assumed to be raised from 50% to 75%.

c. Payments to independent physicians are assumed to be made under a fee schedule set for the initial year, fiscal 1978, at the level of prevailing charges that would have been recognized by the Medicare Program,[4/] increased to reflect current costs (rather than those 1½ years earlier)[5/] by the economic index specified in the Social Security Act.[6/] At this level of fees (estimated to be 91% of average actual charges), windfall increases in income are estimated to be approximately equal to the excess of charges collected over the allowable fees.

After fiscal 1978 increases in professional fees are assumed to be limited by an economic index similar to that used in Medicare. The net income of physicians and other primary care professionals is assumed to be reduced by 2% per year after 1978 relative to the net income that would have been earned without any national health insurance proposal (as would be the case for fees recognized by the Medicare program). The ratio of the average allowable fee under the program to the fees that would be charged under present law is estimated to be 87% in fiscal 1980.

4/ Prevailing fees as defined in the Medicare program are estimated (under present law) to be approximately 80% of actual charges by physicians in 1980. (Reasonable charges, which involve both customary and prevailing limitations, are estimated to be 78.5% of actual charges by physicians in 1980.)

5/ The Medicare program bases reimbursement rates on data that is on the average a year and half old. It is assumed that when physicians are required to accept the prevailing charges as full compensation for their services, that an adjustment will be made to eliminate the effect of this lag.

6/ This index is now used to determine the maximum increase that is allowed in prevailing charges as recognized by the Medicare program.

d. The earnings of health institutional personnel are estimated to increase after fiscal 1978 at a rate 1% higher than would occur under present law if hospital budgets were reduced by 2.5% per year.[7/]

6. Regulation of providers

The requirements for board certification of specialists and concurring recommendations for surgery are assumed to reduce surgical fees and hospital costs by $.6 billion in fiscal 1980 (5% of covered surgical expenses).

Services of specialists and facilities excluded from the program due to failure to meet standards of the Health Security Board are assumed to be offset by increases in services provided by other providers.

7. Growth in home health agency services

Home health agencies are assumed to expand rapidly in response to a sharply increased demand for their services. It is estimated that currently only about one-third of this demand is met and that less than one-half of the remainder is paid for through insurance programs. The estimates include only that portion of the increase assumed to take place by 1980.

8. Practitioners not currently included in estimates of national health spending

The Health Security bill permits inclusion in institutional services of a number of types of practitioners whose services are not in general included in the estimates of health expenditures; e.g., health social workers, psychiatric social workers, psychiatric nurses, visiting nurse associates, homemakers, nutritionists, and health educators.

6/ The Health Security proposal creates a situation in which additional organization of health workers and collective bargaining with institutions and the Health Security Board could be expected. All wage or fee increases must ultimately be paid for by Federal taxpayers. Strikes by hospital and other medical personnel on a city-wide or regional basis would make such wage increases particularly difficult to control.

It is assumed in the estimates that these services are made available only through home health agencies, prepaid group practice plans and foundation plans. It is further assumed that expenditures for these services are limited to a relatively small proportion of the overall agency budgets.

9. Participation of professional providers

Approximately 95% of physicians and dentists and virtually all other professional health personnel are assumed to participate in the program.

10. Relation to other health programs

a. All covered services paid by Federal, state or local government through third parties are assumed to be entirely replaced by the Health Security program.

b. Covered services (those that are not for custodial care) by Veterans Administration and Public Health Service facilities are assumed to be reduced by one-third. (Appropriations for these facilites are assumed to be reduced by only half of the reduction in services furnished.)

c. Services provided through the military service facilities are assumed to continue at the same level that would have been the case under present law.

d. Budgets of outpatient mental health facilities are assumed to be absorbed into the Health Security program.

e. Half of state and local government spending for public health and school health programs is assumed to be absorbed into the Health Security program. 8/

f. Three-quarters of services furnished by employer health programs are assumed to be transferred to the Health Security program.

8/ If the Health Security Board refused to pay state and local governments for the cost of such services, the latter could transfer all preventive diagnostic and treatment services to independent non-profit agencies which would be eligible as providers. The effect would be the same.

APPENDIX B

ESTIMATES OF HEALTH SPENDING USED IN THIS REPORT COMPARED TO SOCIAL SECURITY ADMINISTRATION NATIONAL HEALTH EXPENDITURE ESTIMATES.

The base for the projections of spending for personal health services in this report is the national health expenditure series compiled by the Office of Research and Statistics (O.R.S.) of the Social Security Administration.[1/] Several modifications were made to the O.R.S. classifications of services and sources of funds to obtain a base more appropriate to estimating the cost of national health insurance proposals.[2/] For example, the O.R.S. estimates are based on hospital revenues (including those for items not reimbursed by insurance, (e.g. hospital gift shops and cafeterias); those in this report are based on hospital expenditures for patient services that would be paid for under an insurance contract.

In addition, there was a concern that this report not understate the potential costs of the various proposals. In general, the O.R.S. series reports spending for health services that can be adequately documented. While the O.R.S. estimates are the best available guide to national spending for health services, the absence of adequate data for some items and the existence of evidence that actual spending may be higher than reported by some of the sources of data used - raises the possibility that certain items are substantially underestimated.

1/ Mueller, Gibson: National Health Expenditures, Fiscal Year 1975; Research and Statistics Note No. 20-1975. (November 21, 1975)

2/ A discussion of the differences between the conceptual basis of the O.R.S. series and that needed for National Health Insurance estimates appears in Section D of Chapter I.

A national health insurance program, however, will report all spending for reimbursable services that actually exists, not just that which can be documented with enough objectivity to be included in national accounts such as compiled by O.R.S. Consequently, in order to prepare unbiassed estimates of the cost of National Health Insurance plans, allowances must be made to include any spending for which the balance of evidence is that it exists, even though there is not adequate data to establish the amount with any precision. The principal adjustments made are discussed below.

1. The O.R.S. estimates of non-Federal hospital revenues are based on the American Hospital Association's data for all hospitals in hospital fiscal year 1971,[3/] increased by the rate of increase in revenues of those hospitals included in the "hospital indicators" sample. The estimates in this report are based on the American Hospital Association data for expenditures during the hospital fiscal year 1974,[4/] less that part of the hospital costs devoted to activities not related to patient care and from which hospitals derive offsetting revenues (e.g., gift shop, public cafeteria, etc.). The data were projected to calendar 1975 according to the increase in spending for those hospitals in the "hospital indicators" sample, and to

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3/ Hospital Statistics, 1971 data from the American Hospital Association Annual Survey.

4/ Hospital Statistics, 1974 data from the American Hospital Association Annual Survey.

fiscal 1976 according to the general methodology followed to project future hospital spending.5/

2. The estimates for all hospitals include allowances for depreciation, maintaining working capital, and capital related expenses.6/

5/ A principal use of the O.R.S. series has been as a measure of the rate of increase in national spending for health. The data reported by the A.H.A. for all hospitals has tended to move somewhat erratically, apparently distorting the trend reported from year to year. Further, the data is known to contain a number of documented inconsistences, omissions, and other errors. The data from the hospitals included in the hospital indicators sample are a much more reliable guide as to the underlying trend in hospital revenues, and are used by O.R.S.

The overall rate of spending reported by all hospitals, however, has increased at a more rapid rate than that for those in the hospital indicators sample. This increase probably includes the continuing effect of Medicare reporting and auditing requirements in upgrading hospital operating data. Thus, while the rate of increase may be distorted by this bias, the overall level of spending reported in 1974 is more likely to be accurate than that for 1971, and hence is used as a basis for the estimates in this report.

6/ Charges by hospitals and other institutions contain allowances for depreciation. To the extent that such allowances are used to finance construction, the O.R.S. methodology results in double counting of capital costs. (When the O.R.S. methodology was devised, hospitals and other medical facilities obtained most of their capital funds for facility construction from sources other than patient revenues. Thus the duplication from including construction spending in addition to hospital revenues was relatively small. With the rapid growth of insurance and government insurance programs which include allowances for depreciation in reimbursements, however, this duplication has grown to a substantial amount. The hospital spending figures in this report are based on patient care costs, including depreciation allowances, plus a small allowance for growth in working capital (approximately equal to the current excess of accrued income over expenses). The implicit assumption is that Federal, state, and local governments will continue to finance a similar proportion of hospital construction in the future, unless a national health insurance proposal explicitly departs from this pattern.)

3. Estimates for outpatient mental health facilities (included in hospitals in the O.R.S. series) include allowances for all patient related expenses. The O.R.S. series include only direct government payments (for which documentation exists).

4. Physician services include an allownace for misclassification and underreporting in I.R.S. statistics and exclude spending for eyeglasses included in ophthalmologists' gross incomes.

5. Other professional services are adjusted to include spending in nonprofit organizations other than those visiting nurse associations who report spending to the Visiting Nurse Association, allowances for misclassification and underreporting in I.R.S. statistics, and an independent estimate of vision care services by optometrists.[7/]

6. The estimate of spending for drugs and sundries is based on information gathered by the Pharmaceutical Manufacturers Association and similar associations of the manufacturers of sundries. The O.R.S. estimates are based on Department of Commerce figures.

7. The estimate of eyeglasses and appliances is based on independent estimates of the total numbers of corrective lenses dispensed and appliances purchased in the U.S.[7/] O.R.S. estimates are based on Department of Commerce data.

8. The estimate of spending in nursing homes includes amounts received by intermediate care facilities from private sources and income

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7/ Trapnell, Gordon R., "The Impact of National Health Insurance on the Use and Spending for Sight Correction Services," January 1976, Optical Manufacturers Association, Washington, D. C.

maintenance programs in addition to funds received from the Medicaid program.8/

9. Expenses for prepayment and administration include all spending by health insurers for administrative expenses and spending by the Department of H.E.W. for administration and planning related to personal health services.9/

10. "Other services" include only employer spending for health services, spending in birth control clinics, and spending in government outpatient facilities.

The differences between the Social Security Administration estimates of national health spending and those used in this report as the basis for national health insurance estimates are outlined in Table B.1.

8/ In many states patients in intermediate care facilities are treated as medically needy who are eligible for coverage under Medicaid when their medical expenses (i.e., the cost of the nursing care) exceed their monthly income (often from a government income maintenance program). The Office of Research and Statistics figures for intermediate care facilities include only spending through the Medicaid program. The estimates in this report include amounts paid from private sources or from income maintenance programs (e.g., welfare, Social Security, Supplemental Security Income, etc.).

9/ The O.R.S. series includes estimates of the net cost of insurance. This amount includes sums that are used to increase reserves for guaranteed renewable level premium policies (which are of the nature of savings to help pay future premiums), excludes expenses transferred to life insurance premiums due to regulations in certain states, and is reduced by any loss incurred by health insurance companies on health business, which have been considerable in recent years. (Due primarily to the requirements of the New York State Insurance Department for companies doing any business in New York State, most life insurance companies charge higher group life insurance rates than needed and lower group health insurance rates than needed. The deficit shown in the health line is thus partially artificial.)

TABLE B.1 COMPARISON OF ESTIMATES OF NATIONAL HEALTH SPENDING IN FISCAL YEAR 1975
(Millions of 1975 Dollars)

	ORS-Published[1/]	NHI Basis[2/]
PERSONAL HEALTH SERVICES:	111,250	121,240
Hospital Care and OMHF's	46,600	48,970
Physicians' Services	22,100	23,000
Dentists' Services	7,500	7,690
Other Professional Services	2,100	3,310
Drugs and Sundries	10,600	13,190
Eyeglasses and Appliances	2,300	2,550
Nursing Homes	9,000	9,350
Prepayment and Administration	4,593	6,830
Public Health	3,457	3,460
Other Services	3,000	2,890
RESEARCH AND CONSTRUCTION	7,250	2,790
Research	2,750	2,790
Construction	4,500	0
TOTAL HEALTH SERVICES	118,500	124,030

1/ Mueller, Gibson: National Health Expenditures, Fiscal Year 1975; Research and Statistics Note No. 20-1975
2/ According to definitions of services and sources of data used as a basis for cost estimates in this report.

APPENDIX C

PROJECTION OF FUTURE SPENDING FOR PERSONAL HEALTH SERVICES[1/]

The principal equations used to project future spending for personal health services and the data used to set the parameters of the equations are summarized below.

1. Inpatient hospital services

Spending for inpatient hospital services was projected as the sum of outlays for labor and non-labor factors (including capital related costs) as follows:

For labor:

$$(C.1) \quad H_p = P\,b\,n\,(\bar{w}_h / \bar{w})\;\bar{w}\,(1 + p_m)$$

Where: H_p is spending for personnel (including fringe benefits) used to deliver inpatient hospital services

P is the population of the U.S., weighted for the variation in demand for hospital services by age

b is a measure of hospital inpatient capacity per capita (taken as the number of beds per capita)

n is the number of hospital inpatient personnel per unit of capacity

$\bar{w}_h$ is the average wages and fringe benefits of hospital personnel

$\bar{w}$ is the average wage of all workers (B.L.S. average hourly wage)

p_m = malpractice premium per unit of service

For non-labor factors:

$$(C.2) \quad H_n = P\,b\,f - (\bar{p}_h / \bar{p})\;\bar{p}\,(1 + p_m)$$

1/ For a general discussion of the type of assumptions underlying these projections, see: Gordon R. Trapnell, "Actuarial Estimate of the Impact of the Economic Stabilization Program on Spending for Health Services in Fiscal Years 1975 and 1976."

Actuarial Appendix, "1973 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund" (and subsequent reports).

Actuarial Appendix, "1973 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund" (and subsequent reports).

Where: H_n is spending for non-personnel factors used to deliver inpatient hospital services

f is the real non-labor factors and capital costs used per unit of capacity

p_h is the average price of hospital non-labor inputs

$\bar{p}$ is the average price of all goods and services (C.P.I.)

For community short term hospitals, the equations, except for the demand-weighted population and malpractice premium adjustment, were fitted to data from the American Hospital Association hospital indicators series, supplemented by some additional data from A.H.A. and Medicare cost reports. In the projections, the level of new (real) factors added each year was assumed to be constant, rather than compounding in proportion to the size of hospital investment and scale of operation. An adjustment was made in the projections to allow for the effect of the current financial position of certain city governments on spending in municipal hospitals. Separate projections were made for community short term general hospitals, non-Federal long term hospitals, private psychiatric hospitals, state and local psychiatric hospitals, territorial hospitals and Federal hospitals. Data for non community hospitals in the base period was obtained primarily from the A.H.A. annual compilation of total hospital spending.[2/] Data for Federal facilities was obtained from data used to compile the Budget of the U.S. Not all elements of the equations were needed in each case.

2. Outpatient hospital services (in community short term general hospitals).

Spending for outpatient hospital services was also projected as the sum of outlays for labor and non-labor factors.

For labor:

(C.3) $$O_p = P\ v\ n\ (w_h / \bar{w})\ \bar{w}\ (1 + p_m)$$

2/ Hospital Statistics, 1975 Edition, American Hospital Association

Where: v is the number of outpatient visits per capita (if age-sex composition of population were constant).

n is the number of hospital outpatient personel per visit and other symbols have the same meaning as in the case of inpatient services.

For non-labor factors:

$$(C.4) \quad O_n = P\,v\,f\,(p_h / \bar{p})\,\bar{p}\,(1 + p_m)$$

Where: All symbols are as defined previously, except that f is defined in terms of real non-labor inputs per visit.

3. Skilled nursing and intermediate care facilities

Spending for services of skilled nursing and intermediate care facilities was projected as the sum of the cost of labor and non-labor inputs (including capital related costs), using the equations:

$$(C.5) \quad N_p = P_{65}\,d\,n\,(\bar{w}_n / w)\,\bar{w}\,(1 + p_m)$$

$$(C.6) \quad N_n = P_{65}\,d\,f\,(\bar{p}_n / \bar{p})\,\bar{p}\,(1 + p_m)$$

Where: N_p is spending for personnel in skilled nursing(intermediate care) facilities

N_n is spending for other factor costs and capital costs

P_{65} is the population over age 65

d is the number of days of service (all ages) divided by the population over age 65

n is the number of personnel per day of care

f is the real non labor factor and capital costs

$\bar{w}_n$ is the average wage of personnel

$\bar{p}_n$ is the average price of non labor inputs

Other symbols have same meaning as before.

Separate estimates were made for skilled nursing facilities and intermediate care facilities. Appropriate time series of data for the components of equations

(C.5) and (C.6) were drived from N.C.H.S. surveys,[3/] Monthly Vital Statistics Reports,[4/] the Medicare program and the Medicaid program. Adjustments were made for the conversion of facilities from one class to another following regulatory changes of H.E.W., especially those relating to quality of care and reimbursement basis. (H.E.W. regulations created intermediate care facilities.)

4. Home health agencies

Spending for services of home health agencies was assumed to grow at the rate of services for aged and disabled persons eligible for Medicare.[5/]

5. Outpatient mental health facilities

Spending for services of outpatient mental health facilities was estimated primarily by relating spending to projected revenues assumed to be available for Federal, state, and local governments. Federal funding was assumed to grow at the rate of total Federal spending for health. State and local spending was assumed to grow at half the rate of Federal funding.

6. Physicians and Dentists

Spending for services of physicians and dentists was projected (separately) by the following equation:

$$(C.7) \quad D = P\, v\, m\, (\bar{p}_p / \bar{w})\, \bar{w}\, (1 + p_m)$$

Where: D is spending for physician (dentist) services

v is the number of visits per capita (with a constant age-sex composition of population)

m is the rate of increase in spending for physician services due to the mix of services (by complexity and specialty) and the number of items charged separately per visit

$\bar{p}_p$ is the average physician fee

Other symbols defined as before

3/ Series 14, Number 12; Series 12, Numbers 21 and 23; and unpublished data from 1973-74 surveys.

4/ Volume 23, Number 6

5/ Actuarial Appendix; 1976 Annual Report of the Board of Trustees of the Federal Hospital Insurance Program.

7. Other professional services

Spending for services of other professionals (e.g. optometrists, opticians, private nurses, chiropractors, etc.) were projected by the following equation:

(C.8) $S_i = P\, n\, (\bar{i} / \bar{w})\, \bar{w}$

Where: S_i is spending for the class of professionals concerned

n is the number of full time licensed practitioners

$\bar{i}$ is the average income of the practitioners concerned

$\bar{w}$ is the average wage of all employed persons.

8. Prescriptions, over the counter drugs, and sundries

Spending for prescriptions, over the counter drugs, and sundries was projected by the following equation:

(C.9) $D = P\, d\, (\bar{p}_d / \bar{p})\, \bar{p}$

Where: D is spending for prescriptions ("OTC" drugs or sundries)

d is average number of prescriptions

$\bar{p}_d$ is the average price of a prescription

$\bar{p}$ is average price of all goods and services (C.P.I.)

P is a demand adjusted population (for use of drugs)

9. Administration and planning

Administrative expenses of insurance programs were divided into those that vary primarily with premiums (e.g. premium taxes, risk charges, sales commissions, etc.) and those that vary with the volume of processing required (e.g. collection of premiums, processing of claims, etc.). The per premium expenses were projected to be the same percentage of benefits paid through insurance as in 1974. The other expenses were projected to grow with the volume of real services insured, adjusted for the projected change in use of services insured.

Expenses in connection with solicitation of charitable contributions were projected to be the same percentage of benefits as estimated for fiscal 1976.

Planning and regulatory expenses of the Federal government were projected to grow at the same compound real rate as during the 1970-1976 fiscal years.

10. Public health expenditures

Spending for public health services, school health programs, and for the general health of employees by employers were projected by the compound increases experienced during fiscal years 1970-1975. Separate projections were made for Federal, state and local government, and private spending.

APPENDIX D

ESTIMATES IN TERMS OF 1980 DOLLARS

The estimates in this report were calculated in terms of real (fiscal 1976) dollars. To obtain estimates of the spending that would actually take place, all estimates in the report must be increased by the ratio of the C.P.I. in fiscal 1980 to such average for fiscal 1976 (a period of 4½ years). This appendix restates the major results in terms of 1980 dollars, using the official estimates of the Council of Economic Advisers. To assist the readers, all estimates are shown in the same format, with the same table numbers as used in the report.

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TABLE 2.2D PERSONAL HEALTH SPENDING AND PERCENTAGE DISTRIBUTION IN FISCAL 1976-80 BY TYPE OF SERVICE

	MILLIONS OF 1980 DOLLARS[1/]					% of Personal Health Spending				
	1976	1977	1978	1979	1980	1976	1977	1978	1979	1980
TOTAL	140,385	162,610	182,080	202,740	223,460	100.0	100.0	100.0	100.0	100.0
INPATIENT INSTITUTIONAL SERVICES	59,660	69,700	78,570	88,340	98,290	42.5	42.9	43.2	43.6	44.0
General Hospital	35,840	42,270	47,820	54,050	60,380	25.5	26.0	26.2	26.7	27.0
General Hospital Psychiatric	1,840	2,170	2,450	2,770	3,090	1.3	1.3	1.4	1.4	1.4
Private Psychiatric	470	540	630	710	810	.3	.3	.4	.4	.4
State & Local Psychiatric	4,080	4,400	4,700	4,990	5,260	2.9	2.7	2.6	2.5	2.4
Long Term Hospital	1,150	1,250	1,330	1,410	1,490	.8	.8	.8	.7	.7
Federal Hospital	4,960	5,530	6,040	6,570	7,090	3.6	3.4	3.3	3.2	3.2
Skilled Nursing Facilities	7,820	9,160	10,450	11,950	13,500	5.6	5.7	5.7	5.9	6.0
Intermediate Care Facilities	3,500	4,380	5,150	5,890	6,670	2.5	2.7	2.8	2.8	2.9
PROFESSIONAL & OUTPATIENT SERVICES	55,100	64,280	72,190	80,300	88,360	39.2	39.5	39.6	39.6	39.5
Hospitals	5,460	6,800	8,090	9,510	11,020	3.9	4.2	4.4	4.7	4.9
Mental Health Facilities	2,830	3,160	3,450	3,780	4,090	2.0	1.9	1.9	1.9	1.8
Home Health Agencies	490	650	760	850	960	.3	.4	.4	.4	.4
Physicians	26,900	31,670	35,600	39,460	43,100	19.2	19.5	19.6	19.5	19.3
Dentists	8,740	9,990	11,120	12,320	13,540	6.2	6.1	6.1	6.1	6.1
Public Health	3,980	4,500	4,940	5,360	5,800	2.8	2.8	2.7	2.6	2.6
Other Professionals & Facilities	6,700	7,510	8,230	9,020	9,850	4.8	4.6	4.5	4.4	4.4
OTHER HEALTH SERVICES & SUPPLIES	17,630	19,340	20,900	22,480	24,010	12.6	11.9	11.5	11.1	10.8
Eyeglasses & Appliances	2,900	3,260	3,590	3,930	4,280	2.1	2.0	2.0	2.0	1.9
Prescriptions	9,520	10,400	11,200	11,990	12,760	6.8	6.4	6.1	5.9	5.7
OTC Drugs & Sundries	5,210	5,680	6,110	6,560	6,970	3.7	3.5	3.4	3.2	3.2
ADMINISTRATION & PLANNING	7,995	9,290	10,420	11,620	12,800	5.7	5.7	5.7	5.7	5.7

1/ Assumes rate of increase in C.P.I. projected by the Council of Economic Advisors.

TABLE 2.3D PERSONAL HEALTH SPENDING AND PERCENTAGE DISTRIBUTION IN FISCAL 1976-80 BY CHANNEL OF PAYMENT

	MILLIONS OF 1980 DOLLARS					% of Personal Health Spending				
	1976	1977	1978	1979	1980	1976	1977	1978	1979	1980
TOTAL U.S.	140,385	162,610	182,080	202,740	223,460	100.0	100.0	100.0	100.0	100.0
PRIVATE SECTOR	87,755	101,370	113,250	126,150	139,030	62.5	62.3	62.2	62.2	62.2
Out of pocket payments	46,660	52,870	58,250	64,200	70,060	33.2	32.5	32.0	31.6	31.3
Through insurance:										
Individual policies	5,750	6,770	7,650	8,620	9,590	4.1	4.2	4.2	4.2	4.2
Employee contributions	8,605	10,020	11,210	12,410	13,580	6.1	6.2	6.2	6.2	6.1
Employer contributions	22,680	27,080	31,030	35,320	39,700	16.2	16.6	17.0	17.4	17.8
Workmen's compensation & TDI	2,110	2,490	2,810	3,150	3,500	1.5	1.5	1.6	1.6	1.6
Philanthropy	1,170	1,260	1,340	1,420	1,500	.8	.8	.7	.7	.7
Employer health services	780	880	960	1,030	1,100	.6	.5	.5	.5	.5
PUBLIC SECTOR	52,630	61,240	68,830	76,590	84,430	37.5	37.7	37.8	37.8	37.8
Government insurance:	2,630	2,940	3,200	3,480	3,730	1.9	1.8	1.8	1.7	1.7
Workmen's compensation & TDI	710	820	930	1,060	1,170	.5	.5	.5	.5	.5
Medicare premiums	1,920	2,120	2,270	2,420	2,560	1.4	1.3	1.3	1.2	1.2
Federal taxpayers	35,130	41,580	47,330	53,230	59,270	25.0	25.6	26.0	26.3	26.6
Through third parties:										
Medicare	15,870	19,470	22,640	26,000	29,430	11.3	12.0	12.4	12.9	13.2
Medicaid	8,420	9,840	11,120	12,390	13,660	6.0	6.1	6.1	6.2	6.2
Maternal & child health	300	330	370	400	430	.2	.2	.2	.2	.2
Vocational rehabilitation	200	240	260	280	310	.1	.1	.1	.1	.1
Veterans Administration	240	280	320	350	380	.2	.2	.2	.2	.2
Defense Department	650	740	810	890	970	.5	.5	.4	.4	.4
Other	700	770	840	890	950	.5	.5	.5	.4	.4
Direct payments:										
Veterans Administration	3,450	3,830	4,200	4,570	4,940	2.4	2.3	2.3	2.2	2.2
Defense Department	2,490	2,770	3,020	3,290	3,560	1.8	1.7	1.7	1.6	1.6
Other	2,810	3,310	3,750	4,170	4,640	2.0	2.0	2.1	2.1	2.1
State & local taxpayers	14,870	16,720	18,300	19,880	21,430	10.6	10.3	10.0	9.8	9.5
Through third parties:										
Medicaid & vendor	6,710	7,770	8,750	9,740	10,740	4.8	4.8	4.8	4.8	4.7
Maternal & child health	290	330	360	390	420	.2	.2	.2	.2	.2
Vocational rehabilitation	40	50	60	60	60	*	*	*	*	*
Direct payments	7,830	8,570	9,130	9,690	10,210	5.6	5.3	5.0	4.8	4.6

TABLE 5.1D PERSONAL HEALTH CARE EXPENDITURES UNDER MAJOR NATIONAL HEALTH INSURANCE PROPOSALS IN FISCAL 1980
(Billions of 1980 Dollars 1/)

Proposal	Spending	Increase	Percent
Present Law	223.5		
Long-Ribicoff	233.3	9.8	4.4
CHIP	234.8	11.3	5.0
Health Insurance Association of America	234.5	11.0	4.9
American Medical Association	243.8	20.3	9.1
American Hospital Association	248.5	25.1	11.2
Health Security (AFL-CIO)	248.3	24.8	11.1

1/ Assumes rate of increase in C.P.I. projected by Council of Economic Advisers.

TABLE 5.2D COMPONENTS OF INCREASE IN SPENDING FOR PERSONAL HEALTH SERVICES UNDER MAJOR NATIONAL HEALTH INSURANCE PROPOSALS
(Billions of 1980 Dollars 1/)

	Long-Ribicoff	CHIP	H.I.A.A.	A.M.A.	A.H.A.	Health Security
Additional services performed	+3.6	+6.0	+7.6	+9.2	+15.3	+21.0
Payment for bad debts & unbilled charges	+2.6	+4.5	+3.6	+4.3	+6.0	+6.0
Full payment for Medicaid services	+2.2	+1.2	+1.4	+1.4	+1.9	+1.9
Full payment for Medicare services	0.0	+.7	+.7	0.0	+1.2	+1.2
Inflation in fees or wages	*	*	*	+1.6	*	+1.4
Utilization controls	-.6	-1.0	-.6	-.4	-1.0	-1.8
Limits on institutional spending	*	-4.5	-7.1	-.9	-1.0	-4.7
Limits on professional fees	-.4	-1.2	0.0	0.0	-4.5	-4.5
Administrative cost of new insurance	+1.4	+2.7	+3.2	+3.0	+5.7	+7.3
Change in administrative functions & type of insurance	+.6	+1.8	+1.0	+1.0	-.4	-5.2
Federal spending for planning, regulation, and evaluation	*	+.1	+.1	+.1	+.3	+.2
Maintenance of appropriations for Federal facilities	+.1	+.5	+.6	+.6	+.7	+.9
Diversion of philanthropic donations	+.3	+.5	+.5	+.4	+.9	+1.1
	+9.8	+11.3	+11.0	+20.3	+25.1	+24.8

1/ Assumes rate of increase in C.P.I. projected by Council of Economic Advisers.

* Less than $.05 billion

TABLE 5.3D SPENDING FOR PERSONAL HEALTH SERVICES BY CHANNEL OF PAYMENT UNDER PRESENT LAW AND MAJOR NATIONAL HEALTH INSURANCE PROPOSALS IN FISCAL 1980
(Billions of 1980 Dollars 1/)

	Present Law	Long-Ribicoff	CHIP	H.I.A.A.	A.M.A.	A.H.A.	Health Security
TOTAL U.S.	223.5	233.3	234.8	234.5	243.8	248.5	248.3
PRIVATE SECTOR	139.0	135.6	133.5	131.6	143.6	133.8	47.4
Out-of-pocket	70.1	66.0	60.5	57.9	59.5	50.1	38.2
Through insurance	66.3	67.1	70.6	71.2	81.7	81.7	7.6
Other Private	2.6	2.5	2.4	2.5	2.4	2.0	1.6
PUBLIC SECTOR	84.5	97.7	101.3	102.9	100.2	114.7	200.9
Government insurance premiums	3.7	3.7	11.6	14.9	3.7	6.6	1.1
Federal taxpayers	59.3	74.9	68.7	67.0	82.0	95.7	189.4
State and local taxpayers	21.5	19.1	21.0	21.0	14.5	12.4	10.4

1/ Assumes rate of increase in C.P.I. projected by Council of Economic Advisers.

TABLE 5.4D PROGRAM SPENDING UNDER MAJOR NATIONAL HEALTH INSURANCE PROGRAMS IN FISCAL 1980 FOR PERSONAL HEALTH SERVICES BY CHANNEL OF PAYMENT 1/
(Billions of 1980 dollars 2/)

	Long-Ribicoff	CHIP	H.I.A.A.	A.M.A.	A.H.A.	Health Security
TOTAL U.S.	80.4	121.6	125.9	140.0	159.0	181.7
PRIVATE SECTOR	6.8	44.0	47.8	64.7	67.7	0.0
Through insurance	6.8	44.0	47.8	64.7	67.7	0.0
PUBLIC SECTOR	73.6	77.6	78.1	75.3	91.3	181.7
Government insurance premiums	2.6	10.6	13.8	2.6	5.5	0.0
Federal Taxpayers	58.9	55.6	51.7	66.6	80.5	176.7
State & Local Taypayers	12.1	11.4	12.6	6.1	5.3	5.0

1/ Includes insurance programs set up or altered as a result of a National Health Insurance proposal, including Medicare and Medicaid.

2/ Assumes rate of increase in C.P.I. projected by the Council of Economic Advisers.

TABLE 5.5D SPENDING FOR PERSONAL HEALTH SERVICES ACCORDING TO ADMINISTRATIVE RESPONSIBILITY UNDER PRESENT LAW & MAJOR NATIONAL HEALTH INSURANCE PROPOSALS IN FISCAL 1980
(Billions of 1980 Dollars 1/)

	Present Law	Long-Ribicoff	CHIP	H.I.A.A.	A.M.A.	A.H.A.	Health Security
TOTAL U.S.	223.5	233.3	234.8	234.5	243.8	248.5	248.3
PRIVATE SECTOR	139.0	135.6	133.5	131.0	168.3	138.0	47.4
Paid directly by individuals	70.1	66.0	60.5	57.9	57.9	50.1	38.2
Private insurers	66.4	67.1	70.6	70.6	107.9	85.9	7.6
Other private	2.5	2.5	2.4	2.5	2.5	2.0	1.6
PUBLIC SECTOR	84.5	97.7	101.3	103.5	75.5	110.5	200.9
Federal government	47.6	77.9	48.7	45.4	52.3	83.7	183.2
State & local government	36.9	19.8	52.6	58.1	23.2	26.8	17.7

1/ Assumes rate of increase in C.P.I. projected by the Council of Economic Advisers.

TABLE 5.6D PROGRAM SPENDING FOR PERSONAL HEALTH SERVICES UNDER MAJOR NATIONAL HEALTH INSURANCE PROGRAMS IN FISCAL 1980 ACCORDING TO ADMINISTRATIVE RESPONSIBILITY 1/
(Billions of 1980 Dollars 2/)

	Long-Ribicoff	CHIP	H.I.A.A.	A.M.A.	A.H.A.	Health Security
TOTAL U.S.	80.4	121.6	125.9	140.0	159.0	181.7
PRIVATE SECTOR						
Private insurers	6.8	44.0	47.1	89.4	71.9	0.0
PUBLIC SECTOR	73.6	77.6	78.8	50.6	87.1	181.7
Federal government	62.4	36.0	30.5	37.3	68.9	170.5
State & Local government	11.2	41.6	48.3	13.3	18.2	11.2

1/ Includes insurance programs set up or altered as a result of a National Health Insurance proposal, including Medicare and Medicaid.

2/ Assumes rate of increase in C.P.I. projected by the Council of Economic Advisers.

TABLE 5.7D AVERAGE PREMIUMS AND COST OF NATIONAL HEALTH INSURANCE PER FULL TIME EMPLOYEE IN FISCAL 1980

	Premium Rates			Average per Full Time Employee[1]			
Proposal	Single Employee	Employee With Family	Average Premium	Total	Employer Share[2]	Empl. Share[3]	Federal Share
Long-Ribicoff	$ -	$ -	$ -	$335	$211	$124	$24[4]
CHIP	417	1042	832	806	575	232	0
H.I.A.A.	465	1209	976	897	613	273	0
A.M.A.	562	1501	1191	1042	672	274	96
A.H.A.	603	1588	1261	1091	765	269	57
Health Security	-	-	-	899[5]	700[5]	200[5]	0

1/ Premiums and payroll taxes for national health programs and Medicare. Shows financing for only part of proposals. (All shares will be increased by taxes required to pay for public programs.)
2/ Based on estimated employer contributions made, and may exceed share required. Includes $124 of payroll taxes for Medicare, except in case of Health Security proposal.
3/ Includes $124 of payroll taxes for Medicare, except in case of Health Security proposal.
4/ Estimated excess of value of tax credits over value of deductions to employers.
5/ Includes only part of cost of financing benefits for full time employers. Rest of cost would be raised through general taxation.

TABLE 5.8D NET FISCAL IMPACT OF MAJOR NATIONAL HEALTH INSURANCE PROPOSALS ON FEDERAL SPENDING AND BUDGET
(Billions of 1980 Dollars 1/)

	Outlays		Tax Expenditures		Total Expenditures	
	Total	Increase	Total	Increase	Total	Increase
Present Law	59.3		18.2		77.5	
Long-Ribicoff	74.9	15.6	20.0	1.8	94.9	17.4
CHIP	68.7	9.4	20.3	2.1	89.0	11.5
Health Insurance Association of America	67.0	7.7	23.3	5.1	90.3	12.8
American Medical Association	82.0	22.7	22.2	4.0	104.2	26.7
American Hospital Association	95.8	36.5	25.7	7.4	121.5	43.9
Health Security (AFL-CIO)	189.4	130.1	18.7	.5	208.1	130.6

1/ Assumes rate of increase in C.P.I. projected by the Council of Economic Advisers.

file

THE WHITE HOUSE

WASHINGTON

INFORMATION REQUESTED

October 4, 1976

MEMORANDUM FOR THE PRESIDENT

FROM: JIM CANNON Jim

SUBJECT: Bronx Municipal Hospital

You asked me on Saturday about the status of the Bronx Municipal Hospital.

The information you have is correct: This new hospital is idle and many people are furious that it has not opened.

The reason it has not opened is that New York City's money problems require that it seek greater control of the hospital's budget before it commits funds to its operation.

At issue also is the entire municipal hospital system of New York City and who controls that system. The corporation controlling New York City's hospitals was set up under Mayor Lindsay and is relatively independent of control by the City administration. The issue being fought around the North Central Bronx Hospital is whether or not the City administration can bring under control the hospital system and its budget.

New York State, which is responsible to oversee New York City spending and commitments, is also concerned about a relatively uncontrollable independent hospital corporation; so the New York State Department of Health has declined to give this new hospital the certificate it needs to operate.

The hospital, known formally as the North Central Bronx Hospital, is one of the most modern in the city. The facility is a 420 bed, $100 million medical center with a staff of 1400. It has an outpatient facility which has been in operation since this past summer, but the rest of the hospital and its staff is not permitted to treat patients without the State's operating certificate.

In sum, the New Bronx Hospital is enmeshed in the efforts of New York City and New York State to straighten out New York City's finances.

Since the Treasury Department is responsible to monitor New York City's financial situation, there is some possibility that someone in New York may attempt to blame this Administration. Thus far, this has not happened and the Federal government has not been directly involved in this dispute.

cc: Quern
Johnson

THE WHITE HOUSE

WASHINGTON

October 1, 1976

ADMINISTRATIVELY CONFIDENTIAL

MEMORANDUM FOR: JIM CANNON

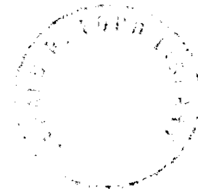
FROM: JIM CONNOR JEC

The following notation was directed to you in the President's outbox:

> "What is story on the delay in opening the Bronx Municipal Hospital?
>
> A friend of mine says this is a new hospital which is standing idle and that people are furious."

Please follow-up with appropriate action.

cc: Dick Cheney



100/1

Comm Health

THE WHITE HOUSE

WASHINGTON

October 4, 1976

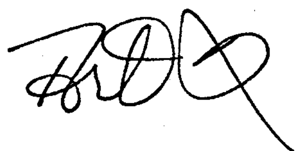
MEMORANDUM FOR: JIM CAVANAUGH
JERRY JONES

FROM: ART QUERN

SUBJECT: Signing Ceremony for H.R. 9019, HMO Act Amendments 1976

Regarding the confusion over Paul O'Neill's attitude toward a signing ceremony for H.R. 9019, The Health Maintenance Organization Act Amendments of 1976, in San Francisco, I have checked with him and he supports signing of the HMO bill and would go along with the planned ceremony.

I hope this removes the last obstacle to a signing ceremony for this bill. As you know, I believe that this is a good occasion for having the President take an action in one of the quality of life areas he designated in Vail.



cc: Paul O'Neill

THE WHITE HOUSE

WASHINGTON

October 4, 1976

MEMORANDUM FOR: JIM CANNON
ART QUERN

FROM: BILL DIEFENDERFER

SUBJECT: BLACK LUNG LEGISLATION

Congress adjourned sine die without passing the Black Lung legislation they had been considering.

The issue paper concerning this subject has been updated to reflect the present situation.

10028

1976 OCT 18 PM 2 45

October 14, 1976

Dear Senator:

Max Friedersdorf forwarded, along with his own personal endorsement, your letter of October 7 suggesting that a public signing ceremony be held for S. 2910. (Public Health Service re: arthritis, diabetes, and digestive diseases.)

Because of the President's extremely heavy schedule commitments, it will not be possible to arrange this ceremony. Please know, though, your interest and thoughtfulness in making this suggestion were greatly appreciated.

With our best wishes.

Sincerely,

William W. Nicholson
Director
Scheduling Office

The Honorable Richard S. Schweiker
United States Senate
Washington, D.C. 20510

Courtesy copy to Sen. Schweiker
bcc: James Cannon - FYI
Routed thru Mr. Friedersdorf before dispatch

WWN:MHR:rg

101816

ACTION

DOMESTIC COUNCIL

FROM:

ART QUERN

SUBJECT:

Letter to Harry Dent on Long Term Care

Date: 10-14/76

COMMENTS:

Dent requested materials for his presentation to the American Health Care Association in Orlando, Fla.

Quern recommends sign.

ACTION:

Date:

101513

Heal. —

THE WHITE HOUSE

WASHINGTON

October 14, 1976

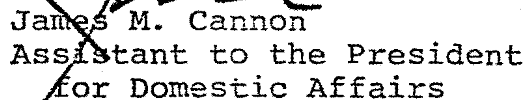
Dear Harry:

Attached are the key points pertinent to long-term care policy. I hope these are helpful.

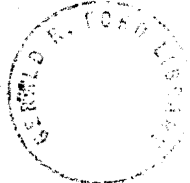
Should you have any further questions please do not hesitate to call Art Quern or myself.

With best wishes,

Sincerely,



James M. Cannon
Assistant to the President
for Domestic Affairs



Mr. Harry S. Dent
Dent, Kirkland, Taylor & Wilson
Granby Law Building
1700 Sunset Boulevard
West Columbia, South Carolina 29169

Talking Points: Long-Term Health Care Policy

-- The Federal government now provides about $4 billion of financial support for care in skilled nursing homes and intermediate care facilities primarily through the Medicaid and Medicare programs. For the past several years, HEW has put particular emphasis on programs that enforce safety standards.

-- In the course of providing needed nursing home care for those who need it, some persons have been placed in institutional care who could be better cared for in their homes. HEW is just completing hearings held throughout the country to explore improvements in home health care as an alternative to institutional care.

-- In addition, Federal efforts to ensure that facilities for the elderly, the sick, the disabled and the retarded are safe have often led to more regulations and red tape, not to better care. As part of President Ford's regulatory reform initiative, HEW is conducting a thorough review in cooperation with State and local governments to separate necessary regulatory provisions from useless ones.

-- The proper Federal, State and local roles in providing long-term care need to be examined. While the Federal government's financial support for such care is appropriate, State and local agencies should have the primary responsibility for tailoring the care provided to individual needs.

GERALD R. FORD LIBRARY

LAW OFFICES
Dent, Kirkland, Taylor & Wilson
GRANBY LAW BUILDING
1700 SUNSET BOULEVARD (HWY. 378)
DRAWER 175
WEST COLUMBIA, SOUTH CAROLINA 29169
TELEPHONE (803) 796-9160

RRY S. DENT
ANCEL E. KIRKLAND
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DISON G. WILSON

HN F. O'CONNOR, JR.

COUNSEL:
NNETH M. ROBINSON

WASHINGTON OFFICE:
(MR. DENT ONLY)
BOX 19527
WASHINGTON, D. C. 20006
(202) 785-9454

October 1, 1976

Hon. James Cannon
Domestic Affairs Council
The White House
Washington, DC 20500

Dear Jim:

I am scheduled to make a 25-minute presentation to the American Health Care Association in Orlando, Florida, on October 28 on the subject: "What Does the Ford Administration Project for Long-Term Health Care?"

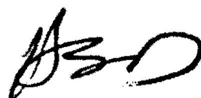
A Carter representative will make a similar presentation.

I am counsel for the S.C. Health Care Association and have made previous presentations to AHCA conventions.

Please send me any materials you feel would be useful to me on this subject.

With best wishes, I am,

Sincerely,



Harry S. Dent

HSD:lwd

THE WHITE HOUSE
WASHINGTON

Sat

10/22

Tue 10/29

THE UNDER SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

OCT 20 1976

MEMORANDUM FOR THE HONORABLE JAMES CANNON

SUBJECT: Prospective Report

In accordance with your request, the following information is hereby submitted.

Potential Policy Matters

It will be announced on October 21 that Ms. Carolyn Betts is to be appointed as Commissioner of the Public Services Administration, a part of the Social and Rehabilitation Service.

GERALD R. FORD LIBRARY

Major Announcements

A press release will be issued announcing the new nation-wide Federal - State Child Support Enforcement Program is off to a successful start. It will be announced that collections during the first year exceeded original expectations that the program would break even.

A press release will be issued October 21 announcing that 29 States are planning or operating performance - based education programs (PBE) in their elementary or secondary schools according to a recent survey conducted by the National Center for Education Statistics.

Major Regulations

The Department will publish in the Federal Register proposed revisions in the regulations governing contract health care services for Federally recognized American Indians and Alaska natives.

Major Speeches

Secretary Mathews will speak at Texas Tech University in Lubbock, Texas on October 26 at the inaguration of Mr. Cecil Mackey.

On October 27 Secretary Mathews will speak before the Town Hall of California and at a University of Southern California Conference on Human Services.

On October 29 Under Secretary Lynch will speak at the University of Osteopathic Medicine in Athens, Ohio.

Attached at Tab A is a listing of the Secretary's and Under Secretary's speaking engagements.

<u>Critical State Issues</u>

An update of critical State issues is included at Tab B.

/s/Marjorie Lynch

Under Secretary

cc: James H. Cavanaugh
David Lissy

Health

THE WHITE HOUSE
WASHINGTON

Date 11/19

To: Allen Moore

From: Spencer C. Johnson

____FYI

____For Appropriate Action

Comments:

No response necessary - not appropriate now - note date of Mathews memo to President

SCJ

THE WHITE HOUSE
WASHINGTON

DATE: 10/25

TO: Spence

FROM: ALLEN MOORE

SUBJECT:

ACTION:

FYI:

Pls. ~~and~~ prepare
a brief acknowledgment
~~for~~ from the Pres. to
Matthews.

DOMESTIC COUNCIL

FROM:

Secretary Mathews

SUBJECT:

Letter to the President re: HEW program to eliminate unwarranted Federal intrusion.

Date:

COMMENTS:

Mathews wants to bring this effort to the President's attention.

Should a Presidential acknowledgment be prepared?

YES NO ______

ACTION:

Date:

INFORMATION

THE WHITE HOUSE

WASHINGTON

October 22, 1976

MEMORANDUM FOR THE PRESIDENT

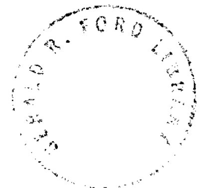
FROM: JIM CANNON

SUBJECT: Communication from HEW Secretary Mathews regarding a program to eliminate unwarranted Federal intrusion.

Attached is a memorandum and brochure from Secretary Mathews that describes an HEW "National Management Planning Study" designed to carry out your mandate to eliminate unwarranted and unproductive Federal intrusion.

Secretary Mathews suggests that you might want to cite this effort as an illustration of your determination to harness the Federal bureaucracy.

Attachments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THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

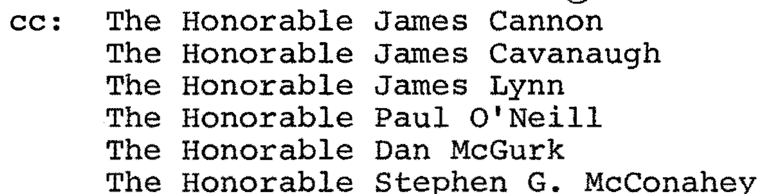
OCT 12 1976

MEMORANDUM FOR THE PRESIDENT

Attached is a brochure that describes a program to carry out your mandate to eliminate unwarranted and unproductive federal intrusion. It attacks problems created by federal planning requirements. State and local officials have already responded very favorably to the corrective actions that are prescribed and we have incorporated those objectives into this Department's management goals. (At the same time we are launching a new study of the massive reporting requirements our programs place on State and local governments.)

I would suggest that you might want to make use of this effort as an illustration of your determination to harness the federal bureaucracy. It could also serve as a basis for launching a new management initiative government-wide should you wish to ask other Federal domestic agencies to undertake a similar analysis of their programs.

We are also mounting, with the support and cooperation of Paul McAvoy, a similar effort to tackle the problem created for colleges and universities by the multitude of federal data collecting procedures. Our objectives are to have only one channel for collecting data and a reduction of forms to three or four basic documents. Again, I thought you should know of this work because it is a good illustration of the fact that the Administration is already acting to carry out your initiatives in education and reform.



Secretary

cc: The Honorable James Cannon
The Honorable James Cavanaugh
The Honorable James Lynn
The Honorable Paul O'Neill
The Honorable Dan McGurk
The Honorable Stephen G. McConahey

NATIONAL MANAGEMENT PLANNING STUDY

U.S. Department
of Health, Education & Welfare

"My biggest clients are outraged Governors"

PLANNING & COORDINATION

required by Federal Law

imply: power to use resources to meet needs

but...

Federal laws & regulations. . . limit state/local prerogatives to apply resources where your needs are.

. . . Impose many other inconsistent administrative constraints

NEEDED

to improve the intergovernmental partnership in human resources programs:

- A better balance of State/Local prerogatives and Federal requirements
- Real planning accountability
- Improved governmental response to people's needs

"This public should know that HEW is not afraid to criticize itself—also that not all Federal red tape is created by bureaucrats"

DR. DAVID MATHEWS
HEW Secretary
March 1976

Copies of the full study report may be requested by detaching and mailing this form to:

HEW—REGION X
Arcade Plaza — MS 610
1321 — 2nd Ave.
Seattle, Wa. 98101

Please send _____ copies of the HEW NATIONAL MANAGEMENT PLANNING STUDY TO:

NAME

ADDRESS

CITY STATE ZIP

MANAGEMENT PLANNING

A term used in this study to describe the decision-making process in human services programs.

Human Services administrators identify human needs, determine what resources are available to meet them, set priorities & objectives, make allocations of resources to achieve those objectives, and evaluate the program's success and the unmet needs which remain.

Study covered 54 of the 142 HEW programs with state/local government-grantees. ☐ - 91% of annual funding to these grantees is in those 54 programs.
- In Health, Education, Income Maintenance & Social Services. (excluding Social Security/Medicare.)

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON

OFFICIAL BUSINESS

PENALTY FOR PRIVATE USE TO AVOID
PAYMENT OF POSTAGE, $300
(GPO)

The President
The White House
Washington, D.C.

INFORMATION

THE WHITE HOUSE

WASHINGTON

October 22, 1976

never sent

MEMORANDUM FOR THE PRESIDENT

FROM: JIM CANNON Jim

SUBJECT: Communication from HEW Secretary Mathews regarding a program to eliminate unwarranted Federal intrusion.

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Attachments

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

OCT 12 1976

MEMORANDUM FOR THE PRESIDENT

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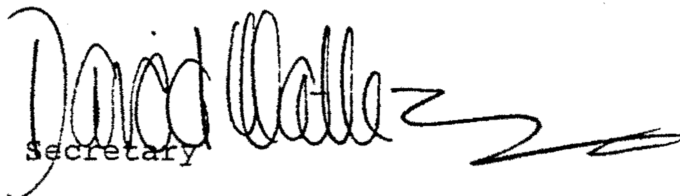

Secretary

cc: The Honorable James Cannon
The Honorable James Cavanaugh
The Honorable James Lynn
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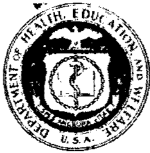

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

OCT 12 1976

1976 OCT AM 8 17

MEMORANDUM FOR THE PRESIDENT

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/s/ David Mathews
Secretary

cc: The Honorable James Cannon
The Honorable James Cavanaugh
The Honorable James Lynn
The Honorable Paul O'Neill
The Honorable Dan McGurk
The Honorable Stephen G. McConahey

101301

Hush

THE WHITE HOUSE

WASHINGTON

November 19, 1976

MEETING WITH SUSAN (SUZY) BERGE, THE NATIONAL EPILEPSY POSTER CHILD

Saturday, November 20, 1976
12:15 p.m. (10 minutes)
The Oval Office

From: Jim Cannon Jim

I. PURPOSE

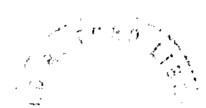
To be photographed with 12 year old Suzy Berge of Sussex, New Jersey, the 1976 National Epilepsy Poster Child.

II. BACKGROUND, PARTICIPANTS & PRESS PLAN

A. Background: Suzy was chosen by a panel of judges from applications which were submitted from across the United States. Suzy is very active and is also a little leaguer. She is bringing in a glove and baseball in the hopes that you would autograph them for her.

B. Participants:
Suzy Berge
Charles Berge, Suzy's Father
Mr. Fred Abrams, Vice President, National Board of Directors, Epilepsy Foundation of America
Mrs. Fred Abrams
Mr. Peter Van Haverbeke, Director, Professional and Public Health Education, Epilepsy Foundation of America

C. Press Plan: White House Photographer



III. TALKING POINTS

1. I am delighted, Suzy, to have you here at the White House for a visit.

2. I commend you for your courage and your activities to remove misunderstanding and fear which many associate with this disability.

3. Also, I congratulate the Epilepsy Foundation for their special emphasis this year on improving public attitudes toward epilepsy and employment, a concept which I supported in my message.

Health

THE WHITE HOUSE

WASHINGTON

November 22, 1976

MEETING WITH OFFICIALS OF THE AMERICAN LUNG ASSOCIATION
TO RECEIVE THE SHEET OF 1976
CHRISTMAS SEALS

Tuesday, November 23, 1976
12:30 p.m. (10 minutes)
The Oval Office

From: Jim Cannon

I. PURPOSE

To receive the sheet of 1976 Christmas Seals and a silk screen reproduction of the Christmas Seals.

II. BACKGROUND, PARTICIPANTS & PRESS PLAN

A. Background: This year Dick Cavett, the National Christmas Seal Chairman, was to have made the annual presentation to you but has been told by his doctor not to travel.

The presentation will be made by the 1976 Christmas Seal Youth Ambassador, Janet Lynn (Mrs. Salomon), a former Olympic Gold Medal figure skater. She also skated professionally with the Ice Follies but has developed exercise-induced asthma. Mrs. Salomon is expecting her first baby in March.

B. Participants: Janet Lynn Nowicki Salomon

Dr. James Kieran, President, American Lung Association

Miss Helen Jones, Director, Public Relations, American Lung Association

C. Press Plan: White House Photographer

III. TALKING POINTS

None required