

Social Security

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Chapter 9

Possible Future Development of the Medicare Program

In considering the possible future changes in, and development of, the Medicare program we may examine two distinct phases. The first phase deals with the existing Medicare program as it might be expanded in terms of services provided and in terms of covering more categories of OASDI-RR beneficiaries, or as its financing might be changed. Special attention is paid to proposals that have been made by the Executive Branch or that were passed by one house of Congress, even though they were not finally enacted.

Then, going well beyond this, the various national health benefit proposals which have been proposed are considered. One such proposal would be to apply Medicare to the entire population (as was contained, to a considerable extent, in legislation sponsored by Senator Javits, Republican).

It is often argued that the benefit protection under the Medicare program must be expanded because only about 45 percent of the health expenses of those aged 65 or over are met by it. The fallacy of this argument is that several important items are included as "health expenses," which either do not relate primarily to health or medical care or are not intended to be covered by Medicare. The most important of these items is custodial nursing-home care, which largely represents daily living costs. Other such items are medicines used at home (both over-the-counter and prescription), dental care, and physical examinations. HI covers about 90 percent of the inpatient hospital cost for Medicare beneficiaries (after allowing for the effect of the cost-sharing provisions). SMI pays about 70 percent of the cost for the services which it covers (after allowing for the effect of the cost-sharing provisions and the amounts billed by physicians in excess of the recognized or allowable charges).

On the other hand, at times, proposals are made to make Medicare benefits more restrictive, such as by means testing them, or by increasing the enrollee premium payments. For example, in early 1991, the Bush administration proposed that the SMI premium rate should be tripled for persons with income of at least \$125,000 per year (no mention being made about the notch that would be created as between those just under and those just over this limit). The high-income people who would be affected would be paying, on average, for about 75 percent of the cost of their benefit protection, instead of 25 percent as under existing law. This proposal was received by Congress and the general public with little enthusiasm.

Expansion of the Medicare Program

Coverage of Additional Types of Beneficiaries

The Medicare program applies only to persons aged 65 and over, to disabled OASDI and Railroad Retirement beneficiaries who have been on the benefit roll for at least two years, and to persons with chronic kidney disease who are insured under OASDI or RR, or are dependents of such persons. Expansion to more types of beneficiaries has frequently been proposed. On the other hand, the minimum eligibility age of 65 might be increased in tandem with the rise in the NRA under OASDI (or in another manner).

The most logical extension would be to disabled beneficiaries who are on the roll for less than two years. This limit was set largely, although not entirely, on cost grounds. There should always be some requirement as to length of time on the roll because of the difficulty arising due to the lag in adjudicating disability claims. Disabled-worker beneficiaries may not have their claim finally adjudicated by the time the waiting period for benefits (which averages 6½ months) has ended and thus will not know whether their disability will be deemed severe enough to meet the definition. They would not then know whether they are currently covered for Medicare benefits. Accordingly, so that beneficiaries will know where they stand as to Medicare protection, it seems desirable to retain some requirement as to time on the cash-benefits roll.

Extension of the Medicare program might also be urged for all other types of OASDI beneficiaries, such as retired workers between ages 62 and 65 and auxiliaries of retired and disabled beneficiaries regardless of their ages. Also, Medicare coverage might be urged for

young-survivor beneficiaries, although many of these already have reasonably adequate health insurance as a result of the employment of the widowed mother or father. The Senate version of the 1972 Act contained a provision extending the voluntary HI system for persons aged 65 and over, which was enacted in this legislation, to OASDI and RR beneficiaries aged 60–64 on the basis that such individuals would pay premiums equal to the full cost of their protection under both Hospital Insurance (HI) and Supplementary Medical Insurance (SMI). This provision, however, was deleted in the conference committee between the House and Senate.

Coverage of Unemployed Workers

In early 1975, great interest and concern developed for the many workers who had become unemployed and thereby no longer had health insurance through their employer's plan. Senator Bentsen proposed that HI be extended to apply to workers receiving unemployment insurance benefits and their families, with the cost to be met by the General Treasury. This proposal was criticized on the grounds that HI was not suitable for short-term coverage and that this approach could lead to Medicare coverage for all workers.

Senator Kennedy proposed to handle this problem, although supposedly for a temporary period, by continuing each such worker's previous health insurance plan, with the cost met by the General Treasury. On the other hand, the Rostenkowski Bill, which was proposed in April, would require the employer to continue its health insurance plan to workers receiving unemployment insurance (UI) benefits and to pay such cost in the same manner as when they were employed. The Rostenkowski Bill would be applicable on a permanent basis. Because all groups—such as the AFL-CIO, the AMA, and insurance carriers—favored action in this general area, it seemed likely that some such legislation would be enacted in 1975. However, this did not occur—probably because Congress did not receive many demands for such coverage from the persons adversely affected.

Relatively little pressure for the Bentsen-Kennedy type of coverage occurred in the 1982–83 recession. However, legislation was enacted in 1986 that required employers to continue health insurance coverage for unemployed workers.

Coverage of Specific Catastrophic-Cost Cases

The 1972 Act covered one catastrophic-cost group—those with chronic kidney disease. It might be urged in the future that categories

with similar diseases or medical costs should be covered, such as those in need of open-heart surgery or organ transplants.

Resurrection of Catastrophic Health Benefits Proposals

As discussed previously (in Chapter 7), the Reagan Administration aroused interest in catastrophic-health-benefits protection under Medicare by its proposal in 1986 to move in this direction. Congress significantly broadened the proposal, and the result was the Medicare Catastrophic Coverage Act of 1988. However, after much strong criticism of the manner in which this extension of protection would be financed, it was completely repealed in 1989, and no further discussion or support for catastrophic-benefits protection occurred later. And all this was in spite of the fact that catastrophic protection, rather than first-dollar protection, is really "the name of the game" of insurance!

Coverage of Additional Medical Services

Relatively few medical services are not covered by Medicare. Of these, it is unlikely that private-duty nursing services will be covered. Such services no longer seem to be medically necessary due to the widespread availability of intensive-care units (covered by HI). Nor is it likely that HI will cover the additional cost of private room occupancy (covered now only when medically necessary).

There has been considerable public pressure for liberalization of the skilled nursing facility (SNF) benefits under HI. Such benefits have posed a problem because of the difficulty of separating the recuperative and convalescent services for acute conditions which had required prior hospitalization from the services involved in preventive and supportive matters or in domiciliary and custodial care for chronic conditions. Many individuals would like to have a broadening of the concepts involved in the strict, limited basis provided in the Medicare law, even to the extent of covering all SNF services regardless of prior hospitalization or medical condition.

The greatest pressure for expansion of covered medical service under SMI has been for coverage of out-of-hospital prescription drugs. In the late 1970s and early 1980s, when there were serious economic and budgetary problems, little discussion along these lines was heard. Under some proposals, all such drugs would be covered after a small cost-sharing payment (perhaps \$1) for each prescription. This would involve huge and expensive administrative machinery, because about 500 million claims per year would need to be handled. Other propos-

als in this area involve a relatively large annual deductible (such as \$100 or \$200), and then 20-percent cost-sharing thereafter. The latter type of coverage is advocated on both "insurance" grounds (no need to cover the relatively small expenditures involved for those who have only occasional use for such drugs) and the administrative ground of not handling such huge numbers of small claims.

Such coverage of drugs could be effected under either SMI or HI. The coverage would be financed under SMI with an increase in the premium rate and the matching government contribution, and under HI with increased payroll taxes. Because what is involved is an out-of-hospital benefit, it would seem more logical for such coverage to be under SMI.

Proposals have been made that only certain types of prescription drugs should be covered, such as the so-called maintenance drugs, which are normally prescribed for chronic conditions. The Senate version of the 1972 Act contained such a provision. In this case, certain specified drugs for treatment of 13 named conditions (such as diabetes, cancer, and chronic cardiovascular disease) would be covered under HI, after a \$1 cost-sharing payment by the beneficiary. The drugs were selected because they would be easy to administer, and they would be used predominantly by persons with large recurring expenses for them. This provision, however, was deleted in the conference committee between the House and Senate.

When the Reagan administration proposed the addition of catastrophic benefits to Medicare in 1986, coverage of out-of-hospital prescription drugs was not included. However, both the House and Senate bills contained such benefits, and the final legislation in 1988 provided for such coverage under a program that would be separate from HI and SMI, with a deductible of \$600 in 1991 (increasing thereafter) and with 50 percent coinsurance in 1991 (decreasing to 40 percent in 1992 and to 20 percent in 1993 and after). This new benefit would be financed partly by a flat monthly premium and partly by the receipts from a surtax on the income taxes of high-income persons. The catastrophic drug benefit provisions were totally repealed, along with the other catastrophic-benefits provisions, in 1989. Although a few such benefits (e.g., mammography screening and hospice benefits) were later reenacted, little interest in doing so for catastrophic drug benefits was evident.

Still others argue for expansion of SMI coverage into the areas of annual physical examinations, eyeglasses, and dental care (including dentures). The advocates of coverage of annual physical examinations make much of the point that prevention of illness is better and more efficient than subsequent cure. On the other hand, some

experts argue against the indiscriminate use of annual physical examinations because they do not detect very much hidden illness. Moreover, the cost of a comprehensive annual physical examination for each of the approximately 35 million persons now under Medicare would be very high. Furnishing such examinations would severely tax the capabilities of the health care delivery system and would make unavailable adequate health care for acute conditions for the entire population that would otherwise be possible. Of course, it should be recognized that, under present law, many persons receive what are essentially physical examinations under the guise of routine office visits. The coverage of eyeglasses and dental care would involve significant cost and utilization problems.

Proposals have been made to eliminate the SMI initial deductible. One reason for this is that it is believed to be a barrier to receiving medical services for low-income persons. Another reason is that it produces considerable administrative difficulties (generally claims are filed in all cases instead of being accumulated until the deductible is met). Some would merely eliminate the deductible, but others would do so on a no-cost basis by simultaneously increasing the coinsurance rate from 20 percent to about 27 percent.

Other proposals that have been made are of a relatively minor nature, primarily for simplification. The provision for lifetime-reserve days under HI causes problems because of its elective basis. It could easily, with only slight additional cost, be applied on an automatic basis for each spell of illness. In this connection, however, the House version of the 1972 Act would have moved in the other direction by increasing the number of such days from 60 to 120. However, this provision was deleted by the Senate.

A suggestion was made in a 1975 study by the Department of Health, Education, and Welfare that expansion of Medicare benefit protection to such features as out-of-hospital prescription drugs and more catastrophic coverage should be accompanied—and thus partially financed—by increased cost-sharing along the lines of the ill-fated proposal made by the Nixon administration in early 1973.¹

The Reagan administration made proposals in its Budget requests in 1984 for catastrophic HI benefit protection by eliminating the maximum on the number of days covered in a spell of illness. These proposals were accompanied by proposals to have more cost-sharing payment by the beneficiaries for short hospital stays. The net effect

1. See "Health Program Memorandum, Fiscal Year 1975 Budget," *Congressional Record*, July 24, 1973, p. S14480.

costwise would be a reduction in HI outlays. Congress paid little attention to these proposals.

The 1984 Advisory Council on Social Security, which reported early in the year, recommended several benefit changes, as described in Chapter 7. Again, Congress paid little attention to these recommendations, and they were not even supported by the Reagan administration. The benefit changes proposed were, in the aggregate, very surprising because, in total, they represented a significant expansion of the program—for those who would fully participate in HI and SMI, unlimited hospital days with no cost-sharing payments whatsoever, other than for the initial deductible.

Long-Term-Care Benefits

Long-term-care benefits consist of two types—custodial nursing-home care and home care (primarily, homemaker services). The availability of the latter may reduce the need for the former, although many people will utilize home-care benefits who would not have used custodial nursing-home benefits. Both these benefits, although often quite essential, are largely not really “health” or “medical” services benefits. The need for such services is, by far, greatest for the “old old” (i.e., those aged 80 or older), but some such need is present for disabled persons under age 65.

Oddly, many individuals believe that Medicare provides such benefits through its skilled-nursing-facility benefits, which are actually only for convalescent and recuperative purposes. Increasingly, because of the aging of the population aged 65 and over, the inclusion of such benefits under Medicare is advocated—but little enthusiasm to pay for the high costs involved is evident.

The U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission) proposed that a broad range of home-care services and the first three months of nursing-home care should be covered under Medicare. Others have proposed the reverse—namely, that benefit coverage would start after several months of nursing-home care has occurred. In the view of the author, neither of these approaches would be desirable or financially feasible. The lack of benefit coverage during the entire nursing-home stay would cause many (even the vast majority under some proposals) to require Medicaid benefits. So, it might just as well be that the problem should be handled by a revised Medicaid program.

Further, the long-term-care risk is not, in the opinion of the author, an insurable one because adequate controls on utilization cannot be

developed and administered successfully. No objective, clearly definable criteria are possible as to who will really require such care. The control that is usually proposed is the use of the several so-called “activities of daily living.” However, these are so imprecise and subjective, and so subject to evasion through “coaching” by persons who know the rules and seek to make their clients eligible for benefits from the “deep pockets” of a social insurance program, as to result in little control of costs. It must be recognized that many people will be materially better off with the benefits of long-term care, whether in home or in an institution, than they have been during most of their lifetime.

The only way that the risk could be insurable would be to have relatively large cost-sharing (more, for example, than the OASDI benefits of the individual). This approach would be undesirable for social insurance for the vast majority of the beneficiaries involved because they would have to turn to Medicaid anyhow; private insurance, when selling only to the highest-income persons, could successfully adopt this procedure.

The best solution to the problem—or, at least, the least worst one—is a liberalized Medicaid program. Under this approach, the spend-down of assets would be eliminated. However, upon the death of the individual (or, if married, the death of the surviving spouse), the assets should—unlike the situation at present—pass over to the government to the extent of its prior expenditures. And strict requirements would be instituted (and enforced) against transfer of assets in anticipation of the usage of long-term-care benefits. After all, why should the children of the beneficiaries gain at the expense of the general taxpayer?

Modification of Reimbursement Basis

The 1975 HEW study mentioned previously also suggested that physician reimbursement under SMI should be further restricted by limiting the charges of physicians to the so-called customary charge recognized by Medicare. Then in nonassignment cases, physicians could not charge the patient the excess of their *actual* customary charge over the recognized “customary” charge, as was possible then (and as continued until the restrictive legislation in this area was adopted in 1989—an eventual limit of 15 percent on the differential). The result could be that many physicians would cease to treat Medicare patients if their charges were controlled in this way. In any event, this might tend to make Medicare beneficiaries look even more like second-class citizens, with “charity” medical fees by government fiat.

Another proposal to restrict further physician reimbursement

would limit the benefit payment on the so-called reasonable-charges basis to doctors who agree to take all of their Medicare patients on an assignment basis.² All other physicians would have to be on only the nonassignment basis, with the beneficiary being reimbursed on a flat-fee schedule that would be at a lower level than that arising under the assignment basis. Thus the pressure would be on doctors to be "participating physicians," since otherwise they might not always be paid their bills. And likewise, patients would exert pressure on their physicians to "participate," because they would be given lower benefit protection when their physicians did not do so.

In 1984, the leadership of the House Ways and Means Committee made a strong, but unsuccessful, effort to restrict the reimbursement basis for in-hospital services rendered by physicians and surgeons. It was proposed that, in all such cases, assignment would be required, and no billing of any amount above the recognized or allowed charges could be made to the patient.

Over the years, strenuous efforts have been made to compel physicians to take assignments in all cases. Economic pressures in this direction have been introduced from time to time, as discussed in Chapters 7 and 8, by making reimbursement under the assignment procedure more attractive (largely through higher amounts being paid). Some individuals and groups continue to push for an all-assignment procedure. Massachusetts, Pennsylvania, and Rhode Island have required that all physicians, as a requirement for licensure to practice medicine, must accept Medicare assignments in all cases.

Restructuring the Medicare Benefits Package

The Congressional Budget Office (CBO) has made an interesting study as to how the design of the Medicare program could be altered without any increase in overall costs ("Restructuring Health Insurance for Medicare Enrollees," August 1991). All of these restructuring plans would depend on enacting legislation which would prohibit Medigap policies from covering *any* of the required Medicare cost-sharing items (but would not relate to employer-provided retiree supplementary health insurance).

The CBO estimates that such first-dollar coverage by Medigap policies increases utilization under Medicare for such policyholders by 24 percent. The resulting estimated savings would be used to provide additional Medicare benefits, with five equivalent (costwise) packages being given. Questions might be raised as to whether the reduced

2. See "Let's Not Multiply Medicare's Mistakes," *Medical Economics*, January 7, 1974.

utilization is the result of elimination of unnecessary services (or, undesirably, the elimination of necessary services).

Two of the packages would leave unchanged the present cost-sharing provisions, but would introduce a catastrophic cap on the annual cost-sharing payments which the beneficiary would be required to pay. Under one alternative, the cap would be \$1,500 initially (indexed in the future, as would be all dollar amounts in all alternatives). The other alternative would have a \$3,200 cap, but would allow the cost of prescription drugs to count toward the cap.

The other three packages would increase the present cost-sharing amounts. The first would have a \$1,000 catastrophic cap and a \$200 SMI annual deductible. The second would have a \$2,200 cap, with prescription drugs counting toward it and a \$200 SMI deductible. The third would have a \$2,400 cap, coverage of prescription drugs on the same basis as other medical expenses, a \$500 SMI deductible, and 25-percent coinsurance under SMI (instead of 20 percent).

Revised Financing of Medicare Program

A number of proposals have been made for changing the financing basis of Medicare, both the direct financing applicable to those with current or prospective protection (taxes and premiums) and the indirect financing through the cost-sharing provisions applicable to those who obtain medical services.

Introduction (or Increase) of Government Subsidy

Those individuals embracing the expansionist philosophy would prefer to remove as much "evident" financing as possible. They would eliminate the SMI premiums payable by the enrollees and shift the cost burden to the payroll tax and to government subsidies. They would also shift part of the cost of the HI program to general revenues by a government subsidy of perhaps one half of the cost. Further, they believe that the various cost-sharing provisions should be lowered to eliminate the alleged "cost barriers" to urgently needed medical care.

The 1974-75 Advisory Council on Social Security recommended gradually changing the financing of HI from payroll taxes to general revenues. This was done to prevent the OASDI-HI payroll-tax rates from becoming too large and because it was believed that it was not logical to finance the nonearnings-related HI benefits by payroll taxes. One can well wonder who gains (or who is being fooled) by

substituting taxes that are required to produce general revenues for visible payroll taxes.

The Carter administration, which entered office in 1977, made no significant recommendations on the Medicare program, because it devoted its efforts in this field to the development of a national health insurance plan.

The 1978–79 Advisory Council on Social Security made a recommendation somewhat similar to that of the previous council. The only differences were that the switch in the financing source would be made immediately, and the general revenues would be obtained half from earmarked personal income taxes on income up to the OASDI earnings base and half from corporation income taxes (but by reallocating existing revenue income, not by raising new income). The 1981 National Commission on Social Security, by a narrow margin, recommended financing half of the cost of HI from general revenues. The 1984 Advisory Council on Social Security recommended that no government subsidy should be provided, but that excise taxes on alcohol and tobacco products should be increased and the additional proceeds given to the HI Trust Fund (the author believes that such a procedure does represent a government subsidy).

Direct-Financing Provisions

The Nixon administration, during 1969–72, proposed that the SMI premium payments by the enrollees should be eliminated, and that the cost should be shifted to payroll taxes. Congress considered this during the course of the legislation enacted then, but apparently was not sympathetic to the idea, because it applied the premium approach to the new category of disabled beneficiaries, as well as maintaining it for the aged. Since then, many liberal groups have also proposed this, along with financing one third of the cost of the combined HI-SMI program from general revenues.

In recent years, proposals have been made to increase the proportion of the cost of the SMI program which is borne by the enrollee premium rate. For the rate for those aged 65 and over, the minimum proportion would be gradually increased from the present proportion of 25 percent to 35 percent.

Increased Cost-Sharing

In 1973, the Nixon administration proposed increasing the cost-sharing provisions under Medicare. The HI provisions would be an

initial deductible of the first day's average room-and-board charges in the particular hospital and 10-percent coinsurance on all other charges thereafter. This basis would produce larger cost-sharing for the vast majority of cases, although smaller for a few long-duration cases. The SMI provisions would involve an annual deductible of \$85 (instead of the \$60 legislated in the 1972 Act) and 25-percent coinsurance (instead of 20 percent). The \$85 figure represented what the original \$50 amount applicable in 1966 would have been in 1974 if it had been adjusted to reflect changes in the level of cash benefits (a figure of about \$75 would have resulted if the increase had been based on changes in physician fees). Moreover, the \$85 initial deductible proposed would be changed in the future in accordance with changes in cash-benefits levels. This proposal, although logical in many ways (especially if the program had started off in this manner), met with strong opposition from members of Congress of both parties and was not adopted.

The House version of the 1972 Act would have introduced daily cost-sharing under HI for the 31st through 60th days of hospitalization at a rate of one eighth of the initial deductible (i.e., if applicable in 1973, at \$9 per day); this provision was not agreed to by the Senate and was deleted in conference. At the same time, the Senate version of this legislation would have reduced the daily cost-sharing for the lifetime-reserve days from one half of the initial deductible to one quarter thereof; this provision was not agreed to by the House and was deleted in conference.

In early 1975, President Ford proposed changes in the Medicare program somewhat paralleling those made earlier by President Nixon. More cost-sharing would be introduced, although this would be partially offset by catastrophic protection such that the maximum annual cost-sharing per capita would be \$750 under each part of Medicare. Again, this proposal met with no enthusiasm on the part of Congress.

As mentioned previously, the Reagan administration proposed several times that the HI cost-sharing should be increased but, as a partial offset, with increased catastrophic protection. On the other hand, again as mentioned previously, the 1984 Advisory Council on Social Security, in essence, recommended both reduced HI cost-sharing (except for the few persons who had HI protection but not SMI) and increased catastrophic protection.

It would seem desirable that the initial-deductible amount under SMI should be automatically adjusted for changes in physicians' fees in the future—just as is done under HI (on the basis of hospitalization

costs). If this had been done from the start, the deductible for 1991 would be \$324, instead of the actual \$100.

The SMI initial deductible was provided primarily to reduce administrative expenses—by eliminating claims-payment procedures for persons with relatively low medical costs in a year. This result is not achieved, however, if the vast majority of bills are filed, rather than being held until they at least equal the deductible. In actual practice, however, all bills are now being filed by the physicians and other suppliers of medical services (regardless of the assignment procedure). In combination with the fixed size of the deductible (i.e., decreasing steadily in real terms), this raises the question as to the value of retaining the initial deductible, which confuses administration of the program (and beneficiaries too).

In order not to increase the cost of the program, if the initial deductible were eliminated, as some urge, the coinsurance rate could be increased from 20 percent to 30 percent. At the same time, a catastrophic cap could be introduced to provide protection for those with very high medical costs.

National Health Benefit Proposals

Views of Supporters of National Health Insurance

Those holding the expansionist philosophy of social security feel quite strongly that all residents of the United States should receive high-quality medical care under government auspices. For the last 70 years, they have been trying to achieve this goal—either by direct action or by a gradual approach, whichever gives promise of being successful.

A popular slogan of the expansionists is that “people should have available high-quality medical care at a price which they can afford to pay.”³ Although this sounds very appealing and politically attractive, it is fatally flawed from the standpoint of logic and economics. After all, if the people of the nation cannot, in the aggregate, afford (or believe that they cannot afford) the level of medical care that they desire, who will foot the bill? There is also the difficulty that virtually no limits prevail on the amount and quality of medical services possible (and satisfying, as well). Furthermore, many people do not enjoy

3. For example, see Robert M. Ball, “National Health Insurance: Comments on Selected Issues,” *Science*, May 26, 1978, p. 864.

spending for medical care as compared with spending for other things, and thus feel that they can "afford" very little for it.

Another problem in connection with National Health Insurance (NHI) proposals which involve extensive and comprehensive controls on the utilization of medical services and on reimbursement therefor is the effect on the quantity of services available. Proponents of such controls argue that this approach will reduce the nation's aggregate cost for medical care, while at the same time producing better medical care more equitably distributed.

This first raises the question that if costs are lowered, who will have reduced incomes resulting therefrom, and what effects will this have on the provision of medical care? For example, will lowered costs mean that physicians will, if their incomes are drastically cut, work fewer hours and with less interest? If so, the medical care "pie" may be much more equitably divided, but it will be so much smaller that the vast majority will receive a smaller "piece." What will be the advantage of having a few at the lowest-income levels receive better medical care if the great majority receive worse? Is there not a better way to improve the care for the poorest without lowering that for virtually everybody else?

Then, too, in connection with NHI proposals that are comprehensive and of a monopolistic nature, the point arises of whether people should not have some personal choice with regard to what they want to spend for their own health care. If some would prefer to use a large portion of income for such purposes, even though the care obtained is not deemed to be "cost effective" by the social planners and medical economists,⁴ why should they not be permitted to do so? Conversely, if others prefer to spend more on current needs and to skimp on medical care, why should they not be permitted to do so?

Finally, it is interesting that some expansionist proponents of NHI are wealthy and have high incomes. It is likely that, if their proposals for NHI were adopted, they would continue to obtain their medical care in the same manner as they now do, from private fee-for-service physicians.

Views of the Public on National Health Insurance

It is very difficult to determine with any degree of precision what the general public's attitude is about NHI. Opinion surveys are likely to

4. For example, if a certain medical test costs \$100 and detects only one case out of one million that would otherwise result in death within a short period, this would not be considered cost-effective. Yet some people might be desirous of the test.

produce misleading results, because the questions asked are not completely informative about all aspects of the matter. For example, many people might say that they favor complete “free” medical care, with no cost-sharing being applicable, which would be financed wholly or largely from general revenues. They might well view this as reducing their out-of-pocket costs without realizing the impact of the taxes needed to provide the additional general revenues.

Among the many surveys made, one that might be mentioned was done by the Roper Organization, Inc., for H & R Block, Inc. (income-tax preparers). People were asked whether they wanted the present system of financing medical care for persons under age 65 replaced by NHI, which would be paid for through increased taxes. About 58 percent of those who answered preferred the continuation of the present system. On the question of whether such an NHI program should cover all medical expenses or only major medical expenses, there was an almost equal division of opinions; those who opposed an NHI program, rather surprisingly, voted only about 64 percent in favor of a catastrophic-only plan if there were to be NHI. As to the financing of NHI, if there were to be such, a surprisingly large proportion (59 percent) believed that employers should provide the complete financing. Only 11 percent favored financing through payroll taxes, and another 11 percent favored the income tax (with the other 20 percent favoring “some other kind of new federal tax”).

Developments Following Enactment of Social Security Act

When national health insurance was not included in the proposals of President Franklin D. Roosevelt that led to the enactment of the Social Security Act, the expansionists next tried to have such a program enacted separately in the 1940s (the several Wagner-Murray-Dingell Bills). These failed to gain favorable consideration by Congress because the attention of the nation was focused on World War II, and then later because of the phenomenal growth of private insurance (Blue Cross-Blue Shield and insurance companies). The expansionists next focused on the Achilles’ heel of private health insurance—the population aged 65 and over, who were sparsely protected. And so there came the numerous proposals for this age group, which led to the enactment of Medicare in 1965.

Developments Following Enactment of Medicare

The next step by the expansionists came as a result of the inflation arising from the Vietnam War. A hue and cry of “crisis” was raised by

the expansionists in the late 1960s and early 1970s.⁵ They saw a need for the complete tearing down of the existing health care delivery system to solve the problem of rising health care costs which had increased much more in absolute dollar terms than other prices or, much more significantly, had risen at about the same rate as the general wage level.

As a result of these efforts by the expansionists and the concern of the general public over rising health care costs, various organizations developed their own proposals in this area. Because the term *national health insurance* or, perhaps, *nationalized health insurance* seems to have such an appeal—unlike *socialized medicine*—most of these proposals have been so designated. In actuality, many of them should be termed *national health benefits* proposals, since NHI really means a program under which virtually all health care for practically the entire population is financed through the federal government. *Socialized medicine* may be defined as one extreme of NHI—namely, when virtually all health care for practically the entire population is not only financed by the government but also provided through government-owned facilities by salaried employees of the government.

Several proposals made in the recent past were truly NHI, but most were not. None of the proposals of an NHI nature are socialized medicine, but they could readily develop into that form of health care delivery.

National Health Insurance Proposals during 1972–1975

Next, let us consider the major entries in the national health legislation field as they were in 1974–75. We give here a brief description of each plan, its cost as estimated at that time, and its likely impact on the medical profession. Proposals for purely catastrophic health benefits plans are discussed in a later section.

American Hospital Association Proposal

This organization developed a general proposal, which it called Ameriplan, that would require individuals under age 65 to have pri-

5. For more details on why the claim of "crisis" was (and is) an exaggeration, see Harry Schwartz, *The Case for American Medicine: A Realistic Look at Our Health Care System* (New York: David McKay, 1972); Marvin H. Edwards, *Hazardous to Your Health* (New York: Arlington House, 1972); and Robert J. Myers, "Fallacies Expounded by Advocates of National Health Insurance," *New York Medicine*, November 1971. For views on the other side, see Edward M. Kennedy, *In Critical Condition: The Crisis in America's Health Care* (New York: Simon & Schuster, 1972); and Abraham Ribicoff, *The American Medical Machine* (New York: Saturday Review Press, 1972).

vate insurance for their basic health protection, with a government plan for catastrophic costs. The aged and the medically indigent would be completely protected under government plans. An underlying feature of the AHA proposal would be the virtual requirement that all medical care be furnished by so-called health care corporations, which would be nonprofit community-based organizations that would probably be run essentially by hospitals. This proposal would have a significant impact on the manner in which medical care is provided and on the practices of physicians.

The AHA proposal was never put into legislative form, although a bill introduced by Congressman Ullman, which had AHA support, bore certain similarities to it. However, there was no requirement in this bill that all medical care be furnished by health care corporations, although this would be strongly encouraged by federal subsidization of 10 percent of the insurance premium cost when such organizations are used. No cost estimates have been made public for this proposal by its sponsors. (In 1975, Mr. Ullman succeeded Mr. Mills as chairman of the House Ways and Means Committee.)

American Medical Association Proposal

The AMA in 1974 proposed the Mediredit plan, contained in the Fulton-Broyhill Bill. The general concept of this proposal was to give credits against personal income taxes for the premium costs of qualified private health insurance plans or policies for persons under age 65. Such tax credits would be a proportion of the premiums paid, varying inversely with income, from 100 percent for low-income persons to 10 percent for high-income persons. (Actually, because the present medical-expenses deduction could not be used if these tax credits are used, the tax credit would wash out for higher-income persons.)

To qualify under the Mediredit proposal, a health insurance policy would have to provide quite comprehensive protection, including catastrophic coverage, with only relatively small cost-sharing requirements on the part of the individual. The cost of the Mediredit proposal to the federal government would be about \$14 billion per year initially if it were widely used. There are, however, cost offsets of about \$2 billion annually to both the federal government and the states as a result of elimination of the Medicaid program. Interestingly, the Department of Health, Education, and Welfare set a much lower cost on this proposal (about \$8 billion per year). This lower cost resulted from the theory that it would not be used widely by middle-income persons.

The Medigap proposal would have relatively little effect on the manner in which health care is provided, although the AMA stated that this was a separable issue and that it had certain suggestions in other areas which it made in other proposals.

In 1975, the AMA drastically revised its proposal. The tax credit basis would no longer be used for the vast majority of persons, but rather there would be an employer-mandated plan for employees, with the employer responsible for at least 65 percent of the cost. The self-employed would still have the tax credit approach, as would the unemployed and nonemployed. The proposal was thus quite similar to the 1973–76 Nixon plan, to be discussed later.

Committee for Economic Development Proposal

The Research and Policy Committee of this organization proposed a plan in 1973 under which employers would be required to provide health insurance policies, to be financed jointly by the employers and employees, which would meet certain minimum standards, including catastrophic coverage. Those not covered by such employer plans or by Medicare would be protected under federally sponsored community trusteeships, which would furnish the same basic coverage as the employer plans. This part of the program would be financed primarily by the federal government, with the participants paying cost-sharing amounts for services related to income. Persons with sizable incomes not under an employer plan (such as the self-employed) could contract out of the community trusteeships by purchasing an adequate equivalent private policy. Medicaid would continue in operation to meet the residual, catastrophic needs above the standard plans.

Health Insurance Association of America Proposal

This association sponsored a plan, called Healthcare, which was supported by other insurance-business organizations. This proposal was contained in the McIntyre-Burleson Bill. It would encourage voluntary health insurance on the part of employer-employee plans and voluntary plans for other individuals, as well as state plans for the indigent. The benefit structure of all three of these types of plans would be the same and would ultimately provide a comprehensive range of benefits, which would be phased in over a period of several years. Catastrophic coverage, however, would be provided for persons who incur more than \$5,000 of medical expenses (whether or

not covered by insurance) within 12 consecutive months. This part of the HIAA plan was first contained in its 1973 version (previous ones strongly opposed catastrophic coverage). Employers would be encouraged to upgrade their plans to meet the minimum standards, because otherwise they would not be able to take their entire health insurance costs as business expenses for income-tax purposes.

The cost to the federal government for the Healthcare proposal would probably be about \$10 billion per year, primarily for protection to indigent persons and for the various planning provisions and for the loans and grants provisions. State governments would, however, have cost reductions of about \$3 billion annually due to the larger federal financial participation in the proposal than under the present Medicaid program. This proposal would have some effect on the manner in which health care is provided, because of its encouragement of ambulatory health centers and health maintenance organization (HMOs).

Javits Proposal

Senator Javits introduced a bill which would, in essence, extend the Medicare program to persons of all ages and expand the benefit protection provided by including such items as physical examinations, dental care for young people, and out-of-hospital prescription drugs for chronic conditions. The Javits Bill would have a cost of about \$40 billion per year initially and would be financed from payroll taxes and from a government subsidy of one third of the cost. Much of this cost would reflect a decrease in costs not paid directly through the private sector. This proposal would probably have a very significant effect on physicians because fees would be determined by the government; there would no longer be available the yardstick of customary and prevailing fees for persons not under the program.

Kennedy-Griffiths Proposal

Senator Kennedy and Representative Griffiths in 1973 introduced the most sweeping proposal of all—a plan, termed Health Security, that was developed by the Committee for National Health Insurance and was supported by the AFL-CIO. In essence, the Kennedy-Griffiths Bill would result in virtually all medical care for persons of all ages being financed through a government system under which about 13 percent of the cost would be met by worker payroll taxes and by taxes on unearned income, 37 percent by employer payroll

taxes, and the remainder by a government subsidy. The total cost to the federal government would have been in the neighborhood of \$90 billion in 1976, so very sizable tax burdens would be involved. About \$10 billion of this federal cost would be a shifting of expenditures from the present Medicare and Medicaid programs, which would be abolished. State and local governments would have reduced expenditures of about \$5 billion annually as a result of the elimination of Medicaid. It must be remembered, however, that a considerable part of the remainder of the cost would come from a shifting of costs from what is now being done in the private sector. The sponsors of the legislation, however, asserted that the gross cost would have been only \$76 billion in 1976.

The Kennedy-Griffiths proposal was established in such a manner that physicians would virtually be forced into group practice on an institutional basis, because solo practitioners might receive quite reduced income from the program if the anticipated financing were insufficient (because the bill provided that they would be the last ones to be paid) and because beneficiaries would receive less benefit protection if not in a group plan (because then only maintenance drugs, not all drugs, would be provided). Some supporters of this bill asserted that they were not in favor of socialized medicine—in the sense that physicians would become government employees or else employees of organizations which are rather strictly controlled by the government—but this could inevitably result from its operations. Quite obviously, this plan would have the greatest impact on the status of physicians.

When this proposal was reintroduced in 1975, it was designated as the Kennedy-Corman Bill, since Griffiths had retired from Congress, and Corman took her place as sponsor in the House. Under this new version, the tax rates were 3½ percent on employers on their total payroll, 1 percent on employees with a maximum taxable wage base equal to 1½ times the OASDI base, 2½ percent on the self-employed with the same base as employees, and 2½ percent on unearned income. The unearned income, however, would be taxed on no more of such income than the excess of the employee earnings base over the total wages and self-employment income (if any) which had been taxed; further, there would be an exemption of the first \$3,000 of unearned income for persons aged 60 and over.

Mills-Kennedy Proposal

Chairman Mills of the House Ways and Means Committee, in conjunction with Senator Kennedy, introduced a bill in early 1974 that

somewhat paralleled the 1974 version of the Nixon administration proposal (described later) insofar as benefit protection was concerned. However, the Mills-Kennedy Bill would provide somewhat larger benefits for persons under age 65 (by having somewhat lower initial deductibles and also lower limits on when catastrophic coverage begins) and would leave the Medicare program unchanged. The major difference, and a most significant one, between the two proposals is in connection with the financing and administration. The Mills-Kennedy Bill would be financed by payroll taxes (with no government subsidy) and administered by carriers as under Medicare, whereas the Nixon administration proposal would be on an employer-mandated basis, with the financing and administration being completely in the private sector.

It will be observed that the Mills-Kennedy Bill was a substantial departure from the Kennedy-Griffiths Bill. Although Senator Kennedy thus significantly shifted his approach, most supporters of his original proposal did not change their views and instead strongly criticized the new bill. This bill was not reintroduced in 1975.

Various Nixon Proposals

President Nixon, in 1971–72, made an extensive proposal in the national health field, including significant encouragement of the health-maintenance-organization approach. This proposal was contained in a bill introduced by Senator Bennett and also, in slightly modified form, in a bill introduced by Congressman Byrnes. This plan was termed National Health Insurance Partnership. Under this proposal, employers would be required to establish private health insurance plans meeting certain specifications, financed in part by the employees (no more than 25 percent). Although employers would be required to establish such a plan, individual employees could opt out.

In addition, a federally operated health insurance plan, with somewhat lower benefit protection than would be required under the mandated employer plans, would be provided for low-income families with children. Such a plan would be financed predominantly from general revenues, although with certain cost-sharing payments and with certain premiums being paid by covered persons who are above the lowest income level but yet not above the maximum income limit.

The Nixon proposal would have an annual cost of about \$3 billion per year initially insofar as the federal government is concerned and correspondingly of about \$10 billion per year for private plans as they are established or liberalized to meet the minimum requirements. It

would have relatively little impact on the health care delivery system, other than its significant encouragement of the HMO approach.

In early 1974, the Nixon administration proposed a considerable revision of its original plan. The same general approach of an employer-mandated basis for employed persons was taken, but the differentiation in benefits between the employed and the eligible medically indigent was dropped. For those under age 65, the required minimum-benefit standard would be a per capita annual deductible of \$150 (\$300 per family) with 25-percent coinsurance; further, catastrophic coverage would be provided, because no family would be required to have cost-sharing of more than \$1,500 in a year (after which the plan would meet the entire cost). Low-income persons and families would have lower deductibles and catastrophic limits.

The 1974 Nixon administration proposal would drastically change the Medicare program. All disabled persons under age 65 would cease to be covered under Medicare and instead would be under the program for the medically indigent. The HI and SMI programs would be combined (but an enrollee premium would still be required), and there would be an annual deductible of \$100 per person with 20-percent coinsurance and with maximum required cost-sharing of \$500 per year per person and \$1,000 per family. However, this cost-sharing (both the deductible and the catastrophic limit) would be lower for persons with low incomes—as is the case for most persons aged 65 and over. Such an approach raises a significant question of philosophy. Should a social insurance program have a means test incorporated into it?

Some time after the proposal of the Nixon administration had been introduced, two others were put forward—the Mills-Kennedy Bill (as discussed previously) and one by the Chamber of Commerce of the United States. The latter plan was incorporated into a bill introduced by Senator Fannin; it paralleled the Nixon proposal but would provide a somewhat lower level of benefit protection.

Ford Proposals

When President Ford took office in August 1974, following President Nixon's resignation, he urged prompt enactment of a national health bill along the lines that the Nixon administration had proposed. In 1975, President Ford seemed to continue to favor this approach. He urged, however, that because of the business recession and the budgetary situation, no action should be taken on any national health proposals in 1975.

Mills Attempt for a Consensus NHI Plan in 1974

In August 1974, Chairman Mills sought to obtain a consensus on a national health bill from his committee. He suggested a compromise which moved further from his previous position in the bill that he jointly sponsored with Senator Kennedy by dropping the approach of a national program supported by payroll taxes and administered by the federal government. Instead, he put forth for consideration a basic plan to be financed and operated in the private sector (as in the Nixon approach), a payroll-tax-supported catastrophic plan (as in the Long approach), and replacement of Medicaid by a national "insurance" approach.

The committee staff, at the direction of Chairman Mills, had developed this proposal, which was stated, as not being the recommendation of anybody.⁶ Apparently, it was hoped that the proposal might obtain a consensus of views among the advocates of the several previously developed proposals. It is worthwhile to consider this plan in some detail because it might have represented the starting point for legislative activity after 1974.

The staff proposal incorporated three separate plans, as well as revising the Medicare program (and would result in the Medicaid program having only a residual role to play). These were the employer health insurance plan, the alternate health care insurance plan, and the catastrophic health insurance plan.

The employer plan would require all employers (including state and local governments, but not the federal government) to provide for their employees a health insurance plan that would meet certain minimum-benefit standards. Such plans could be with an insurer, such as Blue Cross-Blue Shield or an insurance company, or could be self-insured. The employer would be required to pay at least 65 percent of the cost for the first three years and then 75 percent. Employers who have relatively high costs—in excess of 3 percent of payroll—would have part of such excess cost subsidized by the federal government—75 percent in the first year, grading down each successive year until being phased out in the sixth year.

The range of benefits required under the employer plan would be very comprehensive, including, in general, all services covered by Medicare, plus out-of-hospital prescription drugs and dental, vision, and hearing services for children under age 13. No duration limits

6. This proposal is described in a committee print, "A National Health Insurance Proposal," Committee on Ways and Means. House of Representatives, August 19, 1974.

would apply except for SNF services (100 days per year) and mental illness cases (60 hospital days per year and an annual dollar limit for outpatient services based on the average cost of 15 visits to a private practitioner, but double that amount for treatment at a comprehensive community care center). As to cost-sharing payments, there would be: an annual deductible of \$150 per person, but no further payment therefor after three members of the family had met the deductible; a separate annual deductible of \$50 per person for out-of-hospital prescription drugs; coinsurance of 25 percent after the deductible; and annual cost-sharing for a family not to exceed \$1,000. The maximum amount of benefits payable for a year would be \$6,000, since the catastrophic plan would take over then.

The alternate plan under the staff proposal would be available to all persons not covered by the employer plan and would be operated on a state-by-state basis. Persons on public assistance would be required to join, but it would be optional for others. This plan would have the same benefits as the employer plan. The financing would be from premiums paid by the enrollees and from federal and state subsidies. The standard premium rate, varying only between one-person families and other families, would be 125 percent of the average premium in the state under the employer plan. Low-income people—with annual family income of less than \$2,400 for one person, increasing \$400 for each additional member to a maximum of \$4,800—would be exempt from both the premium charge and all cost-sharing payments. Persons above these income limits would be phased in by paying premiums equal to 8 percent of their income in excess of the limit and by having maximum cost-sharing of 25 percent of such excess income.

The catastrophic plan under the staff proposal would apply to virtually the entire population under age 65. The principal exclusion would be persons not under the employer plan who did not choose to join the alternate plan. This plan would be operated in the same manner as Medicare is now. It would be financed by percentage tax rates on all income, including unearned income, social insurance benefits, and public assistance payments, up to \$20,000 of annual income of the individual or, in the case of a married couple, that of the husband and wife combined. The tax rates would be: $\frac{1}{4}$ percent for the employee on his or her wages and $\frac{3}{4}$ percent for the employer, on the first \$20,000 of annual wages of each employee, $\frac{1}{2}$ percent for the self-employed; $\frac{1}{2}$ percent on unearned income; and $\frac{3}{4}$ percent on public assistance payments, paid by the federal government for Supplemental Security Income (SSI) and by the states for Aid to Families with Dependent Children (AFDC). Persons under age 18 and persons

aged 65 or over would not be taxed on unearned income or social insurance benefits. The benefits of the plan for a family would be payment for all costs of covered medical services exceeding \$6,000 per year.

The Medicare program would be revised under the Ways and Means staff proposal to be at least as favorable as the coverage provided under the other plans. Specifically, the limit on hospital days covered would be removed, out-of-hospital prescription drugs would be covered, maximum annual cost-sharing of \$1,000 per family would be provided, and lower cost-sharing would be applicable to low-income persons. At the same time, the disabled beneficiaries under age 65 and the chronic kidney disease cases previously covered would not be covered, since they would be under either the employer or alternate plans. The program would be financed by percentage tax rates on the same income as would be taxed for the catastrophic plan (rates not specified).

Under all three Ways and Means staff proposals, institutional providers of services would be reimbursed on a prospective basis, such that they would receive their costs and possibly even a reward for efficient operation, or vice versa. Physicians would be reimbursed only if they agreed to accept payment according to a fee schedule developed for geographic areas and based on 1973 average fees adjusted for economic changes subsequently; services rendered by nonparticipating physicians would not be covered. In all instances, providers of services would receive full payment from the program, which in turn would collect the cost-sharing amounts from the beneficiaries.

The Committee on Ways and Means, however, could not come to any clear-cut decision on the matter because it was divided in several ways. By a tie vote, it rejected the AMA's Medigap proposal, the Fulton-Broyhill Bill. And it also turned down the insurance industry's proposal, the McIntyre-Burleson Bill, by a one-vote margin. At the same time, Chairman Mills was able to obtain approval for only parts of his suggested compromise by slim margins, so he dropped the whole matter for the current session because there did not seem to be sufficient time to obtain a solid majority of the committee in favor of any specific proposal. This impasse resulted from the split of the committee membership into three apparently irreconcilable factions that could not compromise their differences—conservatives favoring the Medigap approach, liberals favoring the original Kennedy-Griffiths approach, and the middle group favoring the Nixon approach. Most members, however, seemed to favor some sort of catastrophic protection. As a result, no further legislative activity on this subject occurred in 1974.

National Health Insurance Proposals in 1975–1978

President Carter, in his campaign for the presidency, expressed strong support for NHI, although without being specific as to what basis he favored. In 1977–78, the Carter administration set several deadlines for when its NHI proposal would be unveiled, but failed to meet them. Instead, in late 1978, the Carter administration presented a set of general principles for NHI, along with a promise to have a specific plan next year.

The proposed general principles for NHI were as follows (quoted from Presidential Directive/DPS-3, July 29, 1978):

1. The plan should assure that all Americans have comprehensive health care coverage, including protection against catastrophic medical expenses.
2. The plan should make quality health care available to all Americans. It should seek to eliminate those aspects of the current health system that often cause the poor to receive substandard care.
3. The plan should assure that all Americans have freedom of choice in the selection of physicians, hospitals, and health delivery systems.
4. The plan must support our efforts to control inflation in the economy by reducing unnecessary health care spending. The plan should include aggressive cost-containment measures and should also strengthen competitive forces in the health care sector.
5. The plan should be designed so that additional public and private expenditures for improved health benefits and coverage will be substantially offset by savings from greater efficiency in the health care system.
6. The plan will involve no additional federal spending until fiscal year 1983, because of tight fiscal constraints and the need for careful planning and implementation. Thereafter, the plan should be phased in gradually. As the plan moves from phase to phase, consideration should be given to such factors as the economic and administrative experience under prior phases. The experience of other government programs, in which expenditures far exceeded initial projections, must not be repeated.
7. The plan should be financed through multiple sources, including government funding and contributions from employers and employees. Careful consideration should be given to the

- other demands on government budgets, the existing tax burdens on the American people, and the ability of many consumers to share a moderate portion of the cost of their health care.
8. The plan should include a significant role for the private insurance industry, with appropriate government regulation.
 9. The plan should provide resources and develop payment methods to promote such major reforms in delivering health care services as substantially increasing the availability of ambulatory and preventive services, attracting personnel to underserved rural and urban areas, and encouraging the use of prepaid health plans.
 10. The plan should assure consumer representation throughout its operation.

The supporters of the Kennedy NHI plan were, during 1977–78, disappointed that the Carter administration did not directly support their proposal, as they had hoped. They were particularly dismayed at the possibility that private insurance carriers would play a role under the Carter principles. Then, the Committee for National Health Insurance announced its continued support for its own plan and summarized its views in a statement presented by George Meany, president of the AFL-CIO, before the Subcommittee on Health and Scientific Research, Senate Committee on Human Resources, on October 10, 1978.

Quite interestingly, this statement made no reference to the significant changes in its plan as compared with previous versions. The benefit provisions (virtually complete health care with no direct payment therefor) were not changed, but the financing and administration were radically different. Insurance carriers (Blue Cross-Blue Shield, HMOs, and insurance companies) would be given the administrative responsibility for the employed population. This was a considerable shift from the original position, under which such carriers would have played no role whatsoever.

The financing procedure with respect to the employed would no longer be through payroll taxes and government subsidies from general revenues. Instead, the premiums charged by the carriers would be a uniform percentage of earnings for all employers, and there would be no experience rating. Thus the low-cost groups would subsidize the high-cost ones, and carriers with overall low-cost experience would turn their “profits” over to a pool to help out the carriers with high-cost experience. Small employers would be charged lower premium rates, with the difference being met by a government subsidy.

The self-employed would pay a premium based on both earned and unearned income. The cost for the unemployed (including those unable to work) would be met from general revenues.

The NHI proposals of other organizations, as mentioned previously, were continued after 1975, but generally without being strongly pushed. In fact, public interest in NHI was at a relatively low level, especially compared with interest in other matters such as inflation, government expenditures and regulations, and international affairs. Then, too, it must be recognized that some of these proposals were made as "least worst" defenses against the Kennedy plan, and what was really preferred was the status quo plus improvements that could be made by gradualism.

In 1977, Alain Enthoven, a professor of economics at Stanford University, presented a radically different type of NHI proposal, the Consumer-Choice Health Plan.⁷ He described it as being pro-competitive (rather than pro-regulatory) and consumer-centered (rather than job-centered). The cornerstone of his plan was to have health insurance financed by people being continuously enrolled in "qualified health plans," rather than such enrollment being based on employment connections. Employer payments for health insurance would be taxable income for the individual, but there would be uniform refundable tax credits based on "actuarial category" (whatever that might mean, or be computed as), usable only as premiums for qualified health plans.⁸ Thus, people who chose more costly plans would pay the extra cost out of their after-tax income.

The underlying idea, therefore, was to introduce competition to encourage people to go to the lowest-cost, most efficient providers of services instead of seeking (as they would do otherwise) to obtain the most costly and comprehensive services. These services are now largely financed by tax-free employer payments. They have to be "used or lost," because they are available on a group basis.

At the same time, Enthoven believed that the practice of medicine should be changed by eliminating the fee-for-service basis and, instead, having only group practice, with competition among groups on the basis of both price *and* services. He cited the Federal Employee Health Benefits Program as an outstanding example of how the pro-competition approach worked. There still remains, in the author's

7. See Alain Enthoven, "Memorandum for Secretary of HEW Califano on National Health Insurance, September 22, 1977" and "Consumer-Choice Health Plan," *New England Journal of Medicine*, March 23 and 30, 1977.

8. Low-income people would receive vouchers based on the average cost of medical care in their area, varying by age and sex. The value would be reduced gradually with increasing income.

view, the fundamental dilemma in the medical care area—do people wish to place a higher emphasis on efficiency and low cost or on quality and quantity of services?

National Health Insurance Proposals in 1979–1980

Although the serious economic conditions confronting the United States in 1979–80 made any action on NHI seem unlikely, various groups continued to put forth their proposals in this field.

Carter Proposal

In September 1979, Phase I of President Carter's so-called National Health Plan (NHP) was introduced into Congress in specific bills (H.R. 5400 and S. 1812). This was based on the general principles presented in mid-1978, as described previously.

A package of benefits would be provided for virtually all persons (about 95 percent of the population), including (1) full-time employees and their dependents (through their employers) and (2) the Medicare eligible population, the remainder of the aged population, persons with incomes below the poverty level, and unemployed persons and their dependents who are not "poor" (on a "purchase" basis). The second category would be covered under a government plan called HealthCare, replacing Medicare and Medicaid. The employer plans would be required to provide at least the same benefits as HealthCare would.

The HealthCare benefits under Phase I would be as follows: (1) unlimited hospital, physician, and diagnostic services; (2) outpatient mental health care (\$1,000 annual maximum); (3) mental hospital care of 20 days per year; (4) 100 SNF days per year; (5) 100 HH visits per year; and (6) prenatal, delivery, and all child health care up to age 1. Cost-sharing for the employee covered group could be of any form—and, in fact, no basic plan at all would be required—but out-of-pocket expenses would be limited by the plan to an annual maximum of \$2,500 (whether per family or person). No cost-sharing would be applicable to the poor (those under 55 percent of the poverty standard), with phased-in coinsurance up to 25 percent for the near-poor. Medicare beneficiaries would continue to have the existing cost-sharing provisions, but an annual maximum of \$1,250 on out-of-pocket expenses would be introduced.

The financing under Phase I would be at least 75 percent by employers for the employee covered group. Medicare would be financed

by a continuation of the present HI taxes and the SMI premium of \$8.30 per month applicable in July 1978–June 1979 (but neither being increased in the future) and such general-revenues funds as necessary. Costs for the poor and the balance of the cost for the near-poor would be met from general revenues. The increased cost to the federal government for the first year was estimated at \$18 billion, while that for employers would be increased by \$4 billion (with decreases in cost of \$4 billion for individuals and \$2 billion for state and local governments).

Physicians would be reimbursed by Medicare and for poor and near-poor beneficiaries in the first year by a fee schedule based on the present Medicare reasonable-charges levels. In subsequent years, this would be renegotiated. Thus, all cases would be on an assignment basis.

The ultimate NHP would be developed from Phase I. The definition of the poor would be raised to 100 percent of the poverty standard. The benefit coverage would be extended to include: outpatient prescription drugs, with an annual deductible of \$250 per person; all child health care up to age 6; and preventive care at all ages. As to cost-sharing, no deductibles would be permitted (other than for prescription drugs), but coinsurance of 25 percent would be applicable for all services except prenatal, delivery, child care up to age 6, and other preventive care. All physician reimbursement would be on the fee-schedule basis.

Kennedy Proposal

Also in September 1979, legislation was introduced (H.R. 5191 and S. 1720) to implement Senator Kennedy's so-called Health Care for All Americans plan. Coverage would apply to the entire population through the employer-plan approach for the employed and through a government plan for the remainder of the population. All Medicare beneficiaries would be under both HI and SMI.

The required benefits would be unlimited inpatient and outpatient hospital care and physician care, 100 SNF days (as in HI), 100 HH visits (as in SMI), other medical services (as in SMI), preventive services for maternity cases, and well-baby care, and maintenance drugs (for chronic illness) for Medicare eligibles. There would be no cost-sharing provisions. The financing method was set forth in the bill, but the precise amounts were not (because they would be determined from estimated costs of the plan). Medicare beneficiaries would pay premiums in the same manner as at present (with general revenues

paying the balance of the cost). The HI tax would be continued, but would be applicable to all employment in the country. For employees, a premium related to wages would be paid by the employer, with the employee being subject to sharing such cost up to a maximum of 35 percent. Self-employment income and unearned income in excess of \$2,000 per year (or \$4,000 for a couple) would be subject to payment of the premium, but at half the rate applicable to wages. A maximum would apply to the amount of premium to be paid by an individual (which would approximate the value of the protection provided). The federal government would pay the premiums for SSI recipients, and the states would do the same for AFDC recipients (but with federal matching).

Incentive payments (i.e., refunds) would be available to persons who are members of plans which have lower-than-average costs. (The author, however, questions whether or not such lower costs might be due to other factors—e.g., favorable health or demographic nature of the membership—rather than to medical efficiency.)

The increased annual cost to the federal government, on a comparable basis with the costs given previously for the Carter proposal, would be \$31 billion. Similarly, the increased cost for employers would be \$33 billion, while the reduction in cost for employees would be \$25 billion, and that for state and local governments, \$3 billion.

Physician reimbursement would be entirely by negotiated fee schedules.

Other Proposals in 1979–1980, Comprehensive

A number of other proposals were offered, in legislative form, for comprehensive health benefits in 1979–80.

Representative Corman introduced, once again, the bill that he and Senator Kennedy had jointly sponsored in the mid-1970s (a completely federally funded and controlled plan, as described earlier in this chapter). However, Senator Kennedy had dropped this proposal and substituted a new plan using primarily the private sector for administration.

Representative Dellums proposed a national health service providing full medical and dental services without direct payment from the beneficiary for all residents of the country. All services would be provided by federal employees.

Congressman Dingell proposed a comprehensive NHI program for all residents. This plan would be financed by payroll taxes and general revenues.

Other Proposals in 1979–1980, Catastrophic Benefits Only

Various other proposals related only to catastrophic medical expenses.

Senator Dole proposed that employers be required to establish plans that would pay all family medical expenses in excess of \$5,000 per year. The employer would be required to pay at least 75 percent of the cost. Medicare and Medicaid benefit protection would be increased.

Senator Long proposed that employers be required to establish plans that would provide prenatal and well-baby care, childhood checkups, and payment of all family medical expenses in excess of \$2,000 per year. Medicare and Medicaid benefit protection would be increased.

Representatives Martin and Jones proposed that very large medical expenses which were not compensated for by insurance could be claimed as credits against personal income taxes.

Representatives Martin and Rhodes proposed that protection against catastrophic medical expenses be provided by tax incentives. To qualify as a business expense for income-tax purposes, an employer-sponsored plan would be required to pay all the medical expenses of a family in excess of \$2,500 per year. A federally financed program would apply to other than Medicare and Medicaid beneficiaries, with initial deductibles, coinsurance and a catastrophic cap, all varying with family income. A catastrophic cap would also be provided for Medicare beneficiaries.

Action in Early 1980s

At least in part because of the unfavorable economic conditions in 1979 and after, little public discussion was given to NHI, or even catastrophic health insurance, in the early- and mid-1980s. Those who had supported NHI in the past continued to give lip service to it, but with little hope for any legislative action. Advocates of HMOs and other forms of comprehensive medical plans continued to push for these types of group-medical-practice services, with some success.

The Reagan administration urged dollar limits on the amount of employer-paid, tax-free health insurance which could be provided. The purpose of this was both to raise tax income for budget-balancing purposes and to attempt to hold down the cost of health care by making the beneficiaries more cost-conscious.

There was a considerable amount of concern in the early 1980s

about the pending (in the late 1980s or early 1990s) crisis in the HI program, which it now appears will be deferred until the late 1990s or early 2000s. Many solutions were suggested—including increased cost-sharing, means testing of benefits or premium rates, higher tax rates, and restrictions on hospitals and physician reimbursement (but without any indication as to where the lowered reimbursement would be “made up”). However, no significant legislative action was taken in the 1980s, other than the change in the method of reimbursing hospitals that was incorporated in the Social Security Amendments of 1983 (i.e., the DRG procedure).

Catastrophic Health Benefit Plans in Lieu of NHI

Catastrophic health benefit plans have been proposed as a substitute for NHI. The underlying theory of this approach is that the vast majority of people have adequate basic protection, but they need protection against unlikely catastrophic costs. Further, those relatively few who do not have basic protection should be taken care of through public assistance programs like Medicaid.

Senator Long, former Chairman of the Finance Committee, for some time favored a purely catastrophic health insurance proposal, financed from payroll taxes applicable to persons under age 65. Such a proposal was added to social security legislation in 1970 that was not finally enacted because of lack of time for a conference between the House and Senate on differing versions. The Long proposal would cover, with certain cost-sharing, hospitalization in excess of 60 days per year per person and physician and related expenses in excess of \$2,000 per year per family. This proposal was once again strongly advocated by Senator Long in late 1973, with the support of Senator Ribicoff and a majority of the members of the Senate Finance Committee. The proposal would have an annual cost initially of about \$3 billion per year. Its impact on the manner in which medical services are provided would be relatively minimal. In addition, the Long-Ribicoff Bill would extend the protection furnished by the Medicaid program, at an initial cost of about \$5½ billion a year.

The Long-Ribicoff Bill for catastrophic health insurance was strongly opposed by both those who want a broad comprehensive program such as would be established under the Kennedy Bill and those who advocate health insurance protection being provided completely through the private sector. Such opposition occurred, however, for completely opposite reasons.

The expansionists fear that passage of a catastrophic bill would

greatly diminish the pressure for a broader program. The private-sector supporters fear that any catastrophic program supported by payroll taxes will be gradually liberalized, by people being willing to pay just a little more in order to obtain more benefits, until it develops, or degenerates, into a broad, comprehensive plan.

Senator Ribicoff, in supporting only a catastrophic plan that time, had stated his belief that the country was not ready yet, either philosophically or administratively, for a broad comprehensive NHI plan.⁹ Further, he expressed his belief that we should proceed in the national health area on a step-by-step basis. Some of those who oppose this approach do so on the ground that it will expand ultimately to a Kennedy basis. On the other hand, those who support the Kennedy Bill either do not think that this will occur, or else believe that it will take too long.

Other proposals for catastrophic health insurance under governmental auspices took a different approach. For example, a bill sponsored by Senator Brock in 1975 would provide such protection to the entire population, with financing from general revenues. The Brock Bill quite simply would pay for 85 percent of all health care costs in excess of 15 percent of a family's income, as defined for income-tax purposes.

In any event, considering the events in connection with the Medicare Catastrophic Coverage Act of 1988, especially its lack of public support and its repeal, it seems unlikely that steps in this direction in connection with Medicare will be undertaken in the near future. And all this despite the desirability of catastrophic protection in "insurance" programs! It is noteworthy that, in connection with the repeal of MCCA, the prospective beneficiaries complained, most anomalously, about both the high cost involved and the failure to include long-term benefits (which have a cost many times that of the catastrophic benefits).

Resurrection of NHI Proposals

With the steadily increasing relative costs (as compared with prices and with the Gross National Product) of medical care, many proposals have been made for changes in the methods of delivering health care for the total population of the United States. The Pepper Commission was long on proposals for reform, but short on how to finance them.

9. See "National Health Insurance; The U.S. Isn't Ready for It!" an interview with Sen. Abraham Ribicoff, *Medical Economics*, July 8, 1974.

Some proposals would do away with Medicare and establish instead national health insurance on a "free" basis for the total population, financed from general revenues (necessitating new taxes, of course; but at least they would be partially offset by the elimination of private health insurance premiums). Such an approach could be, in general, like the Canadian system, under which physician care is provided, without out-of-pocket cost on the patient for services rendered, in the same manner as services are provided in the United States. The financing in Canada is from general taxation, with physicians being reimbursed on a fee-for-service basis, with a ceiling on annual total reimbursements (so that the individual fees are controlled thereby).

Other proposals would build around Medicare. For example, Congressman Fortney Stark has proposed a plan that would be applicable to all persons other than those covered by Medicare; his plan would be patterned on the Medicare program and would be financed by a 2 percent tax on gross income, a flat premium of \$200 per year for working adults (other than those with low incomes), and employer payroll taxes (up to a maximum of \$800 per year per employee).

Others would solve the problem by requiring employers to provide health insurance for their workers—or else pay a tax. Naturally, employers would provide insurance to the extent of the taxes which they could thus avoid, so that their employees would have some advantage from the situation. Senator Edward Kennedy has proposed this for the nation; his state (Massachusetts) has a law on the books to do so, beginning in 1992, for firms employing six or more workers. Other states, such as Washington, have been working forward incrementally to have health insurance be universal.¹⁰

State Catastrophic Health Benefit Plans

An interesting development in connection with catastrophic health insurance occurred in January 1975 when Rhode Island initiated such a plan. Out-of-pocket medical costs were to be reimbursed for a family after these costs surpassed an amount that varied depending on whether the family had a qualified health insurance policy, as shown in the table on the next page.

A qualified policy under the Rhode Island plan, for example, must provide 120 hospital days, 120 in-hospital physician visits, and in-

10. For more details of state action in the health care field, see Linda Demkovich, *The States and the Uninsured: Slowly, But Surely Filling the Gaps*, Intergovernmental Health Policy Project, George Washington University, Washington, D.C., October 1990.

<i>Health Insurance Policy</i>	<i>Deductible Is Larger of</i>	
	<i>Amount</i>	<i>Percent of Income</i>
None	\$5,000	50%
Qualified policy, but not major medical	1,250	25
Qualified policy, with major medical	500	10*

* 12½ percent for income over \$40,000.

hospital maternity care. The major medical requirement is satisfied by a policy with a \$100-per-person annual deductible (only two per family) and 20-percent coinsurance. For persons covered by Medicare, the deductible is \$5,000 or 50 percent of income, if larger, when no supplemental health insurance is carried, and a \$500 deductible, or 50 percent of income, if larger, when there is a supplemental policy which fills in all the Medicare cost-sharing (a \$1,000 deductible for a supplemental policy that is not this comprehensive). Although specific provisions are expressed for qualification of a policy, one that has somewhat different ones of at least equivalent actuarial value also can qualify. The plan is administered through private insurers and is financed from general revenues of the states.

Several other states, since 1975, established similar plans emphasizing catastrophic-cost aspects. The Alaska and Maine plans were similar to the Rhode Island one. The Connecticut plan was a state-funded catastrophic plan that supplemented a comprehensive-type plan with three optional levels of deductibles (\$200, \$500, and \$750) which must be made available to all applicants, administered through insurance companies (including a state pool of companies). Minnesota had a plan like the Connecticut one.

New York enacted legislation for a catastrophic health care expenses plan for cases where such expenses exceed 50 percent of the excess of family income over the public assistance cash-payment level. When this occurs, there would be equal sharing of further costs (and full payment by the plan when the expenses exceed 75 percent). The plan has never been implemented, because this would be done only when Medicaid will pay half the cost (which it does not do).

The Connecticut plan did not flourish because of lack of funding and, in essence, effectively terminated in 1990, when funds were no longer made available for it.¹¹ The same fate befell the other state plans, and in fact some of them were quietly repealed. At one time, it

11. For further details and information on these little-publicized, little-known programs, see T. Van Ellet, *State Comprehensive and Catastrophic Health Insurance Programs*:

was thought that these plans could well be models for a national program, but such was not to be.

Hawaii Health Insurance Program

An interesting development in Hawaii may give an indication of how a national health benefits program on an employer-mandated basis could be accomplished. In 1974, the Hawaii Prepaid Health Care Act took effect. Under this plan, all private employers must provide health care benefits for their full-time, regular employees. This can be done through an insurance company, Blue Cross-Blue Shield, or an HMO. The benefits must include 120 inpatient hospital days per year, surgical and medical benefits, diagnostic laboratory benefits, and maternity medical service benefits.

This plan is financed by both employer and employee contributions. Employees pay 1½ percent of their wages, but not more than half the cost, while the employer pays the balance of the cost. Employers of less than eight workers can have a subsidy of their cost in excess of 1½ percent of payroll, to the extent that such excess exceeds 5 percent of the pretax net income from their business.

Hawaii has two other health-care programs which serve as "safety nets" to the Prepaid Health Care Program. The first is Medicaid, which Hawaii makes available to people in the categories which meet federal standards (see Chapter 11) and whose incomes are under 62½ percent of the poverty level for Hawaii (mothers with infants under age 1 at 185 percent, with children up to age 6 at 133 percent, and with children aged 7 and 8 at 100 percent).

The second program, the State Health Insurance Program, was instituted in 1990. It provides largely preventive and primary-care services to persons who fall in the "gap" between the employment-related Prepaid Health Care program and Medicaid. Such persons can purchase the insurance on a sliding-scale basis (as their income increases, so does their share of the cost of the insurance). The upper income limit for participation is 300 percent of the poverty level. The benefits are physician office visits (with \$5 coinsurance per visit and a maximum of 12 visits per year), nonelective surgery, diagnostic laboratory tests, preventive services, maternity care, and inpatient hospital care (maximum of 5 days per year).

An Overview, Intergovernmental Health Policy Project, George Washington University, Washington, D.C., October 1981.