ADMINISTRATION HEALTH PROPOSAL

HEARING

BEFORE THE

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WITNESS

ADMINISTRATION HEALTH PROPOSAL

THURSDAY, JANUARY 31, 1974

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 10:20 a.m., in room 2219, Dirksen Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present: Senators Long, Talmadge, Ribicoff, Byrd, Jr., of Virginia, Mondale, Bentsen, Bennett Curtis, Fannin, Dole, Packwood, and Roth.

The CHAIRMAN. Mr. Secretary, we heard the President's State of the Union message last night, and I think you are familiar with the health bills that those of us on the committee have introduced. You have got a plan here that we will be interested to know about, and we will want to see where that would differ from the sort of thing that the Senators on the committee have been advocating.

STATEMENT OF HON. CASPAR WEINBERGER, SECRETARY OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY WILLIAM MORRILL, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; AND HENRY SIMMONS, DEPUTY ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Secretary WEINBERGER. Thank you very much, Senator, and members of the committee.

I must apologize first. I had a difficult choice this morning: I could attend either the Senate Finance Committee or the Lord, and I am afraid I chose the Lord and I am a little late from the prayer breakfast. The traffic was thicker than I had anticipated, but I do appreciate the opportunity to be here with my colleagues, Mr. Morrill and Dr. Simmons, from our office.

There have been so many leaks about this plan, I think what I really should do is simply ask if there are any questions, because most everybody knows all about it. But I do appreciate the opportunity to say a few words about it and as you heard last night, the President does intend to make it a major initiative of the administration, and that means that we will be seeking as early hearings as possible and pushing as hard as we can all during the session to get this.

And I am very pleased indeed that Senator Packwood, who is here, could be one of the principal sponsors for the bill. He is also thoroughly familiar with the plan, and he can fill in, I am sure, any of the points that I miss, which may be numerous.

Basically, this is a plan, Senators, which is designed to provide a very comprehensive form of coverage for all Americans. There is no group that we know of that is excluded, and it is designed to provide a very comprehensive form of coverage for all Americans. There is no group that we know of that is excluded, and it is designed to provide it by building on the strengths of the existing system and not by tearing that down and nationalizing the health insurance industry or the health providers. And it is designed to be done at a cost that can be afforded by both the Government and the individuals concerned. It is a plan that we think will have a significant effect on the delivery and distribution of health care services. It will improve them, we believe.

It is a plan that takes into account the lessons that I think we have learned from the introduction of medicare in 1965, when we put into the system a very large amount of additional health care demand. We did not have anything in the nature of cost controls, and the inevitable result followed that there was a huge inflation of costs of health care because we put into the system this new demand. We guaranteed payment of almost any bill submitted in any amount, and we had a considerable shortage of medical personnel at that time; and with those factors coming together and with no cost, the costs went virtually perpendicular on all of the indexes.

Now we have tried to recognize that we will be injecting an additional demand for health care services into the system, and we have tried to build into this plan suitable cost control for it. We have tried to have a minimal role for the Federal Government. We have tried to provide that there will, of course, be supervision and guidelines established by the Federal Government for the plans, to make sure that the insurance policies are comprehensive and that they do have the benefits provided in the basic plan.

When you say "basic plan," it sounds sort of minimal, but actually, as I hope you will see, there are very substantial comprehensive benefits in this basic plan, and it is one that is really far in excess of the insurance that covers most people right now.

There are some large companies that have plans that are as comprehensive, but very few people are covered under such plans, even though some 90 percent of the people are paying for some form of health insurance. Our information is that the premiums that the individuals are now paying would be very little different from the premiums which individuals would have to pay under this plan.

Well, now, without further basic introduction, let me just run through the structure of it.

The coverage would be provided through insurance from private companies. We started frankly, Mr. Chairman and members of the committee, with a model of the Federal Government, in which a number of different kinds of insurance are offered to Federal Government employees; and the Government has a general supervision through the Civil Service Commission to make sure that the policies are as they were described and that they are offered by companies that are struc-

turally and financially sound enough to pay, and that the premium charged the employee bears a reasonable relationship to the cost of providing the insurance. And all of these things we followed in setting up this system.

So what we would have would be roughly two plans, with the coverage identical. There is no difference in coverage for any person in the United States under this plan. There are different methods of payment and there are different methods of coverage, but the benefits are the same for everyone.

The employer plan would be offered by employers to all full-time employees. The employees would pay approximately, after the plan has been in operation 3 years, 25 percent of the premium cost, and employers would pay 75 percent.

You will see the word "Draft" on the document that we have circulated, and that is to indicate that there are still some minor differences being thrashed about in connection with the drafting of the actual bill.

I might say that when the President's message transmits this plan to the Congress on Tuesday, February 5, there will be a bill attached, a complete bill.* We will not be separating rhetoric from legislation, as has happened too frequently, I am afraid, in the past. We are going to have an actual bill, and that is why we will be pushing as hard as we can for early hearings, because we will be ready this time. That has taken a very long time. It is a very difficult—and as all of you know from your experience with working on other bills of this kind—a very complex subject. But we have spent a lot of time on it, and we do have a bill.

The employer plan, then, would cover the bulk of the people, the work force. There will be a Government plan, where again the benefits are identical, but this would be designed for people of lower income, or people of very high risk employment or very poor health, who could not otherwise obtain coverage except at ruinously high rates.

For the low income, the Government would pay—and that would be the principal Government contribution—the Government would pay a portion of the premiums for those who could not otherwise afford it. So that there would be coverage for all.

The relationship between income and premium payments under the Government plan is set out in the memorandum.

I would like to spend a moment or two on the benefit package, and then one or two other small points and then have as much time as you wish for questions.

The benefit package, we think, is very comprehensive, and far more so than most policies provide today. And we believe it is far better designed, because as you know, Mr. Chairman, most of the private health insurance in this country now lays heavy emphasis on hospitalization, as indeed does medicare, to the point that the recommendation by the physician that the patient go in the hospital is almost the first choice, rather than being the last mode of treatment that should be used and the one used only when it is completely necessary. Hospitalization costs are enormous now, and have been going up at a very steady rate. I think the national average is $146 a day, and there are many more that

*The bill, S. 2970, was introduced by Senator Packwood on February 6, 1974.

are higher than that. So a lot of the insurance that people now have is comparatively illusory in the sense that it may be $1,500 or $2,500 and most of it is for hospitalization, and in a very few days you just exhaust that. So what we have tried to provide is coverage for hospital services and physician services, and we have tried to provide it in a way that did not lead or induce or persuade the doctor to send a patient to the hospital as a first resort.

We are not saying that it should not be used where necessary, only that it should be used only where it is necessary, so that there will not be the concern, or rather almost the eagerness, to send a patient to the hospital.

We provide for a number of preventive services in our memorandum: maternity care; well-child care up to the age of 6, which I think is very important; various examinations for children up to the age of 13, including dental work; and mental illness is covered, including alcoholism and drug abuse, for a limited number of days—30 days of full hospitalization, and the equivalent of 30 outpatient visits in a community mental health setting, for example.

This latter benefit has a twofold purpose: it can encourage treatment in what I believe now most people feel is the most effective method of treating mental illness, close to home with an opportunity to get back into a happy, useful life a lot sooner; and also it can encourage, through the use of the funds that will be flowing from this program, the development of community mental health centers.

We have, as we have testified—and I know there are different opinions on this—demonstrated the effectiveness of this concept and feel that the Government should not be directly supporting the operating costs of these centers, but in any event this benefit would be a very large new source of revenue to community mental health centers, and so support facilities where you can get better and more effective treatment.

Home health services and posthospital extended care are covered up to 100 days a year. Drugs, prescription drugs, and blood transfusions would also be covered, as would all of the other medical services as in medicare. And also there is the provision of catastrophic coverage, so that health costs that exceeded a calendar year limit of $1,500 per person, which under the cost sharing and deductibles would mean care roughly in the nature of a total cost of $5,000, $1,500 to the individual, then everything above that would be fully and completely covered by the insurance.

There is also an HMO option; that is to say, an employee who wishes to have his employer pay not premiums on an insurance policy, but dues in an HMO, can direct that. This would encourage, I think, a greater use and formation of HMO's, at the same time that we are putting the act, which was worked out very well by the Congress and the executive branch and signed last month, into effect.

The cost sharing that I mentioned and the income relationship under the Government plan are set forth in tables in my statement.

I think it remains only to mention that the medicare would be retained. It would be, in a sense, integrated into the system, in that the

benefits provided by the new comprehensive coverage for the two insurance plans, the Government and employer plans, would also be applicable to medicare; therefore we would improve substantially the benefits of medicare and would again follow the basic goal that the President has insisted on, that everyone in the country be given uniform, equal coverage of a very high and comprehensive nature, rather than having different standards of care.

Some question has been raised that medicaid would be terminated, except for certain services that might not be covered by this program. But the medicaid people would be brought in within the coverage of this plan.

Indian Health and Veterans' Administration programs would continue as at present, without termination or reduction of their service benefits.

The health card would be the identification of everyone who was eligible and covered. It would also have some very valuable information, I think, included on the card, such as blood type and other things that would help in an emergency nature. This was not our suggestion; this was a suggestion of one of the Congressmen, Congressman Carey, when we were briefing the Ways and Means Committee, and we think it is a very good one and one that should be added to and included in the plan.

There has been some feeling that there might be differences in care because there are different procedures for reimbursement and billing provided. That is, those doctors who wish to have the insurance companies take care of their billing and their collections would be classified full participating providers, and their reimbursement would come through their acceptance of the various fee schedules. The insurance companies, through the health card, would make all of the collections for them, take care of all of those problems. Those who did not wish to do that could charge a higher rate if they wished to have individuals covered under the employee plan, but that would simply be mostly, I would think, eaten up by the additional administrative costs within their own offices. It would not entail, provide, or call for, any differences in care, and I do not think there would be any differences in care.

Some doctors might not wish to join the plan at all, though I think they would be very few, given the number of people who would be covered. And if they did not wish to join, they would not, obviously, have to, since this is a plan that uses the private system and does not nationalize, or turn into a Government operation, this activity.

There would, of course, be regulation of the insurance carriers provided by the States who would perform the function of making sure that the premiums bore some reasonable relationship to the cost of coverage; making sure that the company was financially sound and could pay the benefits; making sure that the company was in fact providing the benefits that they said they were. But in keeping with the regular practice on insurance regulation, this would be done under this plan by the States.

We have various provisions involving the cost controls that are set forth in our statement and they are attempts to monitor utilization,

prevent overutilization, to insure that the services of doctors and others are within the basic community standards as certified by the PSRO, and are not exceeding that standard; that there are not 12 house visits being paid in 3 days in order to build up charges or anything of that kind. And the entire reimbursement schedules would be worked out and administered by the States and would be full payments for the Government plan and for medicare and for those physicians who wish to, as I said before, turn over their billing, collections, and administrative details to the insurance companies to administer.

The basic role of the Federal Government is set out, as I tried to outline it in my statement, and also the State government role.

The financing would come, as we have said, from payment of joint premiums on a 75–25-percent basis when the plan is fully in operation, with the employer bearing that.

The Government plan costs would be as shown on those earlier tables, and would be income related.

And again, the basic idea would be to try to secure complete and full coverage for everyone of the same uniform, high quality, and comprehensive case.

Additional costs to the Federal Government would be in the neighborhood of $5.9 billion. I think that is a conservative estimate in the sense that I think there would be additional savings and I would hope that the costs would not run quite that high, but I think that is a fair estimate to place before the committee. We hope we might do better.

The State spending under the Government plan, in which the State would share some of the costs, would be, or is estimated at approximately $1 billion, spread over the States, but would be offset by substantial reductions in various State health programs that would be made unnecessary by the comprehensiveness of this coverage.

There is a great deal more I can say about it, but I appreciate so much this opportunity to be able to present it to you that I want to keep it as brief as possible and have the maximum time reserved for questions.

If I have left out anything significant or misstated anything, or there is anything that Assistant Secretary Morrill or Dr. Simmons wish to fill in, why this might be a good time, and then we would open ourselves to as many questions as you care to ask.

Mr. MORRILL. Mr. Secretary, I would add one note.

In our document there is a collection together of a number of provisions designed to ease the situation for the small employer, which, in the debate on the previous bill, was a very substantial problem. This is an area in which there is still some final work going on with respect to the details. It is not whether we will include such as provision, but the precise form, and it may be adjusted somewhat from the recitation that is on that last page.

Secretary WEINBERGER. Dr. Simmons, anything?

All right, sir; thank you very much.

The CHAIRMAN. I think we will start on the far end of the table, with Senator Roth. I would suggest that we stay with the 5-minute rule this morning. That will give everybody a chance to ask at least one question during this morning's session.

Senator ROTH. Well, my first question in a sense is unrelated, but one of the things that has concerned me, Secretary Weinberger, is the supply of medically trained personnel.

On several occasions I have attempted to look a little bit into it because it seems to me if we are going to increase the services and keep the costs down, that it is extraordinarily important that we have adequate personnel. And I find in my own State, not only in the rural areas, but even in the urban areas, we have shortage.

On the other hand, I have had a number of instances—a robin does not make spring—but people, students who have had excellent backgrounds and grades cannot get into medical training.

My question is, what are we doing in this area to insure this? I have met with people in the past from HEW and they say we are training enough. I find that hard to believe. And to me, this is a very important part of the program.

Secretary WEINBERGER. I think our principal problem here is distribution, given the people who are in training and the plans to train those in the future. But Dr. Simmons may want to go into much more detail about it than that.

My impression is that we do have a substantial number planned, but that there is a distribution problem; because there are too many counties in the area of the country that are underserved. And we are trying and hope through this plan to make some readjustment and some better distribution.

Henry?

Dr. SIMMONS. The pipeline in health professions is very full. In fact, the increase, even the proportion of the population, is going to be very substantial—some 30 to 60 percent increase. So the problem, I think, is as the Secretary stated, not in the supply that is coming out of the pipeline now and will come out in the future, but how you get them to locate.

Senator ROTH. Of course, if you had a large enough supply so that they were glutting the more desirable offices or areas, then they would go in the other.

Dr. SIMMONS. We do not have any evidence to support that. As a matter of fact, they probably would create problems from their oversupply in possible unnecessary utilization. That might be much worse.

Mr. MORRILL. It might be well to add that we have a companion effort, about which more will be said, subsequently, directed at this health manpower problem. The problem of the geographic distribution, including emphasis on primary care and other aspects that relate to this distribution problem, is something we hope to address specifically in legislation in connection with our health and manpower activities. We want to see if, in terms of the support that is being provided by the Federal Government to the training of medical professionals, we can begin to influence the direction in which that goes, to solve those specific problems which are not problems of aggregate numbers, but distributional problems.

Senator ROTH. My second question would relate to the Long-Ribicoff legislation.

I wonder if you could spell out the primary differences and problems you see between the two approaches?

Secretary WEINBERGER. Well, I would hesitate to do that in the presence of the authors. I have indicated ours, and my understanding is that their primary emphasis is on catastrophic coverage and on low income families and that it is a plan which would require a substantially higher outlay from the Federal Government. And I am sure, and I know there are a great many other differences, but I would at this point——

Senator ROTH. Do you have any figures on the estimated costs?

Secretary WEINBERGER. I would rely on your figures, sir. I have heard somewhere between $17 and $25 billion, something of that kind.

Mr. CONSTANTINE. No, sir, $5.3 billion additional cost in Federal general revenues for the Long-Ribicoff bill, related to health care for low-income persons, and $3.6 billion in trust funds, not general revenues, for the catastrophic health insurance part.

Mr. SIMMONS. A total of $8.9 billion as I recall. One of the key differences——

Mr. WEINBERGER. $8.9 billion more?

Mr. CONSTANTINE. Yes, sir.

Mr. WEINBERGER. So $17 or $18 billion is roughly the additional new outlay of the Federal Government required under that?

Mr. CONSTANTINE. No, sir. Total new Federal expenditures of $8.9 billion, of which $5.3 billion is general revenues and $3.6 billion trust funds.

Mr. WEINBERGER. I see.

Dr. SIMMONS. One of the key, and I think obvious, differences is whether you have some sort of approach to the employed population, and that is the fundamental difference, I think, between the plans. And part of our objective in terms of the plan that we are advancing, is that we intend to change a bit the nature of the coverage and provide some influence on the nature of the care. It is pretty hard to do that with the partial coverage many have, as we discovered in the public programs, even though there were efforts made to have, for example, some sort of cost containment. They represented a sufficiently small fraction of the total that it was hard to achieve that.

Also, there is a need to balance out the system, if you will, so that outpatient services are on an equal footing with hospitalization, so there is not the skew to influence people to go into the hospital—that also is a pretty hard objective to achieve if you do not deal with all of it.

Senator ROTH. My time is up.

The CHAIRMAN. Senator Bentsen?

Senator BENTSEN. Mr. Chairman, I had to attend a Public Works Committee. We are setting budgets, and they are pretty important, so I would like to defer my questions until later. I did not get to hear the presentation.

The CHAIRMAN. Senator Packwood?

Senator PACKWOOD. I might comment, Mr. Chairman, on three or four things, because I have worked with Bill Morrill at length on this. I think there are some philosophical questions that this committee could come to early, and I think, apart from Senator Kennedy's plan, which is substantially philosophically different, all of the rest of the plans, including yours and Senator Ribicoff's, are harmonizable. It is

a question of how much money you want to spend and where you want to put the threshold. But the questions we are going to have to face up to are first are we going to use private insurers, or are we going to wipe them out?

Senator Kennedy would simply wipe them out. The Government would be the direct writer of the insurance and the direct payer of the providers.

Second, are we going to pay for all benefits from dollar one, or are we going to have some kind of a deductible and coinsurance?

All of the plans except Senator Kennedy's have some kind of a deductible and coinsurance, except for the very low income, in which case you do not have it. We can pay from dollar one, but it is extraordinarily expensive when you start it. And if other nations' experience is comparable, there is a tendency to abuse the delivery system when everybody gets paid from the very first dollar. The cost is tremendous.

There is a third provision in this that may cause the physicians to go up in arms. In your statement where you are talking about a State fee schedule for physicians, there is just one little sentence here. But what you are saying is to the State, you can set the physicians' fees, and that is what they will be paid and will accept for the Government plan and medicare people. How will we provide reimbursement for providers? It is a question we have got to come to.

The fourth philosophical question is, whether we are going to limit this to health?

There will be a strong effort made to include extended facility care, custodial care, not really health care, but custodial. It is very expensive, and it is not really related to health. We must deal with it, but we may or may not want to include it in the bill. But you ought to look at the expense if you do it and the social implications, and realize it is not really as much a health cost as a custodial cost.

And the fifth philosophical question is, how do we finance it?

Do you want to go the general fund route or the trust fund?

And included in trust funds are mechanisms like this employer plan, where employers and employees buy insurance. My preference would be for the assisted plan, that we stick very closely to some kind of guaranteed source of revenue, rather than hoping each year that we get adequate appropriations. This may mean loading even more of the cost onto the employers. Also the question of total cost, depending on benefits and catastrophic levels. Senators Ribicoff and Long's catastrophic trigger is lower. It goes into effect quicker, as I look at it, than this does. It costs more money.

Those are the philosophical tradeoffs I see. And, I think if this committee wants to go we would be wise to address ourselves to the philosophical questions first and decide what we can agree upon, and then see where we want to go with it.

Mr. WEINBERGER. I want to say just one thing, Mr. Chairman. And that is on the financing side. We think that catastrophic is equalized in both bills in the sense that ours is, we believe, somewhat more comprehensive. There may be a somewhat lower threshold, but with the cost saving in the deductibles, I think it is very similar, although we have a certain pride of authorship and we think ours is perhaps better.

On the financing, when the President said last night that this plan can be put into effect with no new taxes he was right. Assume the cost is $5.9 billion, and as I say I think it will be a little bit less than that, and could be substantially less than that, but let us take that range.

What he had in mind was that that should come from the Treasury, and that given the 2-year leadtime on this bill there will be ample time to fit that in as the high priority which he assigns it, with the additional revenues that can normally be expected to be earned on the present tax base within that time.

The payroll tax route was considered and rejected because we have now a very high payroll tax. It was a source of surprise to me to find out that for a majority of families the payroll tax is higher than the income tax. I think that line was crossed about a year ago. And that is a very substantial consideration. And if we would load this onto the payroll tax, it would not just be employers, it would be employees also, who would have a very substantial additional payroll tax over the very substantial amount that is not only there now, but programed to increase in the next few years.

The CHAIRMAN. Are you through, Senator Packwood?

Senator PACKWOOD. Yes.

The CHAIRMAN. Senator Gravel is not here, so then the next Senator would be Senator Dole.

Senator DOLE. Do you have some sheets floating around, information that would sort of separate all of the different plans that are before this committee?

Maybe the staff?

Mr. WEINBERGER. We have not done that. We could do that. I think some sort of a comprehensive tabular sheet could be done in a short time for you, Senator. We would hope it would be impartial, though some of the authors of other plans might feel that we had not stated theirs properly. But we would try to do it as comprehensively and as accurately as we could.

Senator DOLE. I think we all have our own little charts. But I think it would be helpful in view of the new program, particularly as far as benefits.

Now, I understand this covers everyone?

Mr. WEINBERGER. There is no group that we know of that would be excluded by this plan. There are some who have said the unemployed would be excluded. That is not correct. They would be covered, because the Government plan would pick up at this low-income level. The self-employed would be covered. The employed would be covered. There is no specific exclusion, like farmers or household help or anything like that. Everyone so far as we know of would be covered.

There is a feature in the plan which I think is important to maintain, and that is that while the employer would have to provide the coverage, the employee is free to choose or not to choose. If he does not want it, he would not be required to take it. And that obviously would be true of the self-employed. But that is not an exclusionary category as we see it. That is a voluntary decision, and there is no group that is excluded.

There are now approximately 90—87 or something like that—percent of the people who have some form of health insurance. We be-

lieve this would be a much more comprehensive, better designed, complete package, and I would think there is no reason to suppose that there would be anything less than 95 percent of the people or 90 percent of the people who would be covered by this plan should it be put into effect.

Mr. MORRILL. It might be well to supplement that with a few illustrations. We have an estimated population of three to four million people who are in the category of early retirees, no longer covered by an employer plan, not yet into the medicare program, who even though they may have satisfactory incomes can either not get insurance at all or get it only at very high rates. There would be an opportunity for them, should they so desire, if they cannot get insurance coverage on the basic plan at less than 150 percent of the State average group rates, to enter the Government plan at that price, so that they could obtain access to coverage.

And we have created that, if you will, as a safety valve in that Government plan that, failing all else at a reasonable rate the individual could enter that plan at a reasonable rate.

Senator DOLE. Well, I think, second, just a broad question.

As I look at the outlay, which I have done before, and listen to the Secretary, it appears that it is a much broader program than we have had before from the administration as far as dental coverage and others.

Does it cover podiatry?

Is that included?

Mr. MORRILL. Yes, it—although, Henry, you may want to——

Dr. SIMMONS. It covers preventive foot care. We have not yet defined whether that is——

Senator DOLE. One of my podiatrists is already worried.

It covers most everything, is that right?

Mr. WEINBERGER. We think so.

Senator DOLE. Chiropractic?

Dr. SIMMONS. Well, we have not spoken to that.

Mr. WEINBERGER. The medicare rules on chiropractic are a model that conceivably could be followed.

Mr. MORRILL. Honestly, you know, that is the one medicare benefit that we have been a bit reluctant about including, that one.

Senator DOLE. I think you have to make some adjustments in the proper sense of the bill.

Senator CURTIS. Would you yield to me right there?

Senator DOLE. I want to make a point about rural Americans.

Senator CURTIS. On this chiropractor business and all these others, particularly for that block of people where the Government does not pay any part of it and the service is provided by private insurance coverage, what business has the Government in that? What kind of physician or healer you want to go to?

Now, why do we have to cross that bridge?

Mr. WEINBERGER. I suppose, Senator, one of the problems is that the desire is to make uniform and complete the coverage for everyone, rather than saying that the employer plan has certain benefits and certain items and the Government plan for the low income has other ones. The desire here was to say that everybody should have the same

care, but obviously there are going to have to be different means of financing and paying for it, and that would be one thing. And I would suspect that the desire to have that kind of similar treatment for everyone regardless of income would be one of the main factors here. There is a Government interest in this kind of plan because the statute, would require the employers to furnish it, and that kind of interest has led in the past in Medicare and other programs that are based on a contributory system to have a substantial Government interest in the kind of care and in the quality qualifications of the health providers.

Senator DOLE. I think my time is about up.

Senator CURTIS. Excuse me. I am sorry. Charge that time to me.

Senator DOLE. I just want to supplement what Senator Curtis said. In many of our Western Kansas counties, the same question that Senator Roth raises and everybody in this room that has rural areas, there are not any M.D.'s. And the chiropractor, I think, provides a real service. At least he knows how to get hold of a doctor if he needs one. And in many cases he can provide appropriate care.

So hopefully they will not be totally excluded.

Mr. WEINBERGER. I do not think there has been any decision to exclude at all. We have had the problem, as you know, of trying to define it in regulations with the medicare coverage and medicaid coverage, and there are different——

Senator DOLE. Osteopaths are included?

Mr. WEINBERGER. Yes, they are. Osteopaths I think for the most part are equivalent to physicians at the moment in most States.

Senator DOLE. Right.

Mr. WEINBERGER. But there are differing degrees as you move down or across the spectrum, however you want to phrase it, and you do sometimes get into some fairly strong cults that claim to be able to administer these services and are not slow about demanding reimbursements. And there is the protection of the public idea that is involved here. And I think it is fair to say on the two that you have mentioned there has not been any decision, and we would certainly be more than willing to listen to various arguments on it.

Henry, you might want to add something on that.

Senator PACKWOOD. Cap, I think you might want to add, on the employer plan where you are talking about covering the bulk of the people in this country—this bill sets forth a base, not a ceiling, and if they want to negotiate for anything additional, they will simply pay more.

Mr. WEINBERGER. That is right. It is a very high base, but it is a basic plan. And whenever you say basic plan or minimum plan everybody thinks that maybe 1 day in the hospital and a visit to the doctor every year or something like that. But this basic plan is very comprehensive. But it is a base, and obviously, as the Senator has said, anyone who wishes to bargain for more or pay for more would be perfectly free to do so.

The CHAIRMAN. Senator Mondale?

Senator MONDALE. What is your estimate of the increase?

The CHAIRMAN. If I might just interject, gentlemen, all I can do is call on the Senator for his turn. It is up to him to guarantee that he gets the benefit of his 5 minutes.

Senator MONDALE. Well, I would like to, Senator Long.
Is time running now?
[General laughter.]
The CHAIRMAN. All right, start now.
Senator MONDALE. What is your estimate of the aggregate increased dollars that would be spent on health over the present level, if this plan goes into effect, when it is fully in effect?
Mr. WEINBERGER. That would be 2 years, a little over 2 years downstream. And I will ask Secretary Morrill to see if he can deal with that one.
Mr. MORRILL. The total of what we call induced demand is in the range of about, we believe, $4 to $6 billion.
Senator MONDALE. In other words, for all of the increased public and private spending it would only be $4 to $6 billion additional aggregate spending for health in the country?
Mr. MORRILL. In terms of demand on the system, and most of that will go in the direction of the outpatient services.
Senator MONDALE. I am not asking were it goes now. I just want to know how much additional money would be spent, from whatever source, over what would have otherwise been spent, assuming this is the system.
Mr. MORRILL. I would like to doublecheck that number, Senator, but I think $6 billion is the one I am carrying in my head for that, the answer to that question.
Mr. WEINBERGER. There is a real hypothetical factor in that we have to estimate what would have been spent in any event 2 to 3, 4 years downstream, which is not all that certain. But trying to do that, that is the extra we have estimated.
Senator MONDALE. If this is supposedly a dramatic new program to bring adequate health care to all Americans, how can you do it for $4 to $5 billion?
Mr. MORRILL. Well, the total industry, as you I am sure know, is indeed a very large one in terms of how those health costs are now distributed in the society. There are, in our view, some things on which one would expect to go minus as well as plus. That is, to the extent that overutilization exists out there or that there is hospitalization at a higher costs when outpatient services would do as well as a lower cost to meet the medical need, there are both pluses and minuses involved in a forecast such as total induced demand.
Dr. SIMMONS. Senator, that is a difficult question, because you have to take two assumptions: One that we will continue to do things exactly the way we have now, but just do more of it, or two, that some of the programs this committee has instituted like PSRO will start taking effect. Because there are substantial differences from the way we can practice medicine today that will give better quality care at a very substantial savings. You know, if cataract patients just start staying 1 day the way our best evidence now shows is actually safer for them, that is a three-quarter billion dollar saving a year.
Senator MONDALE. Well, so in other words, what this program involves is a modest increase of new spending on health of $4 to $6 billion. But in addition you argue it is basically a reshuffling in the way in which health care is delivered so that you get better health care, in your opinion, for less?

Mr. WEINBERGER. I think, Senator, it is more than a modest increase. It is a substantial increase. But there are also some substantial nets against what is now being spent, I might say unnecessarily or in a way that does not necessarily benefit the health of the Nation.

Senator MONDALE. Well, I follow that.

How much is being spent this year totally on health do you estimate?

Mr. MORRILL. I think we are getting close or heading close to $100 billion.

Mr. WEINBERGER. $90 billion is the figure we use.

Senator MONDALE. So this is maybe a 5-percent increase, maybe a 7-percent increase in spending for health?

Mr. MORRILL. In total, yes.

Senator MONDALE. Now, I notice in your outline IV (7), you refer to (e) tax provisions, but my copy does not have any tax provisions.

Mr. MORRILL. There were two items that the Department had discussed in terms of what might be done, and I think they are probably both reasonably well known. One is a proposal with reference to the treatment of employee contributions to health insurance premiums as to whether those ought to be allowed as a deduction. And the other was——

Senator MONDALE. They are now, are they not?

Mr. MORRILL. They are now.

Senator MONDALE. And have you decided yet what you are going to do?

Mr. MORRILL. The Treasury Department was, I think, before the committees last spring suggesting as a part of the tax simplification package that the elimination of that deduction was one change that ought to be——

Senator MONDALE. How much would that save the Treasury?

Mr. MORRILL. There was in addition to that the treatment of employer contributions to the premium, a question of whether those ought to be treated as wages to the employees or as they are now, not treated in that fashion. The value in terms of revenue loss, if you will, to the Treasury because of those two provisions was on the order of about $4 billion. Most of it was in connection with the treatment of the employer contributions to premiums.

Senator MONDALE. If I could just ask one more question——

When you talk about Government costs and say $6, $7 billion, are you talking about an addition of Federal revenue if you change the tax treatment?

Mr. MORRILL. If a change in the tax treatment on those two items were to be proposed, the $5.9 billion additional would be offset by additional revenues flowing into——

Senator MONDALE. So it would not cost the Government anything?

Mr. MORRILL. Yes; a couple of billion dollars.

Mr. WEINBERGER. The financing provision, Senator, was proposed when we first devised the plan as a sort of alternative. That is to say, you can do it by making it a high priority and adding it to the total cost to the Government out of the Treasury 2 or 3 years downstream, or you could get this additional revenue in. And if you took the latter, as you say, there would be very little cost. And that was the choice that we put, or we offered in the plan.

Senator MONDALE. It has not been made yet?

Mr. WEINBERGER. No, it has not been made yet. But it has been made in the sense that it has been decided that it would probably be better not to do it in this bill, but to let the Treasury effort on tax simplification proceed with all the tax provisions incorporated. It is more a matter of arrangement than anything else.

Personally, I think it would be a better way to go. But the desire is not to try to do it in this bill, and I think there is a lot of sense to that.

Senator PACKWOOD. Cap, I wonder if I might add a comment on your fiscal figure, because I worked with Jay and Jim, and I think their estimate is low as to what this is going to cost. If you assume $90 billion in expenditures this year, a rough estimate, had this plan been in effect this year I think we figure, what, someplace between $105 and $110 billion total. Not new, total.

Mr. CONSTANTINE. About that. Yes, sir.

Senator PACKWOOD. The reason being, the basic plan is so high, it is so relatively costly, where the new money is coming from is the employers. The employee contribution will probably actually go down because there are very few plans at the moment, even limited plans, where the employer is paying three-quarters of the cost. It is very unusual to find that situation.

Mr. WEINBERGER. Well, Senator, you are not talking of the cost to the Government being low.

Senator PACKWOOD. Well, I am not sure. I think Senator Mondale was asking how much total new money is going to go into medical.

Mr. WEINBERGER. That may be a bit low. It is very hard to estimate that figure, and every once in a while one of our estimates is not quite right. So I am a little hesitant to offer too many of them. But I think it is true that for the average person, for the average employee in this country, this plan contemplates either the same or lower payment for a far more comprehensive coverage.

The CHAIRMAN. Senator Fannin?

Senator FANNIN. Thank you, Mr. Chairman.

Mr. Secretary, in your statement you cover the Federal programs, what we talked about today. I notice quite extensive changes being made in the medicare, but when you get over to medicaid, you say medicaid would be terminated except for certain services not covered by NHI. And then you give the list here of some of the additional services.

What cost controls do we have in this program that are not present in the existing medicaid program?

Mr. MORRILL. In terms of the existing medicaid program, there is a reimbursement schedule, but most States do operate in terms of what they will reimburse providers, and that varies very substantially as between States.

One of the features of the new plan is that the reimbursement schedules, both for the institutional providers and the individual providers, would be uniform for all plans in the State. And what would tend to happen, at least in some of the States, is that the medicaid reimbursements would be low relative to what they would likely be under the plan.

The cost controls on the institutional providers now are basically under the phase 4 system and are being operated through that direc-

tion, although, obviously, the public programs now are paying attention to their reimbursements in light of those controls.

We would expect States to do more in the way of oversight of new facilities and certificates of need. Some of them are now doing it. By and large, those States which have very large medicaid programs have stepped in and done a fair amount of oversight, because if they did not, the program would eat them alive. They have been quite aggressive in terms of getting on top of it. Other States, with smaller programs, have done less.

Senator FANNIN. The reason that I am so concerned about the costs and what would happen is because, as you know, my State happens to have particular problems in this regard, and perhaps more so than most any State in the country. But we have hesitated, our legislature has hesitated, to go into some of these programs, just because the experiences that have been related to them from other States, some in the neighboring State of New Mexico that you are probably familiar with.

But we do have a peculiar problem, too, with the number of Indian citizens we have in the State. And, of course, I understand that the Federal Government offered them a separate program to insure Indians now eligible for IHS, and this, too, has been something that we have been negotiating with you. But I think that is probably something I should discuss individually, rather than to bring it up at this time, but I am vitally concerned as to just what is being done in that regard and how we can proceed to take care of our Indian citizens in the perspective of what will be done for the other citizens of our State and Nation.

But, as I understand it, on this program you have further explanations of your plans that might cover some of these areas?

Mr. MORRILL. Yes, sir.

Senator FANNIN. And, so I would await that, but I would hope that we could be able to get through legislation this year that would help take care of some of these needs now that are certainly lacking. And we have cases where some of the load is thrown off onto the communities that I would hope would be taken care of in this particular program.

Do you think that that will be more effective in that regard?

Mr. MORRILL. Well, with reference to the Indian population that is now eligible for IHS services, they would clearly be made no worse off and not disadvantaged in any way. Indeed, we tried to open up within the framework of the plan additional opportunities for them. The IHS would continue to provide services to that community, but in addition—and the benefit structures, of course, would be essentially identical for all—we would provide in a non-IHS setting for Indians to participate in our program, should they so choose and be eligible.

Senator FANNIN. Well, I am still vitally concerned about just what procedures will be followed that will insure that these costs will be held down and that we will not have the serious problems that some of the States have experienced over the past few years.

Thank you.

The CHAIRMAN. Senator Ribicoff.

Senator RIBICOFF. Mr. Chairman, this plan is so complex that it is mind-boggling. I hope somebody knows what is in it. I was rather

intrigued with the President's statement, the statement by Mr. Weinberger, that this would not cost the Treasury—the taxpayers any money.

Do you assume that it is not costing the taxpayers as individuals any money?

What is the total cost of the premiums that the employer and employee will have to pay?

Secretary WEINBERGER. We estimate that the premium cost for employees would be somewhere in the neighborhood of $200, around in that range. And we also believe that that is at or below the present average that the 85, 88 percent of the people who have health insurance are paying at the present time.

Senator RIBICOFF. What does the employer pay?

Secretary WEINBERGER. And the employer would pay somewhere in the neighborhood of $420 to $440, I think it is, and that is a bit more than employers are paying at the moment.

The President's statement, Senator, was entirely based on governmental costs, and there is just no question that people are going to have to pay something for this coverage on a personal basis, unless they are very low-income or people in the categories covered by the Government plan.

Senator RIBICOFF. So, really, there is no free lunch here?

Secretary WEINBERGER. Well, of course not.

Senator RIBICOFF. Well, I don't think you should kid the American people that this plan won't cost them by way of taxes or social security or otherwise. It is going to cost them money out of their pockets somewhere.

Secretary WEINBERGER. Certainly. As Government employees we pay for the health insurance. Somebody is going to have to pay.

Senator RIBICOFF. It is going to cost money.

Secretary WEINBERGER. Oh, yes, sir. His statement was that it will not require any additional taxes.

Senator RIBICOFF. But it is going to cost money whether you pay a tax bill to an insurance company or you pay it to the Government?

Secretary WEINBERGER. There is no way you can get free medical care unless you pay taxes for it or costs for it.

Senator RIBICOFF. OK.

What do you figure total premium costs will be to the employers and employees; more than they are paying now?

Secretary WEINBERGER. Well, as far as employees are concerned, a little less.

Senator RIBICOFF. I want the total.

Secretary WEINBERGER. The total figure would be the $200 plus the $440 that I mentioned.

Senator RIBICOFF. What does that add up to for the whole package, nationwide?

Mr. MORRILL. I was going to suggest, Senator, there is a description of the premiums that we are projecting for both the family and the individual and what, for the composite or average group rate, it would be nationally, with the total being $625 for the family, of which the employer would carry three-quarters at full——

Senator RIBICOFF. I know, but I want the bottom line for the whole country.

Mr. MORRILL. The total dollars through premiums? I am going to have to get you that number, and I will do so.

Senator RIBICOFF. It becomes very important. The Long-Ribicoff plan costs $3.6 billion through social security and $5.3 billion through general revenue; that is $8.9 billion. That is what it is going to cost.

Now, what is yours going to cost overall? In one way or another, it is coming from the people.

Mr. MORRILL. Right.

Senator RIBICOFF. All right. Let us find out what it is, in all fairness.

Secretary WEINBERGER. If you are using the Long-Ribicoff figure, Senator, as the cost to the Government, we have those. Your own plan, of course, would mean the people would also still be paying a very substantial amount for other insurance and so on.

Senator RIBICOFF. That is right. But I want to know what the total package is.

Secretary WEINBERGER. Well, the total package is as we have presented it, and the total additional cost to the Federal Government is as has been stated. The total additional cost to the individuals and the company we could only pull together after we could find the total cost that is now being paid by each employer and try to measure it against this 2 years downstream, taking into account the guesswork that is involved and what collective bargaining agreements would bring with or without this bill in the next 2, 3 years.

Senator RIBICOFF. Well, you people have been working on this for years, and you do not have a total cost?

Now, in addition, as I see, you are paying 75 percent of the amount if the total premium for an employee exceeds 10 percent of the worker's wages. What does that amount to?

Secretary WEINBERGER. We did mention that there is still some discussion going on with respect to providing some relief for small employers, employers of a small number of employees. And that is what that provision is all about, and that is one of the ways in which we try to ease the burden to smaller employers.

Mr. MORRILL. With respect to the additional subsidy for low-income employees and employers, as we have it in the plan, as indicated on page 13, we estimate that it will cost about $800 million.

Senator RIBICOFF. Do you still intend to charge to the employee as income, the total premiums paid by the employer?

Secretary WEINBERGER. That was the point we covered a moment ago, Senator, and that was initially suggested for inclusion in this bill. At the present time, the suggestion is that that not be included in this bill but that it will possibly be presented to the committee in the form of the Treasury's overall tax simplification measure.

Senator RIBICOFF. But, generally, if we are going to do it, we have got the responsibility to see what you are driving at.

Secretary WEINBERGER. That is correct, but there are two ways you could finance it. You could simply say we would finance it 2 years downstream by assigning a high enough priority to it in the budget process, so that the extra $5.8, $5.9 billion is taken out of general revenues. Or we could say we would take in approximately $4 billion

of new revenue by making it taxable to the employee and, therefore, substantially reduce the total net new cost to the Federal Government.

And at this point, the decision is to submit the bill to this committee without that additional taxation feature, which would mean that there would be about a $5.8, $5.9 billion additional cost to the Federal Government to be financed as recommended in this bill, by general taxation out of the general treasury ,which would not require additions to the tax rate because it would be included in the budgets.

Senator RIBICOFF. Just one comment. It is very ironic that it is not going to cost the taxpayer anything, but it is going to cost the Treasury $5.9 billion.

Well, who pays the money that goes into the Treasury? The taxpayer.

Secretary WEINBERGER. Senator, it is exactly the same problem we had with cost sharing. We have a $6.5 billion program that is not costing the taxpayers any more than they had to pay before because it is assigned a higher priority than some of the other requests.

Senator RIBICOFF. Well, my only comment is, whether your plan is good or bad, the one thing you shall not get away with is kidding the American people.

Secretary WEINBERGER. There is no intention or suggestion of doing that, and I think the President's statement last night is quite accurate, that it will not cost the American taxpayer any more. By itself, the passage of this bill will not result in an additional demand being put on the American taxpayer for Federal tax payments. I think that is clear.

Senator PACKWOOD. Let me give you a rough answer to your——

Senator RIBICOFF. It is not my time. If Senator Long will allow you, that is fine.

The CHAIRMAN. I yield you 1 more minute, and you can do whatever you want to with it.

Senator RIBICOFF. I yield to Senator Packwood.

Senator PACKWOOD. Jay, Jim and I have tried to play with these figures. Again, assuming that $90 billion was the cost of health care in the country this year, and if this plan had been in effect, it would have been $110 billion, roughly, $6 billion of it from general fund—it is a guess—$14 billion of it from the employer plan, which is three-quarters employer, one-quarter employee. So you have got a new cost there that the employers are not otherwise covering.

Then, my hunch is, of the existing $90 billion, of which a fair portion is covered by insurance, you are going to have a shift a little bit more toward the employer, a little bit less from the employee, because of the 75 to 25 split.

Senator RIBICOFF. Well, that is exactly what Senator Kennedy's argument—in other words, you are shafting Senator Kennedy by saying, My God, you have got a plan that is costing $90 billion, $100 billion.

Well, Senator Kennedy says, all I am doing is substituting an overall plan in which the overall costs to the individuals come to the same thing.

Now, you say that is horrendous, what Senator Kennedy is trying to do. But what you are arguing is exactly the Kennedy approach.

Secretary WEINBERGER. Well, no, sir, Senator—oh, excuse me.

Senator PACKWOOD. And also the very significant philosophical difference of whether or not you are going to use private insurance companies.

Senator RIBICOFF. Well, I am not for the Kennedy plan, but in all fairness to Senator Kennedy, what you are really coming up with is the Kennedy approach, but instead of social security or Government funds, you are using the private insurance companies. So it is unfair to Senator Kennedy. I am not here defending him, because I criticize the Kennedy plan.

Secretary WEINBERGER. There is a tremendous difference between the two, Senator. We have in the department now 126,000 employees. I do not want that figure to go over 250,000, and I do not want to have all of the doctors in this country be Federal employees, and I do not want to have all of the health insurance be a Federal responsibility, and we are not talking about any attempt to conceal overall total payments for health by the American people. But we are talking about how it is done and what you get for the money and whether or not you are going to have an enormous and unwarranted expansion, as we see it, of Federal authority and Federal taxes.

The cost—somebody is going to certainly have to pay for health care. There is no free lunch, as you said. But the difference between who pays it, how it is paid, and what you secure for your money is the difference between day and night, and we think that is the difference between this bill and Senator Kennedy's bill.

The CHAIRMAN. The staff is working on a table comparing the cost and features of all the different plans so that everybody can see the different elements of the various plans and they can put whatever interpretation they want on it. I am sure everybody can give their own interpretation, and I doubt if you are going to give the other fellow's plan quite as good a break as he gives his own. That is how it tends to work out.

Dr. SIMMONS. Mr. Chairman, before Senator Mondale leaves, though, there are three questions that have come up here—Senator Ribicoff's, Senator Curtis', and Senator Mondale's—on costs. It seems to me it would be very unfair to talk about, you know, costs alone, unless you consider one thing.

This committee knows better than I do that there are a lot of problems in the medical care system. There is tremendous overutilization, misutilization, a lot of what we do makes no sense, and we have no preventive program.

Senator Curtis said why put in a whole program, why not put in just a piece. Well, there is a good reason, you can provide leverage on the whole system by the plan you put in. You could affect it by the plan you put in. And what we are saying is that with the same amount of dollars, or maybe more, you could provide a lot more care, depending on whether you encourage outpatient utilization. If preventive services really work, and there is good evidence that it does, that is going to affect costs.

And if, in addition, you put in a utilization review system that affects the total amount of care given, not just medicare, medicaid, and not just inpatients care—that system is important to consider when you talk about costs. There could be substantial differences by

the kind of system you put in. It seems to me that is one of the beauties of this kind of an approach.

Secretary WEINBERGER. The only amendment I would make to that is I do not think Senator Curtis said that. Some people have said that there should be a much smaller partial plan. And the reason we are putting in, are recommending, a comprehensive plan, is because we think we can get an overall net benefit of delivery and restructuring.

The CHAIRMAN. Senator Curtis.

Senator CURTIS. Is this compulsory on all employers?

Secretary WEINBERGER. On employers? Yes, sir.

Senator CURTIS. Is it compulsory on the self-employed?

Secretary WEINBERGER. No. The self-employed and the employee would have the choice as to whether they wished it.

Senator CURTIS. Well, now, the employers' burden is going to be three-fourths of $625 when this is in full motion. How are you going to enforce it?

Secretary WEINBERGER. Well, it would be enforced initially by overall guidelines.

Senator CURTIS. No, what I mean is, what are you going to do if he cannot do it?

Secretary WEINBERGER. If he does not pay?

Senator CURTIS. If he cannot do it. You see, you have got to view the burdens of Government cumulatively. And we go to the little fellow that has got one or two employees, they are all making a living. They are not upon the Government. But we hit him on the head with Occupational Safety and Health requirements, and now we say to him, here is an additional $100 a month compulsory payment.

What are you going to do with him if he says I cannot do it?

Secretary WEINBERGER. We do have some provisions to ease the burden for small employers. I think, Senator, the ultimate answer to your question is the same that would be true if he is unable to meet Occupational Health and Safety standards or if he is unable to meet minimum wage, or if he is unable to meet any of the other things that are now imposed by the Government.

The problem we have here is that at the present time, a very large number of employers have some kind of health insurance that they are paying for as a result of either collective bargaining or other negotiations with their unions. The trend of this is such that we think, in the 2 years downstream when this plan would be fully operational, most of them and a great many more will have very much higher payments to make than they have at the present time and that would be required by this proposal.

There is no doubt—and I agree with you—there are a great many burdens on employers of labor today. This would be another, but it would be one that is not wholly new and would be ultimately, I think, because of the improvements that we could make in the whole health delivery system, a lower amount than they would otherwise be forced into making by negotiations and bargaining.

Senator CURTIS. Well, that applies to the larger employers where labor is organized. But my hometown—and I do not think the business-

men average five employees apiece and they are not asking to be subsidized.

Secretary WEINBERGER. No.

Senator CURTIS. And, now, all of this will be handled through the insurance companies?

Secretary WEINBERGER. Yes, sir. We would not have the Government collecting or paying premiums, and we tried to keep the role of Federal Government to an absolute minimum.

Senator CURTIS. Well, I can further minimize that for you, too, and I will do my best to do it. [General laughter.]

My ideal of a healthy country is one where the Government keeps its hands off. That would be the best thing for blood pressure and peace of mind and enjoy vacations and so on.

Now, suppose, under this plan, there is too much paid for a particular medical service. It costs the insurance company, less profit for them, and they are in a less competitive position, and I know of no reason why the Government should set fees, because you have told them what their obligation is. If they do not perform, they are out. If they pay too much for what they get, they do not have any profit, and that is a better restraint than you ever can establish by a Washington bureau.

Secretary WEINBERGER. Senator, I am fully as strong a supporter of the free market system as you, and I appreciate and agree with all the things you are saying. There is one additional problem here, and that is, you do not really have all that free a market in the health care field, because you have had the Government enter already in many ways, with medicare and with medicaid and with a number of other programs and guarantee up to this point repayment of any charge that is made, and do it for a very large number of people, with a cost of some $18 billion.

The problem is that in the years since medicare has come into effect, without a free market, and with that kind of a Government intervention already, the inflation in health care alone has eroded——

Senator CURTIS. No. I am talking about medicare; I am talking about this new plan.

Secretary WEINBERGER. Well, there is such a large chunk of the market already invaded, so to speak, by Go rnment in the medicare field that you do not have the forces that you were speaking of that can operate in the rest of it. I wish there were, but I do not think——

Senator CURTIS. I think all you would have to do is, the Government will not pay more than the insurance company is paying, a fee beyond that.

Mr. MORRILL. One specific response, Senator, with respect to the cost control features, be it for individual hospitals or individual doctors, is that it would not be done as a Federal program, but, indeed, would be done within each State by the State in accordance with what is more nearly customary for them.

Senator CURTIS. If the insurance companies pay too much for that, they are going to pay it out of their profits, and let them worry about it. And why do you not just provide that the Government does not pay, in the part where they are obligated for reimbursement, beyond; let the insurance companies pay it.

Secretary WEINBERGER. Well, I am afraid that the testing of that idea with the Government intervention that is already there and the basic policies of reimbursing charges that are made, has contributed very largely to the rapid increase in health care costs. And I feel, Senator, that we could not propose a degree of Government participation in the increase of demand of health care without having some kind of health care cost control built into it, and that is a reluctant and a difficult decision for me to make. But I think the experience that we have had since 1965 when medicaid came in more or less compels that.

Senator CURTIS. But you have a different situation. Prior to the entrance of the Government, the insurance companies did have it under control and did hold down costs. It was the intrusion of Government that created the inflation.

Secretary WEINBERGER. I agree with that.

Senator CURTIS. And I do not think the Government setting fees will save a dime for the taxpayers, and I am sure—I am not worried about the individual doctors; they are going to get along all right; they are smart; they are well educated; they can do anything they want to. But, I have never yet seen an industry, including the oil industry, where they start in for the Government to decide how much money they ought to make and they did not create scarcities. So, I just do not think there is any need of that. But, I will not take any more time.

I am not mad. I have got an appointment.

Secretary WEINBERGER. Thank you, Senator.

Senator BENNETT. Mr. Secretary, I am going to do some nit-picking. I am going to ask some technical questions. In your statement, you say, "The employer plan must cover all employees under age 65 and his family members." Employees do not retire at 65 necessarily, so are you going to put that kind of a limit, that they lose their coverage if they keep working after 65?

Mr. MORRILL. No. They would move at that point in time into the medicare program and could well go on being employed.

Senator BENNETT. That has some dangerous possible effects on the whole social security program, because if in one instance a man can claim social security benefits and go on being employed, then maybe he can claim the cash benefits and go on being employed.

Secretary WEINBERGER. Senator, medicare has been administered separately from the social security system and with separate rules. I would not think you would be setting that kind of a precedent for that.

Senator BENNETT. Well, I was not allowed to go on medicare until I had complied with the social security rule that I was 72 and, therefore, out from under the minimum earning estimates. So, in effect, social security operated with me on the medicare rules.

I just raised the question. I think you had better look that one over.

What happens to the employee who opts out? Can he have a second chance?

Secretary WEINBERGER. Oh, yes. Yes.

Mr. MORRILL. Oh, yes. There would be something like an annual enrollment period during which, if he changes his mind and wants to get in, he could do so. He would have the opportunity at the initial time or the time of employment, and then at specified periods thereafter.

Secretary WEINBERGER. Based on the Government plans where there are the opportunities to shift I think twice a year, maybe once a year. I have forgotten.

Senator BENNETT. You then say, "Employers who desire to do so could offer the Government plan at 150 percent of the average group rate in the State."

That puzzles me. What does that mean?

Mr. MORRILL. Well, there are some high risk employers who are unable to find on behalf of their employees a plan at any reasonable price. This would provide an out for that kind of a group, where if they could not get coverage through normal private insurance mechanisms at a 50-percent increase over the rates applicable to that kind of a group within the State, they could then as a group enter the Government plan.

What that feature is designed to do is to provide access to affordable insurance for all, including that group. Sometimes the insurance premiums run 200, 300, 400 percent; and that seemed like an unreasonable situation to us; so we included this kind of a provision.

Senator BENNETT. So in effect, insurance companies could refuse to cover an employer for any reason of their own; and if he is refused coverage, he can then get a coverage under the state plan for 150 percent of premium.

Mr. MORRILL. Let me say in terms of——

Senator BENNETT. It may be credit. It may not be the qualifications of the people. It may be credit.

Mr. MORRILL. There is every reason for the insurance companies obviously to compete for coverage amongst various employer groups; and indeed, we included a provision you may not have come to, in terms of looking at the coverage for the group under 50 in size. We have established in effect a community rating for that class group, saying to the insurance company you may set your own rate for that class, but once you offer it to one, you must offer it to all for the same price.

Senator BENNETT. Then there was another question. The fee schedules will be set by the State on the State plans. Will they be set for the employer plans in that State?

Mr. MORRILL. Yes, for all.

Senator BENNETT. The same fee schedule?

Mr. MORRILL. Yes, for all plans.

Senator BENNETT. That was not clear to me.

That is all I have, Mr. Chairman.

The CHAIRMAN. Mr. Secretary, this is the first time I have had to congratulate you publicly for doing something I have been advocating for a long time. I see that you have done something about prescription drugs in requiring that they be made available by the generic name. I think you are going to save a great deal of money with no sacrifice to quality. That action is just something that was long overdue. I am

very pleased to congratulate you on being the Secretary who had the courage to bite the bullet and go ahead and make the move.

Secretary WEINBERGER. Thank you very much, Senator. It has drastically increased our mail, but I still think it was the right decision.

Thank you, sir.

The CHAIRMAN. You are just as right as you can be about that; and I have been advocating it a long time. That is a place where we will make a big savings in the cost of medical care.

Secretary WEINBERGER. I hope so.

The CHAIRMAN. Now how much are you going to let the insurance companies charge us for selling and advertising costs under this new program?

Secretary WEINBERGER. Well, the regulation of the companies, Senator, would be a matter of State law with Federal basic guidelines and supervision, since it is coming into being under the hypothesis of a Federal statute. And the guides that I have had in mind generally are those that are used by many of the regulatory agencies at the present time; and that is that the premium has to bear some reasonable relationship to the actual cost of the coverage itself. And that certainly involves a consideration of what are allowable costs, as you have indicated.

And I think if Senator Curtis was here—I wish he could hear this—I think the free market is going to have quite a bit to do with this, because this is a very substantial additional market for insurance companies to compete in.

And I do not think that you are going to have any company, even without State regulation of a reasonable kind, that is going to be allowed, because of market factors, to get very much out of line with very large promotional or advertising costs.

I think there is going to have to be—I think there will be—pretty good competition for the carrier to serve various groups of employees. And I would certainly think that the states themselves would have—and we could conceivably get into some kind of guidelines—standards that would indicate reasonable advertising of what the plan was all about and what kind of coverage there was without allowing quite unreasonable promotional costs that would boost the total charge up.

The CHAIRMAN. Well, it just seems to me that if we do not do something to pin that down, we are just making the employees—we are making the public pay for a great deal of fraud that they are paying for in these name brand drugs. Who would know whether Squibb was better than Pfizer when they put an aspirin tablet on the market? Nobody would know. But the public has for years been paying a fortune; the Small Business Committee staff computed it. They estimated we are paying the cost of $5,000 per doctor per year to go out here and misinform the public about the relative merits of these drugs when nobody really knew whether Pfizer products were better than Lilly's, or Squibb was better than both of them.

It would seem to me that to let the public be charged a lot of advertising and selling costs in order to get the benefit of something that the fellow is required to buy anyhow under law is sort of ridiculous.

Secretary WEINBERGER. Well, Senator, the reasonable and unreasonable promotional and selling advertising costs are traditionally and

typically a matter for examination by State regulatory agencies. And I would think they would certainly continue to be.

Mr. Morrill had a point he wanted to add.

The CHAIRMAN. Well, are you going to let them deduct the costs of contributing to the campaign expenses of Governors and State legislators, then?

Secretary WEINBERGER. Public utiliites are not able to do that, and they are under State regulation.

The CHAIRMAN. Why do you want to get involved in all of that?

Secretary WEINBERGER. We are not. The Federal Government would not be in that.

The CHAIRMAN. But you are going to let it happen, and it seems to me that it is just a great big waste of time. So you find out that the fellow who contributed the most money to the winning candidate for for Governor winds up with a contract; and he also turns out to be the guy who made the largest contribution to the guy in the State legislature and the insurance commissioner.

Secretary WEINBERGER. The man who would make the decision as to which company to award the contract to would be the employer. He would simply buy insurance from the company that offered him the best package within the basic package described by the bill at the best rates. And there would be no problem of his getting campaign contributions. The Government will not be purchasing.

The CHAIRMAN. All right.

Let us put it on that basis then. Are you going to crank in all of the costs of his entertaining the employers, the steak dinners, and the beverages that go to ingratiating himself with all of these various employers and hiring of salesmen?

Why should this program be made to carry the cost of thousands of salesmen out padding the highways, fighting one another trying to get an individual employer, be it a big business or a small business, to sign up with that particular firm?

Why should the public be made to pay for that?

Secretary WEINBERGER. I do not think they will be.

Mr. MORRILL. Could I make two responses to that? First, with respect to the employer plan, we believe that with a standard basic benefit package that the employers will be in a better position than they now are with respect to competition on price.

What now so often happens is even though the big companies are sophisticated negotiators with insurance companies for coverage, middle or small sized companies that cannot hire an actuary, get various companies coming at them with slightly different benefits, and they may not be as certain about the real value of them.

If you have a benchmark in the basic services covered, there will be clear knowledge as to what it is that the employer is being offered by that insurance company. Unless you believe that he is going to pay more money than he needs to provide those basic services. I think that competition will be improved.

Second, with respect to the Government plan, there clearly, in terms of advertising and similar expenses, is a different game; and the State would be franchising a limited number of carriers to offer that plan within a government framework. And advertising clearly is not appropriate.

The CHAIRMAN. They would be franchising a limited number of carriers.

Mr. MORRILL. Right.

The CHAIRMAN. All right.

So we do have the campaign contribution problems all over again then, do we not?

Secretary WEINBERGER. Senator, there is no limit on the number that can be franchised under the employer plan. They can franchise anyone who applies who meets the various requirements.

The CHAIRMAN. Well, can they limit the number?

Secretary WEINBERGER. No. I would think not with the employer plan. There would not be any desire that they do so. As a Government employee at the moment, it seems to me that I have a choice of something like 8 different plans in the Washington area. There is not anything in the civil service rules that says there has to be 8 or 9 or 11 or only 3.

Those companies that wish to do so come in and make a showing that they are a responsible company, that they can make the payments, and that they are willing to provide the coverage that is considered basic and necessary, and then I pick and choose between them.

And that is the way, to my mind, the plan would work when it is fully in effect. So there would not be anything that the State would do in the sense of granting any particular privilege to these companies. They would be certifying that certain companies are fiscally responsible, are able to pay, are offering the benefit as required by the Government, and that the premium charged bore a reasonable relationship to the cost of the insurance, and after that, fine.

Now, if some company did not qualify, and under your hypothesis did not make a proper contribution to the gubernatorial race, I would like to represent them in court as being unreasonably denied the right to sell insurance in that State.

Senator BENTSEN. Mr. Chairman, could I ask my questions now?

I want to say, Mr. Secretary, I think this is a very constructive proposal; and I see a great deal in it that I like. Obviously, I think there are some things that could be improved on.

Secretary WEINBERGER. Sure.

Senator BENTSEN. And I had some concern about the $1,500 exposure on the cost sharing after you have your deductible plus your coinsurance. I think that is rather high, even though we are talking about the private employer plan rather than the Government plan.

Secretary WEINBERGER. The high threshold for the catastrophic?

Senator BENTSEN. Right. That concerns me. But I like the coinsurance feature. I think that is necessary. I like the idea that you keep the private insurance companies involved.

I would say to the chairman that I know the problem he is talking about, but I really believe when they set the benefits with uniformity as they are here that it is going to be awfully easy to compare one price against another one. And a person who would choose to give it to the higher priced carrier—a public official who would do that is going to find himself in an extremely vulnerable political position and would probably pay the consequences at the next election, if not in the court prior to that time.

Secretary WEINBERGER. Perhaps sooner.

Senator BENNETT. Would there really be any higher priced carriers in this situation?

Senator BENTSEN. Well, I will say this; there probably will not. The way the insurance program worked—I know in Government insurance when you fellows provided for higher coverage and one of the major carriers came in and pretty well took the package and then doled it out to the smaller carriers, my company having been one of them, that we took it as fluff. We did not make anything off of it; or if we made anything, it did not amount to anything.

And I really believe on your Government program that you will find carriers making a very negligible return. I think that is the way it will probably work out.

Senator BENNETT. And all quoting about the same rates.

Senator BENTSEN. Yes. I think the rates will almost be identically the same.

Secretary WEINBERGER. That was our hope. And if they were not, they would soon be driven back to that because of the marketplace.

Senator BENTSEN. There is much in it that I think is very constructive. There is one thing that I wish you would educate me on, Secretary Morrill, and that is this question of the improvement of public facilities, capital investments in new facilities. Just what is that—the State government?

Mr. MORRILL. If, for example, some local agency, or what have you, proposed to build, say, a new hospital, it would have to go through a review process similar to a certificate of need system; and the State would have to agree that that facility was indeed a needed increment to those that existed, to provide adequate health services within an area. And were it not to get that certificate of need, it would not then be eligible for reimbursement under the plan.

Senator BENTSEN. I would disagree with one comment of Senator Curtis' insofar as the companies being able to hold costs down. Because I firmly believe that the health companies contributed to the high cost by encouraging people to stay in hospitals to receive their benefits.

Now, in this you referred to the disincentives of staying in hospitals. How is that accomplished in this with regard to outpatient care?

Mr. MORRILL. Well, we have removed the disincentive on the front end about them not going into the hospital at all if that is not necessary. Then in terms of what is an appropriate length of stay once they are in, we would anticipate that the PSRO system and its utilization review would apply.

Senator BENTSEN. I have no further comments.

Senator BYRD [presiding]. Mr. Secretary, what is the cost to the Federal Government of your plan?

Secretary WEINBERGER. Mr. Chairman, it is about $5.8 to $5.9 billion.

Senator BYRD. Now, to that $5.9 billion do you not need to add $800 million?

Mr. MORRILL. Those additional numbers that are shown below the $5.9 billion are a part of that total. They were just to identify the source of the total.

Senator BYRD. They are part of this?

Secretary WEINBERGER. Yes, sir. They are part of it.

Senator BYRD. It would cost us $5.9 billion?

Secretary WEINBERGER. Yes, sir. We believe a little less, Senator, but I think it is proper to use that figure. I think there would be administrative savings and some other Federal programs that could be stopped with the breadth of this coverage. But this is, I think, a sort of overall figure.

Senator BYRD. Well, you were not here, of course, when other estimates have been given to the committee on other programs but I am just wondering how accurate this estimate really is.

Secretary WEINBERGER. I am told our Department made one other mistake in estimating in 1925, but——

[Sustained laughter.]

Secretary WEINBERGER [continuing]. But we are aware of that, Senator, and we have tried to estimate this as fairly as we possibly can. It is 2 years down the road that the program would take effect. This is the full cost to the Federal Government, when it is in complete operation; and we believe it is right.

Senator BYRD. Let us assume that it is $6 billion, in round figures. Where do you get the $6 billion?

Secretary WEINBERGER. Well, I mentioned that, Senator, earlier this morning. And that is, when the President said last night this would not require any additional tax payments by the people, that was accurate. And what he had in mind was this. This program does come into full effect 2 years down the road; and there would be, therefore, time within which to allocate this amount within the existing tax revenues and within those additional revenues that would come in with the normal growth of the economy.

Senator BYRD. But within the additional tax revenues, though, you are running a smashing deficit. We do not have any surplus.

Secretary WEINBERGER. Well, we were just about at balance. With the energy problems, we will probably be somewhere around $9 billion in deficit this year. But it is very similar to the program of revenue sharing, Senator. We had $6 billion added to the cost of the Federal Government, but that is absorbed within the existing tax revenues and the ability to borrow it.

Senator BYRD. It is not absorbed in it, Mr. Secretary. By your own figures it is not. And you just said there is a $9 billion deficit, and that is by using the trust fund surpluses.

Secretary WEINBERGER. When I say within the existing revenues, I mean within the existing revenues and the ability to borrow and staying within the kind of deficit that can still be paid.

Senator BYRD. Oh. Stay within the kind of deficit. You are planning for additional deficit financing then?

Secretary WEINBERGER. I am afraid, Senator—and I do not think you and I differ too much on this—I am afraid deficit financing is a way of life for the Federal Government for some years to come at

least. And there will always be a call for it from those who are Keynesians—and I am not—who believe that the budget is the proper way to meet the problems involved in recessions.

So I do not think we are dealing with any changed condition here, nor do I believe we are dealing with any new program that is going to require the taxes to be increased.

Senator BYRD. Now, let me ask you this. In the upcoming budget, which will be submitted on Monday, is there anything in that budget for this program?

Secretary WEINBERGER. No, sir, there is not, because it is not contemplated that this would take effect in the fiscal year 1975.

Senator BYRD. Do you expect to have anything in the fiscal 1976 budget?

Secretary WEINBERGER. Yes, sir. If this program is adopted, we would. And I cannot give you that exact amount, but Mr. Morrill may have it.

Mr. MORRILL. It clearly would not be the total of $5.9 billion figure. Once the effective date is determined, there will be, understandably, a phasein period to get geared up; and we would expect that you would probably not see the full cost until fiscal 1977 or possibly 1978.

Secretary WEINBERGER. That is right. In that range.

Senator BYRD. And then the cost to the State, as I understand—to the States, as I understand, would be $1 billion.

Secretary WEINBERGER. Yes, sir. That is the estimate that we make now. Again, we believe it to be accurate; and we have tried to make it as accurate as we can.

Senator BYRD. And the cost to the employee would be what?

Secretary WEINBERGER. The cost to the employee, Senator—again we mentioned this earlier—would be about or a little less than the amounts that are now paid by most employees for the health care coverage that they have. And it is very hard to estimate what that would be 2 to 3 years down the road given the collective bargaining agreements and all of the rest.

But we think that it is fair to say that this plan would not require an additional amount over that which employees are now paying for the health insurance they do have.

Senator BYRD. And how about the employer?

Secretary WEINBERGER. As for employer, there would be an increase; and we do not know precisely what it would be. Again——

Senator BYRD. May we have order in this room, please?

Secretary WEINBERGER. Again, we do not know what it would be because we would have to grind into that estimate the amount that employers would bargain to pay through collective bargaining and other agreements with employees 3 years away.

At the moment it would be an amount that is, I would guess, somewhere between $75, $85, perhaps more, than employers are now paying per employee if it took effect tomorrow. But, I think you cannot really look at it as a static thing.

Typically, as you know, Senator, negotiations have resulted in employers having to pay more this year than they had to pay 3 years ago for health coverage; and I think that same thing would apply.

The hope is that with this kind of broad coverage and broad market for insurance, as well as the additional improvements in the medical delivery system that Dr. Simmons was describing a moment ago, would mean that it would net out, so that employers would not have to pay more 3 years down the road than they would otherwise, perhaps less. But, I cannot really give you any better estimate than that.

Senator BYRD. Thank you very much.

Senator BENNETT. This is a vote.

Senator BYRD. Any additional questions?

Senator BENNETT. May I ask one question following up on yours?

Senator BYRD. Senator Bennett.

Senator BENNETT. Under this law, if it were passed, could a group of employees bargain with an employer for a different mix?

Secretary WEINBERGER. Yes, sir.

Mr. MORRILL. For a higher mix.

Secretary WEINBERGER. Not a lower.

Mr. MORRILL. Not a lower.

Senator BENNETT. I did not make myself clear. Could they enter into an agreement where they would pay 10 percent and the employer would pay 90 percent?

Mr. MORRILL. Yes; they could.

Secretary WEINBERGER. Yes.

Senator BENNETT. OK.

There is a vote on, Senator Byrd, but the normal agreement would be 75–25?

Secretary WEINBERGER. Yes; that is the plan.

Senator BYRD. Thank you, gentlemen.

The committee stands adjourned.

Secretary WEINBERGER. Thank you very much, Mr. Chairman. We appreciate it.

[A memorandum supplied by HEW follows:]

HEW NATIONAL HEALTH INSURANCE PROPOSAL[1]

This memorandum highlights the structure benefits, costs and financing features of the HEW national health insurance proposal. The principles underlying the plan include:

Assistance for persons who cannot afford privately-offered health insurance;

Minimization of Federal intervention;

Reliance on States for major aspects of administration where State laws meet Federal standards;

Achievement of evolutionary changes in the health care delivery system, such as the incorporation of provsions for an HMO option, a more balanced use of ambulatory care versus inpatient hospitalization; encouragement in the use of preventive services, particularly for children; and

Regulation of private insurance carriers by the States under Federal standards. These standards include:

An annual CPA audit;

Consumer protection against underwriter insolvency;

Review of premiums, including assessing reasonableness of "pay-out" ratios;

Judicial relief for consumer complaints against carriers or the States;

Federal administration where State laws and regulations are absent;

Information disclosure standards.

[1] This proposal is undergoing final review by the Administration. Several aspects of the plan are still under consideration and could change before the proposal is formally submitted.

The present HEW proposal also makes the following additions and changes, which respond to the fundamental problems in the Administration's previous bill:

All Americans would be *assured* access to *affordable* health insurance, as called for in the President's 1971 Health Message. The Administration's previous bill did not aid several low-income groups, including low-income singles and couples. It also failed to assist unemployed persons, such as early retirees, and certain employer groups who are unable to obtain private medical coverage at affordable rates because of their being high medical risks.

The same services would be covered under both a government-assisted health insurance plan (Government Plan) and a mandated privately-financed health insurance program (Employer Plan); the only difference between the two programs would be reduced cost-sharing for low-income persons under the publicly-assisted programs.

Low-income workers would be eligible to join the publicly-assisted program to ensure that they do not face excessive cost-sharing and that equity is maintained with unemployed persons at the same income level.

The benefit package would be broadened to encompass services not previously covered, in particular, mental health services, outpatient prescription drugs, and dental care for children. At the same time, we propose a higher deductible than was included in the previous bill for persons who are *not* low-income. A fundamental principle that we have followed is that higher cost-sharing with more comprehensive benefits is preferable to narrower coverage with lower cost-sharing.

A "Health Card" payment system for services would be introduced so patients can charge and pay later for the cost-sharing. This system would assist the billing, processing and payment of claims as well as the quality review process.

BASIC STRUCTURE

The Administration's National Health Plan (NHP) would have two parts—

Employer Plan (EP)
Government Plan (GP)

Employer Plan.—Under this system all employers would be required to offer their full-time employees, as a minimum, a basic plan with a mandated benefit package (see below).[2] The employer would be required initially to pay 65 percent, and then after 2½ years 75 percent, of the annual premiums. A full-time employee is one who has worked a requisite number of hours over a 90 day period. Part-time workers and workers in the first 90 days' of employment would be offered coverage but would pay the full premium at the group rate. Once covered after the initial 90 day waiting period, employees could remain covered as part of the employer group for 90 days after the termination of employment with the employer paying 65–75 percent of the premiums. In addition, the employer would be required to offer the employee the right to remain as part of the employee group for another three months but the employee would pay the full premium at the group rate. This latter provision permits the employee either to remain with the Employer Plan during a period of transitional unemployment of up to three months or switch into the Government Plan.

We estimate that for the average firm the annual premium per employee would be about $480 in 1975. Included in this amount is coverage for all dependents under the IRS definition of taxable dependents. The rate for single workers alone would be about $200. On average, an employer paying 75 percent of the premium would be required to spend about $320 per employee. This amount is within $150 of what is presently being spent by employers in more than 70 percent of the companies in the United States. Additional benefits, including complete payment of the premium, could be provided by the employer, but no insurance plan offering less protection could be offered.

EP would be sold by private insurance companies subject to State regulation (under Federal guidelines). Employers could self-insure provided they met minimum standards. Non-employer related individuals and groups would be eligible to purchase the mandated private plans. Insurance companies would be permitted to experience rate each firm's premium except for medical expenses in a family

[2] This includes local, State, and Federal employees.

exceeding $10,000 in one year. Such expenses must be shared among all the policies underwritten by the insurance company.

Those firms where current health insurance coverage is poor also tend to be low-paying and small. Recognizing the problem that these firms will have in meeting the standards under the mandated Employer Plan, we have included the following special provisions:

1. All firms with fewer than 25 employees and average wages below $7,500 will be able to enter the Government Plan (described below) and pay the average group premium in the State. This provision would assist low-wage small businesses by allowing them to pay premiums which for most would be 20 percent below what they would otherwise pay. For some firms with high medical expenses, the savings could exceed 50 percent.

2. Any firm where the net impact of the National Health Plan is to raise its health insurance cost as a percent of payroll above 4 percent, can have up to three (3) years to phase in the mandated benefit plan.

The services covered under EP would be subject to an annual per person deductible of $150, with a maximum liability of three deductibles per family. Expenses above the deductible would be subject to 25 percent coinsurance. However, all cost-sharing (i.e., coinsurance and deductibles) for the family would be limited to $1,500 in a single year. This would mean that even in the event of a serious prolonged illness, no American family would have to pay more than $1,500 in medical expenses. For many families covered under the Government Plan this maximum medical expense would be substantially less. For example, a family with an annual income of $3,000 will be required to spend no more than $180. Although the amount of the cost-sharing in our proposal is higher than in many of the competing bills, the extension of coverage to several important outpatient services will reduce out-of-pocket expenses below that which most American families now spend for medical care.

Government Plan.—This plan is designed to cover the following groups:

Low-income families and individuals regardless of work status;

High-risk persons and employer groups, regardless of income, who cannot purchase private protection at rates less than 150 percent of the average group premium in their State.

Employees of small, low-wage employer groups.

States would contract with a limited number of private carriers who would be required to offer coverage to all eligible applicants. The premium rates would be negotiated in advance but carriers would assume underwriting responsibility. GP would cover the same services as EP. It would, however, have its premiums and cost-sharing structure related to a family's income. An income-related maximum also would be placed on the total amount of the cost-sharing expenses a family would be required to pay. All income-testing would be conducted by a government agency.

The major group covered under GP will be low-income persons without steady employment. However, persons with family incomes under $7,500 who are employed can, if they choose, enter GP rather than take the mandated EP. If they do so choose, their contribution would be related to the average group rate for EP in the State as indicated below. Their employer, if the firm is larger than 25 employees or has an average wage level greater than $7,500, would pay an amount equal to that which he pays for other employees. For firms with less than 25 employees and an average wage of less than $7,500 the special small employer provision discussed previously would apply.

For an individual worker, if his family income is $6,000, and the average group family rate is $600, he would pay an estimated annual contribution of $300 for GP coverage, as compared to $150 for the average Empoyer Plan. This higher premium payment would mean that GP coverage would be only chosen by working families in the $5,000–$7,499 group who expect large medical expenses. For the higher premium, GP coverage would include reduced deductibles and coinsurance and lower maximum liability than under EP. Families below $5,000 income would not have to pay a premium and would have even less cost-sharing. Thus, those families would all elect GP coverage, regardless of their work status.

For employer groups that cannot purchase EP for less than 150 percent of the average group rate in the State, the entire group can buy GP at the 150 percent rate. However, as discussed above, if the firm's average wage is less than $7,500 and it has less than 25 employees, the premium would be 100 percent of the average group premium in the State.

The schedule for a family of two or more persons in GP and EP is as follows:

Annual income	Annual family contribution: Percent of average group rate	Expected 1975 amount [1]	Annual per-person deductible	Coinsurance above deductible	Maximum annual cost sharing
Government plan:					
0 to $2,499	0	0	0	10	3 percent of income.
$2,500 to $4,999	0	0	$50	15	6 percent of income.
$5,000 to $7,499	50	$300	100	20	10 percent of income.
$7,500 to $9,999	100	600	150	25	15 percent of income.
$10,000 plus	150	900	150	25	$1,500.
Employer plan: All income	25	150	150	25	$1,500.

[1] Based on an expected average group family premium rate of $600.

Carriers under both GP and EP would be required to provide their enrollees with a "Health Card," similar to any other credit card. All payments to providers for covered services would be made by the carrier rather than by the enrollee. The carrier would in turn bill the enrollee for cost-sharing. Special credit procedures would be established to limit financing charges to that they would be no higher than those now in effect in the health industry. The Health Card offers several important advantages:

It would greatly facilitate the administration of an income-related cost-sharing system.

Providers would have no reason to discriminate against low-income patients since they are guaranteed reimbursement by the carrier.

Bad debts and the large administrative costs now borne by providers would be substantially reduced. In total such expenses will be lower since carriers are much better equipped than providers to conduct such financial transactions.

The ability to enforce quality and cost controls would be vastly improved, since all bills, including those below the deductible, would flow through the carriers.

BENEFIT PACKAGE

The basic benefit package would be the same for all Americans. Both plans would cover the following services:

1. Hospital Services.—These would be covered without any present upper limits. However, Professional Standards Review Organizations would play a major role in reviewing both the necessity for hospital admission and length of stay.

2. Physician Services.—These would be covered without any upper limits (other than mental health aand preventive care), and subject to PSRO review. Covering physician services on the same basis as other services will assist in bringing balance to the current system of health care delivery. We would, however, exclude routine physician examination for adults. Such expenditures are now excluded under Medicare and most existing private coverage because they are felt to be of questionable medical value.

3. Other Medical Services.—As currently covered under Medicare, except for chiropractic services. These include physical therapy, prosthetic devices, ambulance services, laboratory examinations, x-rays, durable medical equipment, and so forth, where judged medically necessary. In addition, eyeglasses and hearing aids would be covered for children through age 12.

4. Outpatient and Inpatient Drugs.—Coverage would include all drugs available by prescription only, plus selected nonprescription lifesaving drugs, e.g., insulin. Drugs are a necessary part of medical care. Indeed, often the prescribing of a drug is the major outcome of a visit to a physician. Consequently, drug coverage is an integral part of a plan with broad benefits. Minor claims will be minimal due to the high deductible and processing costs will be reduced by use of the Health Card. Also cost control will be emphasized by the use of PSRO and a specal reimbursement system which pays only the lowest price in the area.

5. Preventive Services (Prenatal care, well-child care, family planning and dental care for children).—These services are medically desirable in

maintaining health and have been shown to have a high long-term economic payoff. However, they are intended to be used at regular intervals when free of symptoms and they are the services least used by low-income families. To facilitate their use, insurance protection will begin at once rather than after the standard deductible amount is spent. (The standard co-insurance will, however, apply.) Waiving the deductible would underscore the Administration's priority of assisting mothers and children. In addition, these services have been emphasized by Federally-funded health center programs, from which the Administration seeks to withdraw on the basis that health insurance rather than Federal grants is the appropriate funding vehicle.

6. Mental Health Services (including drug and alcoholism services).—These would be limited to 30 hospital days and 15 outpatient visits. However, partial (day/night) hospitalization and out-patient services provided in an organized community setting would be covered without a limit. Covering mental health services without any upper limit could result in overemphasis on long-term hospitalization and individual psychotherapy. Organized community settings on the other hand have proven to be effective treatment centers and are better equipped than independent practitioners to ensure appropriate utilization. This coverage would also greatly increase the financial base of community mental health centers.

7. Extended Care.—Coverage would include 100 days in a skilled nursing facility on a post-hospital basis and 100 home health visits, applying the Medicare definitions and restrictions.

OTHER CHARACTERISTICS

HMO Option.—EP would require employers to offer their employees the option of joining a Health Maintenance Organization (HMO). GP would also include an HMO option. This would ensure that, where both an HMO and a regular insurance plan were available in the community, the individual could choose between them. This "dual choice" option is essential in order for HMO's to compete effectively for members.

Medicaid.—Those portions of Medicaid to be included in NHP would be terminated. This would leave intact the Medicaid program for long-term care services. NHP would include an extended care benefit for acute patients only, similar to that in Medicare, and would exclude services for chronic patients. There is, however, the continuing need for Federal support of long-term care services for low-income chronic patients. These services are covered under Medicaid and account for some 30 percent of total Medicaid expenditures—approximately $3.5 billion (State and Federal share combined) in 1975. Over the next few months, the Department will undertake a major study of alternative Federal strategies for financing long-term care. Options besides a residual Medicaid program that will be considered include formula grants to States and a cash disability program.

Medicare.—We propose to incorporate Medicare into NHP, both to achieve a unified national health insurance system and because we believe our proposed benefit package is superior.

Disabled persons now eligible for Medicare would be able to buy GP coverage and pay premiums based on income. As a practical matter, the incomes of disabled beneficiaries are sufficiently low that only a very small proportion would pay the full premium. Medicare for the Disabled, as structured, has substantial deficiencies, including a waiting period of 29 months after the onset of disability and the absence of catastrophic protection. This becomes particularly critical for eligible persons with chronic kidney disease who often use $20,000–$30,000 worth of medical services each year, i.e., cost-sharing of $5,000–$7,500. Furthermore, the failure to terminate Medicare for the Disabled would result in unacceptable program overlaps with GP and EP, since they would all be targeted at the under age 65 population.

The aged would continue to become eligible for medical benefits upon reaching age 65 with the Social Security Trust Fund paying for most of the benefits. The current Medicare benefit package, however, would be replaced by the GP benefit package. Under our plan, Medicare beneficiaries would have drug coverage and vastly improved catastrophic coverage. Persons with incomes over $10,000 would have higher cost-sharing than at present for small or moderate medical bills, but less out-of-pocket expenses for very expensive illnesses. Beneficiaries with incomes below $10,000 but above the Medicaid eligibility income limits would be

better off than at present because of the reduced cost-sharing. There are 13.5 million elderly people in this category.

Coverage for the aged would be financed as follows: The basic benefit package, i.e., with the $150 deductible and 25 percent coinsurance, would be financed from the existing 2 percent Medicare payroll tax plus a small premium contribution equal to, or somewhat higher than, the current $80 premium contribution. The actuarial values of the GP basic benefit package and that of Medicare are nearly equal. Persons with incomes below $10,000 would be eligible for reduced cost-sharing, with the additional expenses for the reduced cost-sharing being financed from Federal/State funds.

VA.—We propose that Veterans Administration health facilities be made eligible for public and private reimbursements. This recommendation does not alter the current mission of the VA to provide health care to veterans.

COST-CONTAINMENT

We have been very conscious of the need to use NHP to contain medical costs rather than to fuel inflation, as occurred when Medicare and Medicaid were introduced. Consequently, we have incorporated the following features into the Natoinal Health Plan.

1. An HMO option.
2. A strong role for State planning agencies in the review of capital investments for health facilities.
3. A cost-sharing structure that would remove the present incentive to use hospital care as a first resort.
4. Elimination of the present health insurance tax subsidy to minimize the pressure for first-dollar coverage (this is discussed below as a possible option).
5. Reimbursement for drugs based on the lowest price available.
6. Substantially increased ability to control utilization of services through the "Health Card" mechanism and through reliance on PSROs.

We believe these measures taken together provide strong incentives for cost control, but they may not be sufficient. We are particularly concerned about our policy for payment of physician services in low-income areas and the general reimbursement policy for hospitals. Currently, most States set specific fee limitations on what they will reimburse physicians under Medicaid. No additional charges can be billed to the patient. Medicare, on the other hand, which also has reimbursement limitations, permits physicians to bill patients an additional charge. This voluntary assignment system has resulted in many of the aged paying substantially more than the official 20 percent coinsurance rate. If we adopt the Medicare reimbursement system or those currently used by private insurance carriers, many hundreds of millions of dollars will be spent without providing any new services.

Our cost estimates have assumed that some limitation will be placed on what would be reimbursed for physician services. Three payment options are now being explored:

Establishment of physician fee schedule by State with a mandatory assignment policy for both plans; i.e., no additional patient billing either for EP or GP policyholders;

Establishment of a physician fee schedule by State with a mandatory assignment policy only for GP policyholders;

Establishment of a physician fee schedule by State with a Medicare-type voluntary assignment policy.

In the area of hospital reimbursement, the Economic Stabilization Program affords us a good start in designing a prospective budget approach. While we may not wish to incorporate on a long-term basis the same approach, the experience gained and the precedents set can be very valuable. We are exploring allowing the States to set hospital reimbursement policies subject to guidelines established by the Department. This approach is appealing in view of (1) past experience indicating that the States may pursue cost-containment more aggressively than the Federal government, and (2) our financing strategy, which requires the States to share in the costs of NHP. Beyond that, additional protection against health care cost inflation is needed and will have a high priority within the Department. Consequently, our current thinking is to have the National Health Plan drafted to allow the Department broad authority to set reimbursement standards.

PROGRAM COSTS

As shown in the following table, increased Federal expenditures for covering the aged under the Government Plan is $1.6 billion and for the nonaged $4.0 billion. Total increased Federal spending therefore would approximate $5.6 billion. We have used 1975 as a standard year for cost-estimating, and the estimates assume the full effect of GP as an ongoing program. However, the program could not go into effect until FY 1976 at the earliest. Furthermore, actual costs are likely to be lower initially as a result of normal program start-up time.

GOVERNMENT PLAN EXPENDITURES FOR THE AGED AND NONAGED, 1975

[In billions of dollars]

	Aged	Nonaged	Total
Total GP expenditures:			
Individual and Employer	$15.3	$22.2	$37.5
Contribution	1.5	7.1	8.6
Total, public expenditures	13.8	15.1	28.9
State expenditures:			
Current programs	.6	2.7	3.3
Additional expenditures	.1	.9	1.0
Total	.7	3.6	4.3
Federal expenditures			24.6
Current programs:			
Termination of medicaid	.7	3.3	4.0
Termination of medicare	10.8	2.3	13.1
Reduced Federal expenditures in other programs [1]		1.9	1.9
Total	11.5	7.5	19.0
Total added Federal expenditures	1.6	4.0	5.6

[1] To the extent that national health insurance reimburses for services now provided by other Government programs these payments should be counted as offsets to the cost of GP. We believe this is a conservative estimate.

[Whereupon the hearing was adjourned at 12 noon.]

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