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NATIONAL HEALTH INSURANCE

BRIEF OUTLINE OF PENDING BILLS

COMMITTEE ON FINANCE
UNITED STATES SENATE
RUSSELL B. LONG, *Chairman*

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NATIONAL HEALTH INSURANCE

Brief Outline of Pending Bills

Health Security Act—S. 3/H.R. 22

(SENATOR EDWARD M. KENNEDY/REPRESENTATIVE MARTHA GRIFFITHS)

A. General Approach

A national health insurance plan, administered by the Federal Government, covering all U.S. residents, comprehensive in benefits, and financed by a combination of payroll taxes and general revenues. Includes provisions intended to improve quality and efficiency of health care delivery system; medicare would be repealed, but medicaid would continue as a supplemental program.

B. People Covered

All U.S. citizens and aliens admitted for permanent residence would be covered. Allows for reciprocal and "buy-in" agreements to cover certain nonresident aliens and in some cases U.S. residents traveling abroad.

C. Scope of Benefits

Comprehensive health benefits, including physician services, inpatient and outpatient hospital care, home health services, supporting services such as optometry, podiatry, devices and appliances, subject to the following exclusions:

(1) Dental care initially limited to children under 15; covered age group extended in each of succeeding 5 years until all under age 25 are covered. Once eligible, an individual is subsequently covered regardless of age. Timetable would be established to phase-in dental benefit to entire population.

(2) Drug benefit limited to inpatient drugs, specified drugs necessary for chronic conditions, drugs provided through HMOs or professional foundations.

(3) Skilled nursing home care initially limited to 120 days with provision for expansion when feasible or when facility is owned or managed by a hospital.

(4) Inpatient psychiatric care limited to 45 days per year for active treatment; limit of 20 consultations per year for outpatient psychiatric care if provided by solo practitioner, with no limit if provided through HMO.

Benefits are covered in full with no deductibles, coinsurance, waiting periods, maximums, or cutoffs other than the limitations described above.

Effective date for benefits is July 1 of second calendar year following enactment.

D. Payment to Providers

A total area budget would be established for all services. Hospitals, skilled nursing homes, home health agencies would be paid on basis of negotiated budget designed to pay reasonable costs. Such payments would constitute virtually the total income of a hospital. Health maintenance organizations or professional foundations would be paid by capitation or approved budget. Independent physicians and dentists could be paid on fee-for-service basis or by capitation. Payments to practitioners would come from earmarked portion of total area budget. Supplemental stipends could be paid to practitioners locating in remote or deprived areas. System could also reimburse practitioners for costs of continuing professional education. The Health Security Board would establish schedules of allowances for fee-for-service reimbursement.

E. Administration

Direct Federal administration by a 5-member Health Security Board within Department of HEW. National Health Security Advisory Council, representing consumers, providers of care, health organizations, etc., would advise Board on program operation. Regional authorities would be given strong discretionary powers. The program would substantially supplant private health insurance.

F. Financing

Financed by a 3.5% tax on employer's payrolls (36% of costs); 1.0% tax on employees' wages and on unearned income up to $15,000 a year (12% of costs); 2.5% tax on self-employed (2% of costs); and the balance (50%) from Federal general revenues. Annual taxable wage base for employed persons would always be 125% of the social security wage base. Employers would pay on total payroll without maximum. Persons over age 60 could exempt the first $3,000 in unearned income from the 1% health tax.

Employers could agree to pay part or all of their employees' required contribution. Program would not alter existing employer obligations to purchase health benefits for present or former employees and would require employers to absorb all or part of the employees' tax if employer's current obligation for health benefits exceeded 3.5% of payroll.

G. Cost Estimates

Committee for National Health Insurance estimate: program would cost $73 billion in fiscal year 1976, of which $21 billion represents money which would have been spent on medicare and medicaid.

H. Other Major Provisions

Authorizes a total of $600 million for a Health Resources Development Fund to be used in two years preceding program operation for development of health manpower, education, training, group practice, etc. After the program is in effect, 5% of the Health Security Trust Fund would be set aside for these purposes. Establishes national standards for providers and incentives to encourage preventive health care and formation of HMOs and professional foundations. Would establish at the Federal level a Commission on the Quality of Care to assess standards and regulations safeguarding quality of services under the program.

Health Care Insurance Act—S. 444/H.R. 2222

(SENATORS CLIFFORD P. HANSEN, VANCE HARTKE/REPRESENTATIVES RICHARD H. FULTON, JOEL T. BROYHILL)

A. General Approach

A voluntary health insurance program called "medicredit," under which the Federal Government would pay health insurance premiums for the poor, and allow income tax credits for all others toward the purchase of private health insurance plans. The amount of tax credit would include 1) 100% of premium charges for catastrophic insurance plans and 2) an income-related percentage of premium charges for other health insurance providing certain basic benefits approved by the Government. Medicare would continue as at present.

B. People Covered

The total population under age 65 would be eligible. Those with no Federal income tax liability would receive full payment of their health insurance premium costs. For all others, the Federal share of health insurance premiums gradually decreases from 99% until those with a tax liability of $891 or more would get a tax credit of 10% of premium cost.

C. Scope of Benefits

A health care policy, in order to qualify under this program for purposes of a tax credit, would have to provide, at a minimum, the following benefits:

(1) 60 days hospitalization (with days in skilled nursing facility counting as ½ hospital day or 2 days of nursing home care for each hospital day), including nursing services, drugs, blood, appliances, maternity and psychiatric care, physical therapy—subject to $50 deductible.

(2) Home health services, ambulance service, emergency or outpatient hospital services (including diagnostic services, X-rays, lab tests, etc.)—subject to 20% coinsurance on first $500 of expense.

(3) Medical care by physician, in hospital or office, including diagnosis and treatment, psychiatric care, immunizations, physical exams, lab services, radiation therapy, maternal and well-baby care—subject to 20% coinsurance.

(4) Dental care for children ages 2 through 6 years, and emergency dental services and oral surgery for all ages (age limit to be gradually increased to cover all under age 18)—subject to 20% coinsurance on first $500.

(5) Catastrophic coverage—unlimited hospital days, up to 30 additional days in skilled nursing facility, outpatient blood and plasma after first 3 pints, prosthetic aids. All subject to deductible of 10% of combined taxable income of eligible and dependent beneficiaries, reduced by total of deductibles and coinsurance incurred under basic coverage.

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D. Payment to Providers

Usual and customary charges for all services, including hospital and extended care.

E. Administration

Establishes Health Insurance "Advisory" Board to write policy and regulations. Private insurance companies would each administer their own approved policies.

F. Financing

Costs of health insurance for the poor would be met by Federal general revenue expenditures and by reductions in Federal income tax collections for those receiving tax credits.

G. Cost Estimates

Sponsor estimates cost of program to be $12.1 billion for first full year of operation.

National Catastrophic Illness Protection Act—S. 587/H.R. 1054

(SENATOR J. GLENN BEALL/REPRESENTATIVE ROBERT A. ROE)

A. General Approach

A Federal health reinsurance program, designed to encourage the development by the private insurance industry of policies which would provide extended coverage against the costs of catastrophic illness. The Government would reinsure against losses in instances where private insurance companies paid out more in benefits than they received in premiums. Involves creation of state-wide plans for extended health insurance coverage which insurers or state-wide pools of insurers would be required to offer all eligible individuals at a reasonable cost in order to qualify for Federal reinsurance program.

B. People Covered

Individual State resident (and his dependents) who makes appropriate application for such extended insurance coverage.

C. Scope of Benefits

A catastrophic health insurance plan offered by private insurers would be designed to cover costs of any and all medical care rather than specified benefits. Before payments would be made under the plan, a sliding deductible based upon adjusted income of an individual or family would have to be satisfied. The deductible would be equal to ½ of the amount by which the individual or family's adjusted income exceeds $1,000 but does not exceed $2,000, plus all of the amount by which such adjusted income exceeds $2,000. (A person with an adjusted income of $10,000 would have a deductible of $8,500; an individual with adjusted income of $5,000 would have a $3,500 deductible.) The deductible would be reduced by the amount of any out-of-pocket payments or any public or private third-party payments made on behalf of an insured person.

D. Payment to Providers

Present methods under private insurance.

E. Administration

Federal Government role mainly limited to contracting with private insurers for reinsurance coverage. An insurance company would pay the Government certain premiums or fees for reinsurance. HEW would also set premium rates to be used by private insurers in charging individuals for catastrophic health insurance plans. State insurance authorities would develop state-wide plan for extended coverage and would provide for pooling of risks among private insurers within a State. Where a state-wide plan cannot be established, private insurers would deal directly with the Federal Government.

F. Financing

Catastrophic insurance would be financed by means of payments of premiums to private insurers. The Government's reinsurance program would be financed through premiums paid by private insurers into a National Catastrophic Illness Insurance Fund.

G. Cost Estimates

HEW estimate of additional cost to Federal taxpayer, fiscal year 1974—$3.3 billion.

National Health Insurance and Health Improvements Act—S. 915

(SENATOR JACOB K. JAVITS)

A. General Approach

A national health insurance plan established through a gradual expansion of the medicare program to cover the general population. Benefits would be broadened to include certain services not presently covered under medicare. The medicare Part B premium would be eliminated. Medicaid would be continued.

B. People Covered

Medicare would be extended to all those over 65, the disabled, widows over 60, and widowers over 62 effective July 1974. Effective July 1976, the program would be extended to all citizens and aliens admitted for permanent residence.

C. Scope of Benefits

Same benefits as under medicare at the beginning:

(1) 90 days of hospital care with $60 deductible and coinsurance of $15 per day after 60th day.

(2) 100 days post-hospital extended care with coinsurance of $7.50 per day after 20th day.

(3) Physician and related services including outpatient diagnostic services, home health services, and physical therapy.

Additional benefits would be phased in, as follows:

(1) Maintenance drugs for chronic conditions, effective July 1976.

(2) Annual physical examinations, effective July 1977.

(3) Dental care for children under 8, effective July 1977.

D. Payment to Providers

Until July 1, 1976, reasonable cost for hospitals and institutions and reasonable charges for physicians (as under medicare). Thereafter, new methods, developed in interim, may be employed.

E. Administration

Essentially the same as medicare. Federal administration using private carriers, intermediaries, and State health agencies for appropriate roles. New public insurance corporations could be set up to administer the program if private carriers and intermediaries could not do so properly.

F. Financing

Financed by taxes on employers, employees, and self-employed (3.3% each in 1976 and thereafter) with Federal general revenue contributions equal to ½ of the amount collected through payroll taxes. Annual taxable wages for workers would be $15,000; for employers, no taxable wage base would apply.

G. Cost Estimates

HEW estimate of additional cost to Federal taxpayer, fiscal year 1974—$41.6 billion.

H. Other Major Provisions

Individuals can "elect out" of program by securing coverage from private insurers offering comparable or better protection and thereby exempt themselves from payroll taxation for Federal health insurance. Employer plans may qualify in lieu of Federal program if they pay 75% of the cost and the protection is better than the Government plan. Provides incentives for growth of comprehensive health service systems which would benefit from cost-savings for efficient operation.

National Health Care Act—S. 1100/H.R. 5200

(SENATOR THOMAS J. McINTYRE/REPRESENTATIVE OMAR BURLESON)

A. General Approach

A program which would provide financial assistance for State health care insurance plans for the poor and uninsurable and set a Federal Minimum Standard Health-care Benefits Program as a condition of eligibility for increased Federal income tax deductions for the costs of private health insurance coverage. Individuals who itemize deductions would be allowed an unlimited tax deduction from income equal to all premiums paid under health plans meeting the minimum standards. An employer would be eligible for a tax deduction equal to 100% of his costs in providing a qualified health plan to his employees. However, if an employer failed to establish and maintain a qualified health plan for his employees, no tax deduction would be allowed for premium expense of plans in non-compliance with the requirements of the bill. The program would supplement Medicare and Medicaid.

B. People Covered

Persons on public assistance would be covered through qualified State health-care plans at no expense to themselves. Uninsurable individuals and those with low-incomes could enroll at a modest cost in the State plan. All other individuals participating in a qualified health care plan who itemize deductions would be entitled to receive increased tax deductions for insurance premium expenses.

C. Scope of Benefits

Different levels of minimum benefits would be required for private group and individual plans and for State pool plans for the poor, near poor, and previously uninsurable, with the State pool plans initially being more comprehensive. Effective January 1, 1975, the private group and individual plans would include the following:

(1) 30 days hospitalization—subject to $5 copayment.

(2) 60 days skilled nursing home services—subject to $2.50 per day copayment.

(3) 90 days home health services—subject to $2.50 per day copayment.

(4) All diagnostic, X-ray, and lab exams on an ambulatory basis—no limit and no copayment.

(5) 3 visits per year to physician in office or ambulatory center—$2 copayment per visit.

(6) Unlimited visits for outpatient surgery and radiation therapy—$2 copayment per visit.

(7) 6 exams for well-baby care—no copayment.

(8) Unlimited inpatient physician services—$2 copayment per day, for 1st 30 days, $5 per day thereafter.

(9) Catastrophic coverage—any individual who incurs $5,000 in medical expenses (including expenses reimbursed by in-

surance) within 12 consecutive months would immediately become entitled to the maximum level of benefits outlined in the bill, irrespective of the phasing-in period, and up to $250,000.

Effective July 1, 1974, State pool plans would be identical to the above but also include the following benefits:

(1) Physician visits—6 per year.
(2) Hospitalization—120 days.
(3) Skilled nursing facility—120 days.
(4) Well-baby care—12 visits during 1st two years.
(5) Home health services—180 days.
(6) Additional benefits—dental care for children under 19 (1 annual oral exam—no copayment; fillings, extractions, dentures—20% coinsurance), prescription drugs ($1 per prescription), physical therapy (20% coinsurance); family planning services, prosthetic aids (20% coinsurance), maternity care (20% coinsurance).

By January 1, 1980, private group coverage would be expanded to cover the initial State pool plan level of coverage. Subsequent benefit improvements are provided for in future years.

For the private group and individual plans, coinsurance up to 20% could be substituted for the copayments applicable to covered benefits, and an additional annual deductible could be imposed. However, in the case of employees and their dependents, covered by a qualified employee health care plan, the sum of these copayments and deductibles could not exceed $1,000 for a calendar year.

Aggregate copayments for the low-income under a State pool plan would be income-related; for uninsurable individuals under a State plan, a $1,000 ceiling would be placed on aggregate copayments.

D. Payment to Providers

Payments would be limited to the 75th percentile of prevailing charges for professional services and for institutions, to rates approved by a State Health Care Institutions Cost Commission.

E. Administration

Private insurers would each administer their own policy for qualified group and individual plans. For the qualified State health-care plans, each State would set up a health insurance pool, a portion of the risks of which private insurers would be required to underwrite. One or more private companies would be designated to administer the State plan. Premium rates for the State plans would be determined within each State, subject to review by HEW.

F. Financing

Costs of protection for all people not insured through a State pool would be borne by employers, employees and the self-employed through premium payments to private insurance companies, and indirectly by the Federal Government through tax deductions for these premium expenses.

A State pool would be financed with premium payments from the uninsurable, partial premium payments from the near-poor, and

Federal-State contributions to subsidize, in part, costs of protection for the near-poor, and in full, the costs of protection for welfare recipients. Contributions of the near-poor would vary with income.

The Federal matching payments would vary with a State's per capita income and range from 70% to 90%. Federal matching payments would come from general revenue funds.

G. Cost Estimates

Sponsor estimates cost of program to taxpayers to be $8.1 billion in new taxes for first full year of operation (fiscal year 1976).

H. Other Major Provisions

Includes provisions intended to 1) increase and redistribute supply of health manpower; 2) promote ambulatory care; 3) strengthen health planning; 4) improve cost and quality controls for health services.

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Catastrophic Health Insurance and Medical Assistance Reform Act—S. 2513/H.R. 14079

(SENATORS RUSSELL B. LONG, ABRAHAM RIBICOFF/REPRESENTATIVE JOE D. WAGGONNER

A. General Approach

A national program of catastrophic health insurance for all persons covered by the social security system, their spouses and dependents, would be administered by Social Security and would supplement existing private health insurance protection for basic benefits. A uniform national program of medical benefits for low-income persons, administered by the Social Security Administration, would replace the existing medicaid program. A voluntary Federal certification program for basic private health insurance would be established to encourage private insurers to make adequate basic coverage available in all areas to all citizens at reasonable premium rates. No insurer could serve as a medicare or low-income plan carrier or intermediary who did not offer such coverage.

B. People Covered

Under the *catastrophic health insurance plan*, all persons fully or currently insured under social security, their spouses and dependents, and all social security beneficiaries would be eligible for protection. "Buy-in" agreements for State and local governmental employees not covered by Social Security.

The *Medical Assistance Plan* for low-income persons would be available to all individuals and families having an annual income at or below the following levels: $2400 or an individual; $3600 for a two-person family; $4200 for a three-person family; $4800 for a four-person family; and $400 additional for each additional family member. No assets test would be applied in determining eligibility. Income eligibility levels would be linked to a "spend-down" provision under which an individual's or family's income would be reduced by their incurred health expenses.

Voluntary certification plan—estimated number unknown.

C. Scope of Benefits

Catastrophic insurance would cover the same kinds of services as currently provided under Parts A and B of medicare, except that there would be no upper limitations on hospitals days or home health visits. Benefits excluded from medicare would also be excluded under this program. However, unlike medicare which provides basic coverage, the catastrophic health insurance program would provide hospital and extended care benefits only after an individual had first been hospitalized for a total of 60 days in one year; and medical benefits only after a family had incurred medical expenses of $2000 for physicians' services, home health visits, physical therapy services, laboratory and X-ray services and other covered medical and health services. For

continued services thereafter, the beneficiary would be responsible only for coinsurance amounts (subject to a ceiling of $1,000 per family) equal to:

(1) ¼ of the medicare inpatient deductible at that time, for each additional day of hospitalization;

(2) ⅛ of the medicare inpatient deductible for each day of post-hospital institutionalization in an extended care facility; and

(3) 20% of medical expenses exceeding $2,000.

The *Medical Assistance Plan* for the low-income would cover the following benefits, generally without deductibles or coinsurance except as noted below:

(1) 60 days of inpatient hospital services during a benefit period (catastrophic coverage picks up 61st and subsequent days).

(2) All medically-necessary skilled nursing facility care, intermediate care, and home health services.

(3) All medically-necessary medical and other health services (including physician's services, laboratory and X-ray services)—$3 per visit copayment for each of the first 10 outpatient physicians' visits per family.

(4) Pre-natal and well-baby care (no $3 copayment for well-baby visits).

(5) Family planning counseling services and supplies (no $3 copayment for family planning visits).

(6) Periodic screening, diagnosis, and treatment for children under age 18.

(7) Payment of the Part B medicare premium for eligible individuals.

(8) Payment of any coinsurance required under the catastrophic insurance plan for eligible individuals; for persons not eligible for catastrophic insurance, payment for benefits covered under that plan.

(9) Routine immunizations.

(10) Inpatient mental health care consisting of active care and treatment in an accredited institution; outpatient care in a qualified community mental health center; outpatient psychiatric services limited to 5 visits related to "crisis" intervention, plus additional visits when authorized in advance.

D. Payment to Providers

Payments made to practitioners and providers of services under both the catastrophic insurance plan and the Medical Assistance Plan would be subject to the same reimbursement controls as under medicare. Reimbursement controls would include the payment of audited "reasonable costs" to participating institutions and agencies, and "reasonable charges" to practitioners and other suppliers. However, payments made under the Medical Assistance Plan, along with any required copayment, would have to be accepted by providers and practitioners as payment in full for the services rendered, and no person accepting such payment could charge additional amounts. Quality, health and safety standards, and utilization controls used in the medicare program would also apply.

E. Administration

Same as medicare.

F. Financing

The *catastrophic plan* would be financed by a Federal payroll tax on employers, employees, and self-employed (0.3% in 1975–77, 0.35% in 1978–81, 0.4% in 1982 and thereafter). Trust fund for Federal Catastrophic Health Insurance would be completely separate from other trust funds operating under Social Security programs.

The *Medical Assistance Plan* would be financed from general revenues, just as the Federal share of the current medicaid program is now financed, and also with State funds. A ceiling would be placed on the amount of State contributions. States would contribute a fixed amount equivalent to their total expenditures from State funds under medicaid for the types of benefits covered under the Medical Assistance Plan during the year prior to the effective date of this program. In addition, a State would also pay 50% of the estimated amount that the State and local governments have expended in that same base year for provision of these types of services to people not covered under medicaid who would, however, be covered under the new Medical Assistance Plan.

G. Cost Estimates

Sponsor estimates cost of catastrophic plan to be $3.6 billion in the first full year of operation (effective July 1, 1974). Sponsor estimates cost of Medical Assistance Plan to be $5.3 billion in general revenues above present Federal-State expenditures for medicaid (effective July 1, 1975).

H. Other Major Provisions

A voluntary certification program would be set up at the Federal level for private health insurance covering basic benefits. Certification would be based upon criteria such as adequacy of coverage, conditions of eligibility, reasonableness of premiums to benefits, etc. Three years after the effective date of this provision, no private insurer could serve as a medicare carrier or intermediary unless it offered one or more certified policies to the general public in each geographic or service area in which it did business.

Health Rights Act—S. 2756

(SENATORS HUGH SCOTT AND CHARLES PERCY)

A. General Approach

Establishes two separate health insurance programs to supplement existing private health insurance protection—1) a Federally-administered inpatient plan designed to cover costs of catastrophic illness; 2) an optional outpatient health maintenance plan administered by private insurers under contract to the Government. Inpatient plan would pay for covered benefits when a family's or individual's medical expenses exceeded a "health cost ceiling." Outpatient plan would pay for covered services above a specified deductible. Would replace medicare and repeal the Federal Employees Health Benefits program and Retired Federal Employees Health Benefits program; medicaid would pay only for services not covered under inpatient plan.

B. People Covered

All U.S. residents and aliens admitted for permanent residence would be entitled to benefits. Reciprocal agreements could be arranged to cover aliens temporarily residing in U.S. and employed by foreign countries.

C. Scope of Benefits

Inpatient plan would pay 1) all costs for covered services (listed below), once a family's or individual's medical expenses exceeded a "health cost ceiling," based on family income and size, and 2) 50% of costs of covered services when such expenses exceeded ½ of the health cost ceiling. (For example, a family of 4 with income of $10,000 would have a health cost ceiling of $545. Once medical expenses reached $272.50, the inpatient plan would pay 50% of additional medical expenses up to $545, then 100% of costs beyond that.)

Inpatient plan would cover following services:

(1) Inpatient hospital services.
(2) Inpatient tuberculosis hospital services.
(3) Inpatient psychiatric hospital services—60 days per year, with individual lifetime maximum of 180 days.
(4) Secondary care services.
(5) Post-inpatient home health services.

Outpatient plan would pay for all covered services above an individual deductible of $50 per year, with lower deductibles for the poor. An additional $25 deductible would be applied to covered dental services.

Outpatient plan would cover the following:

(1) Physicians' services, including diagnostic exams, limited physical exams, pre-natal care, 2 well-child care exams per year for children between birth and age 4.

(2) Outpatient physical therapy.
(3) Home health services.
(4) Up to 26 outpatient psychiatric visits per year, with a lifetime maximum of 104 visits.
(5) Dental services (exclusive of most orthodontia) for children under age 11.
(6) Long-term maintenance drugs.

Benefits would become effective July 1, 1975.

D. Payment to Providers

Provides that payment to providers of services under inpatient plan would be in accordance with regulations of the Secretary of HEW. For outpatient plan, insurance carriers or other administrative intermediaries who have contracted with the Government to administer the plan within a particular region would reimburse providers of services, in accordance with HEW regulations.

E. Administration

An Office of Health Care would be established in the Department of HEW to administer, through its regional offices, the Government's inpatient plan. Private carriers under contract to HEW would be assigned responsibility for administering the outpatient plan within a particular region or subregion. A National Professional Standards Review Council would review the operations of PSROs in each State and would also review overall administration of the health benefits program, develop minimum national standards for participating health personnel and organizations, compile a generic list of drugs for use by participating institutions and HMOs, etc. Providers would be required to have a utilization review program. HEW could contract with health maintenance organizations to provide all services covered under both inpatient and outpatient plans.

F. Financing

Inpatient plan would be financed in part through the present health insurance portion of Social Security payroll taxes and in part through general revenues. Supplementary outpatient plan would be financed through individual premium payments which would be supplemented in whole or in part with Federal payments for poor families. Employers could agree to pay part or all of their employees' premiums for the supplementary plan.

G. Cost Estimates

Sponsors estimate cost of the proposal to be "under $20 billion a year."

H. Other Major Provisions

Authorizes Federal grants and loans for planning, development, and construction of health maintenance organizations, with special grant provision for HMOs in physician shortage areas.

Comprehensive Health Insurance Act—S. 2970/H.R. 12684

(SENATOR BOB PACKWOOD, ON BEHALF OF THE ADMINISTRATION/ REPRESENTATIVES WILBUR MILLS, HERMAN T. SCHNEEBELI)

A. General Approach

A program to make comprehensive health insurance protection available to all Americans through 3 separate plans: 1) a mandated Employee Health Insurance Plan (EHIP), covering the majority of the population and offered at their place of employment; 2) an Assisted Health Insurance Plan (AHIP), designed for low-income persons and others not eligible for EHIP; and 3) a modified Medicare Plan, covering the aged.

B. People Covered

For EHIP, all employers would be mandated to offer approved private health insurance coverage to all employees under age 65 meeting the full-time hours of work test. Election of coverage would be voluntary at the option of the employee. EHIP would also be available to the self-employed and non-working families, individuals, and non-employer groups (e.g. unions or professional associations) through private carriers.

The Assisted Health Insurance Plan would cover the following types of groups: 1) families below $5,000 income (individuals below $3500) regardless of work status; 2) non-working families and very high risk families between $5,000 and $7500 income ($3500 and $5250 for individuals); 3) non-working families with unusually high risks, regardless of income; 4) unusually high risk employer groups.

The modified Medicare Plan would continue to cover any person, age 65 or over, currently eligible under Medicare; however, Medicare for the disabled would be replaced, and disabled persons would become eligible under AHIP.

C. Scope of Benefits

The mandated basic benefits offered by the three plans would be identical for all covered persons, regardless of age, income, or membership in a particular plan. Reimbursable services would include the following:

(1) Hospital services.
(2) Physician services.
(3) Out-patient prescription drugs.
(4) Mental health services as follows—for inpatient care, 30 full days or 60 partial days; for outpatient care, 30 visits to a comprehensive community care center or private practitioner (the latter not to exceed 15 visits).
(5) Special and preventive services for children—well child care up to age 6; eye examinations, developmental vision care, and eyeglasses up to age 13; ear examinations and hearing aids up to age 13; routine dental services up to age 13.

(6) Other preventive services—prenatal and maternity services, family planning.

(7) Home health services—100 visits per year.

(8) Post hospital extended care—100 days per year.

(9) Blood and blood products.

(10) Other medical services, as in Medicare (prosthetic devices, dialysis equipment and supplies, X-rays, laboratory tests, ambulance, etc.).

Under the Employee Health Insurance Plan, insured services would be subject to a $150 deductible per person (maximum of 3 deductibles per family), with a separate $50 deductible per person for outpatient drugs. Coinsurance of 25% would also be applied to covered services after the deductible had been satisfied. Maximum liability for cost-sharing (deductible plus coinsurance) would be limited to $1500 in a year.

For the Assisted Health Insurance Plan, premiums, deductibles, coinsurance, and maximum liability would all be income-related, with families earning less than $2500 a year (and individuals less than $1850 a year) paying no premiums or deductibles but subject to 10% coinsurance.

Medicare beneficiaries would have an annual per person deductible of $100 on all services, plus a $50 deductible on outpatient drugs. Coinsurance of 20% would be payable on expenses above the deductible, to a maximum annual liability of $750.

D. Payment to Providers

All persons (including Medicare enrollees) would receive an identification card (Healthcard) which would be evidence of financial protection for all covered services. Participating providers of services would be required to accept the card as evidence of coverage and would bill the indicated carrier for covered services, the carrier then reimbursing the provider and billing the enrollee for the applicable cost-sharing amount. *Full-participating* providers would agree to accept reimbursement through the Healthcard as payment in full for all insured patients (all institutions would be required to be full-participating providers). *Associate-participating* providers would agree to accept Healthcard reimbursement as payment in full for all AIHP and Medicare patients, and as payment of the insured amount of an EHIP enrollee's bills. To collect the remainder of his fee for the EHIP patient, the physician would bill the patient directly.

Professional Standards Review Organizations would review medical services provided under the plans. States would establish prospective reimbursement systems for hospitals. States would be responsible for certifying health care providers as eligible for participation, and State planning agencies would have to approve all capital investment over $100,000 in order for an institution to receive reimbursement under the plans.

E. Administration

The Federal Government would be responsible for establishing standards for eligibility under the three plans, defining reimbursable services, and operating the expanded Medicare Plan for the aged.

States would contract with intermediaries to offer the basic plan to all State residents enrolling in AIHP. States would also regulate the

activities of private carriers offering the basic EHIP plan by reviewing the provisions of policies and the premium rates and rating structures to be applied to the plans.

F. Financing

EHIP would be financed jointly by employers and employees, with employers initially required to contribute 65% of the premium cost and employees 35% (after 3 years the employer's share would increase to 75% with the employee contributing 25%). Federal subsidies would be available to assist an employer whose payroll rises by more than 3% due to required contributions to EHIP coverage.

AHIP would be financed through Federal and State contributions and income-related premiums for enrollees. Families with less than $5,000 annual income (and individuals with less than $3,500 annual income) would pay no premiums. The Federal share would be financed from general revenues.

The modified Medicare Plan would be financed through the current 1.8% payroll tax, plus small premium contributions from insured persons (about $90 per person annually).

G. Cost Estimates

The Administration estimates that approximately $6.9 billion in added Federal-State expenditures would be needed to finance the Assisted Health Insurance Plan. Added State spending under AHIP would equal about $1.0 billion, much of which would be offset by reductions in other State health programs. The Federal subsidy to assist low-income employees and their employers would equal about $0.45 billion. The additional cost of increased benefits for the aged would be $1.8 billion.

Comprehensive National Health Insurance Act of 1974—S. 3286/ H.R. 13870

(SENATOR EDWARD KENNEDY/REPRESENTATIVE WILBUR MILLS)

A. General Approach

A contributory program of national health insurance covering comprehensive health care benefits on a social insurance basis to all Americans, except those covered under medicare. Repeals the present medicaid program and expands medicare to include long-term care, outpatient drugs, and certain other minor benefits. Program would be financed through payroll taxes and taxes on self-employed individuals and persons with unearned income, with general revenues used to finance certain additional benefits for persons with lower incomes. A new independent Social Security Administration would administer the program. Private health insurers would also be used in administering both the institutional and noninstitutional aspects of the program.

B. People Covered

All U.S. residents who are not eligible under medicare would be eligible for the program through their contributions to the system. Contributions would be made by all Americans who have earned or unearned income of any kind, including governmental benefits (excluding active-duty members of the Armed Forces). Each person who is fully or currently insured, as defined under the present social security law, plus dependents of such a person, and social security and railroad retirement cash beneficiaries not eligible under medicare, would be eligible for the new program. Special provisions would provide immediate coverage for the relatively few individuals who, because they are new entrants into the work force, are not fully or currently insured.

C. Scope of Benefits

Benefits covered under the national health insurance plan would be as follows:

(1) Inpatient hospital services.

(2) Physicians' services.

(3) Medical and other health services (as defined under medicare).

(4) Home health services—100 visits per year.

(5) Posthospital extended care services—100 days per year.

(6) Mental health services—30 full days, or 60 partial days, in a psychiatric hospital; outpatient services in a comprehensive community care center equivalent to the costs of 30 visits to a private practitioner and outpatient services of a private practitioner equal to half the costs of 30 visits.

(7) Outpatient prescription drugs and biologicals for specified chronic conditions.

(8) Preventive care services—

a. Routine dental services—for children under age 13.

b. Eyeglasses and hearing aids (and eye and ear exams)—for children under age 13.

c. Well-child care to age 6.

d. Prenatal care and family planning services.

All services except those listed under preventive care would be subject to a combined annual per person deductible of $150. No family would have to meet more than two deductibles. All services, except drugs, would be subject to a 25 percent coinsurance. Outpatient drugs would be subject to a separate copayment of $1 per prescription drug.

Medicare would continue to cover existing people and benefits but would be amended to include outpatient prescription drugs, as under the national health insurance plan, and a new voluntary long-term care program. Present medicare limitations on the number of inpatient hospital days would be removed, as would the so-called blood deductible. Current medicare cost-sharing would continue to be applicable to covered services—not the deductible and coinsurance amounts set for services under the national health insurance plan. However, the medicare patient would be liable for the $1 copayment on drugs.

Under both the national health insurance plan and medicare, cost-sharing for covered services (that is, the sum of the deductible and coinsurance amounts incurred) would be limited to a maximum annual amount of $1,000 (the $1 copayment on drugs would not be included as coinsurance for this purpose).

Special provisions in the bill are designed to reduce the impact of cost-sharing amounts on people with lower incomes. Part or all of the deductible and coinsurance amounts would not be collected directly from the patient if his income was below certain specified levels. The actual amount of cost-sharing for which the patient himself would be liable would be graduated according to income levels.

D. Payment to Providers

Payments to institutional providers of services would be on the basis of a variety of prospective payment systems with incentive payments to better performing providers. Payments for the services of physicians and certain other professional practitioners would be on the basis of fee schedules established by the respective professions. Participating physicians would receive the full fee schedule amount directly from the program (with the deductible and coinsurance amounts collected from the patient through the health benefits credit card system described later). Nonparticipating physicians would be paid by the patient, who would be reimbursed by the program for the fee schedule amount, less deductible and coinsurance; the patient would be responsible for any part of the non-participating physicians' fee which exceeded the fee schedule amount.

Certain conditions would apply to services for which payment could be made under the program, e.g. surgery only upon referral, PSRO review of all covered services, etc. State health agencies would determine compliance with standards of participation for institutional providers.

E. Administration

A newly independent Social Security Administration would administer the national health insurance program and would utilize intermediaries for institutional services, much as it now does under the medicare program. For physicians' and other noninstitutional services, large employers would select private insurance carriers to administer the program on behalf of employees of that employer. For all people not covered by large employers, carrier contracts would be awarded by SSA on a competitive basis, in each geographical area of the country.

Every insured individual, whether covered under the national health insurance plan or the medicare program, would be issued a health benefits card, similar to a credit card, indicating his status as an insured individual for purposes of covered benefits. The Social Security Administration, or a consortium of participating carriers at their request, would be responsible for administering the operation of the health benefits card system.

F. Financing

Financed by 3% tax on employers' payrolls; 1% on employees earnings; 2.5% on income of self-employed; and 2.5% on unearned income (except that AFDC benefits and supplemental security income would be taxed at the rate of 1% on the recipient and 3% on the State and Federal Government). Annual taxable base for all individuals and employers would be $20,000. The cost of the provision for eliminating or reducing billings for incurred deductibles and coinsurance for those with lower incomes would be met from general revenues, plus a continuing contribution from the States equal to their medicaid dollar expenditures in 1973 or their 3% contributions for AFDC families, whichever is higher.

G. Cost Estimates

None available.

H. Other Major Provisions

Establishes a semi-autonomous Health Resources Board within HEW, charged with assuring availability of services covered under the new program, and authorizes continuing appropriations for this purpose. Also sets up a voluntary system of approval for private health insurance supplementing the benefits covered under the national health insurance program.

National Health Standards Act of 1974—S. 3353

(SENATOR PAUL J. FANNIN)

A. General Approach

A two-part national health insurance program which would require employer-purchased health insurance benefits for employees and their dependents and which would replace the existing medicaid program with Federally-purchased health insurance benefits for low-income persons. Medicare would continue to cover the aged and disabled. Employers would pay at least 50 percent of the premium cost for employer-employee plans, with their employees responsible for the remaining percent. Includes a "benefit equivalence" provision designed to allow flexibility for employers who provide their employees with a health insurance benefits package costing more per employee than the proposed benefit plan. Administration would be through private insurance carriers under regulations from HEW and enforced by State agencies. Each State would set up insurance pools to provide coverage for the self-employed and small employers, and a separate pool to provide coverage of low-income individuals. All or part of the cost of premiums for the poor and the near-poor would be financed through Federal general revenues.

B. People Covered

Every employer would be required to provide an approved health care insurance plan to all his full-time employees (those who have worked, or are expected to work, at least 20 hours a week for at least 26 weeks in a 12-month period). Coverage under the employer-employee plans would extend to the employee's spouse and dependents. The self-employed and small employers (with less than 100 employees) would be offered a health care plan through a State-wide pool of private insurers.

Eligibility under the Federally-financed health insurance program for the low-income would be extended to individuals and families with annual incomes at or below the following levels:

(1) $2098—for an individual
(2) $2633—for a two-person family
(3) $3229—for a three-person family
(4) $4137—for a four-person family
(5) $4880—for a five-person family
(6) $5489—for a six-person family
(7) $6751—for a family of seven or more.

Such low-income persons would be eligible to receive full payment of allowable premiums for approved health insurance plans. Individuals and families with income in excess of the amounts shown above could also establish eligibility for the low-income plan by contributing to the cost of the program in amounts graduated according to the percentage of income which exceeded the base amounts.

C. Scope of Benefits

Minimum requirements for an employer-employee plan would include the following benefits:

(1) Inpatient hospital services
(2) Physicians' services, in home, office, or an institution
(3) Outpatient x-ray and laboratory services (including radiation)
(4) Prescription drugs
(5) Outpatient physical therapy services
(6) Outpatient psychiatric care—limited to 2 visits per week
(7) Posthospital extended care services
(8) Medical devices and appliances
(9) Ambulance services.

The plan would pay covered charges for the above services after satisfaction of a $100 per person per year deductible (maximum of two deductibles per family). Beneficiary would also be responsible for 25 percent coinsurance on the next $10,000 of covered charges. After $2500 of expenses had been incurred, the plan would pay all additional covered expenses. However, a separate coinsurance charge would apply to outpatient psychiatric care; the plan would pay 50 percent of covered charges, not to exceed $20 per visit, up to the $10,000 maximum. The plan would also limit payment for obstetrical care to 50 percent of charges up to a maximum of $500 per pregnancy.

The low-income plan would include the same benefits as listed above for the employer-employee plan, but different cost-sharing amounts would apply. The low-income person would be liable for 10 percent of the cost of each service, not to exceed in the cumulative 5 percent of the individual's annual income. Payment for psychiatric care would also be limited to $20 per visit.

Contains a special "benefit equivalence" provision applying to employer-employee plans, intended to allow flexibility for employers who presently provide their employees with a health insurance benefits package which costs more per employee than the proposed benefits plan. An employer could substitute his existing plan if the total expected claims cost per employee of the benefit equivalent plan would equal at least the total expected claim cost of the minimum standards benefit plan, including 100 percent of the expected claim cost for 1) hospital services; 2) inpatient physician services; 3) inpatient and outpatient surgical care services, and 4) diagnostic x-ray and laboratory services, including radiation therapy.

Employers with more than 25 employees must provide their employees with an option to join a qualified health maintenance organization.

D. Payment to Providers

Hospitals would be paid on the basis of prospective budgets and would be subject to review by a group representative of public and private payors. Hospitals would not receive reimbursement or any allowances for costs directly related to facilities or services which were determined by the local health planning agency to be inconsistent with State or local needs. Reimbursement of physicians and other health providers would be on the basis of usual and customary charges.

E. Administration

The programs would be administered by private health insurance carriers under regulations of HEW enforced by the appropriate State agencies. Carriers who wish to participate under employer plans or the low-income program must participate in the formation of insurance pools; a State pool would provide coverage for the low-income while other separate pools would be formed to cover small employer groups and the self-employed. A Council of Health Advisors appointed by the President would analyze and interpret trends in the health care field, evaluate health programs of the Federal government and the effectiveness of quality review programs.

F. Financing

Employers would be required to pay at least 50 percent of the premium cost for a qualified plan for their employees, with the employees responsible for the remaining percent. For the low-income program, the Federal government would provide the States with whatever funds are necessary to purchase the specified health insurance benefits for individuals and families in the income classes set forth under the section dealing with the benefits. Individuals and families with income above these base amounts would pay a portion of the allowable premium for such health insurance coverage, graduated according to income and ranging from 10 to 50 percent of the allowable premium. The maximum amount of income which an individual or family could have and still be eligible for partial Federal payment of premiums for health insurance would be 125 percent of the base amounts specified for low-income persons. The Federal government would finance the program for the poor and near-poor through general revenues.

G. Cost Estimates

Sponsor estimates the additional cost to the Federal government for the low-income plan would be $3.6 billion in fiscal year 1975.

National Health Care Services Reorganization and Financing Act—H.R. 1

(REPRESENTATIVE AL ULLMAN)

A. General Approach

A comprehensive health care benefits program for all U.S. residents, phased-in over a 5-year period. Medicare would continue to cover the aged, but benefits would be expanded to include catastrophic coverage, and low-income and medically-indigent groups would become eligible for coverage under the new expanded medicare program. Employers would be required to provide employees and their dependents with private health insurance covering at least the new medicare level of benefits. After the first four years of the program, Comprehensive Health Care Benefits (broader than the new medicare level) would be mandated for both the Federal program for the aged and the poor, and the privately-financed employer-employee health plans. Health Care Corporations (HCCs) would be established in every geographic area of the country. Newly-created State Health Commissions would be responsible for setting up HCCs and for enforcing regulations pertaining to providers, HCCs, insurance carriers, etc.

B. People Covered

The Federally financed plan would cover the aged (65 and over), the low-income (e.g. family of four with adjusted gross income of up to $6,000 a year), and the medically indigent (e.g. family of four with adjusted gross income of up to $10,500 a year). All employers, except Federal, State, and local governments, would be required to provide private health insurance coverage to their employees and dependents. Self-employed persons and others not eligible for the Federal program or an employer health plan could enroll on a voluntary basis in a State coverage pool.

C. Scope of Benefits

Initially the program would cover the same range of benefits as presently covered under medicare, plus additional catastrophic illness expense which would take effect after health expenditures, by or on behalf of an individual or family, reached a specified limit graduated according to income. Parts A and B of medicare would be merged and the separate Part B premium eliminated for persons eligible for the Federal program for the aged and low income.

After five years, all employer-employee plans and the Federal program for the aged and low-income would have to provide the following Comprehensive Health Care Benefits:

1. Periodic health evaluations
    - (*a*) Screening tests and exams
    - (*b*) All immunizations
    - (*c*) Well-baby care to age 5, with number of covered visits decreasing with age of child

(*d*) Dental services for children to age 7
  (1) 1 free routine exam per year
  (2) Extractions, fillings, etc.—20% copayment
(*e*) Vision services for children to age 12
  (1) 1 free routine exam per year
  (2) Prescription eyeglasses—20% copayment

II. Physicians' services and ancillary care
(*a*) Services on outpatient basis in any appropriate setting (including the home) by physician or allied personnel under his supervision—10 visits per year with $2 copay per visit
(*b*) Outpatient diagnostic procedures—20% copay
(*c*) Hospital or outpatient-center services
(*d*) Supplies, materials, use of facilities and equipment, including drugs used or administered in connection with outpatient services
(*e*) Ambulance services—20% copay

III. Other outpatient services
(*a*) Outpatient institutional care program for mental illness, alcoholism, drug abuse—$2 copay per day
(*b*) Day care or other part-time services for mental illness, alcoholism, drug abuse—3 visits or sessions in lieu of each day of inpatient hospital care allowable for such condition (limited to 45 inpatient days)
(*c*) Drugs, prosthetic devices, and equipment—$1 copay per prescription, 20% copay for devices and equipment
(*d*) Home health services—100 visits with $2 copay per visit

IV. Inpatient services
(*a*) Hospital care—90 days per benefit period, except for mental illness, alcoholism, drug abuse where limit is 45 days (90 days for HCC registrants). Copay $5 per day
(*b*) Extended care services—30 days per benefit period with $2.50 per day copay
(*c*) Nursing home care—90 days per benefit period with $2.50 per day copay
(*d*) Physicians' services to inpatients—$2 copay per visit of attending physician only

V. Catastrophic expense benefits—for low-income persons (individuals with annual income below $2,000, a family of 4 with income less than $6,000), catastrophic benefits would become effective immediately. For medically indigent persons and all other income classes, benefits would become effective after medical expenses (including amounts paid for premiums, copayments on services, etc.) reached a Special Expenditure Limit graduated according to income. For example, a family of 4 with income of $10,500 would be required to incur $750 in out-of-pocket medical expenditures before catastrophic benefits took effect. Once the expenditure limit was reached, all copayments on services would cease, and restrictions on the number of physician visits, hospital days, etc., would be removed, except when such services were provided for mental illness, alcoholism, or drug dependence in non-HCC settings.

D. Payment to Providers

State Health Commissions would determine premium rates for private insurers and/or Health Care Corporations offering mandated Comprehensive Health Care Benefit packages. SHCs would also approve prospectively all charges for covered services provided by HCCs and all other health providers. Federal regulations would prescribe methods to be used in determining reasonable operating costs and sufficient capital payments for institutional providers; and reasonable fees, salaries, or other compensation for individual providers, or groups of providers.

Non-HCC providers would be reimbursed by private carriers underwriting the mandated plan. HCCs would be paid directly by enrollees or by carriers contracting with them on any appropriate prospective or prior-budgeted basis. After the first 5 years of operation, HCCs would have to provide a capitation option to enrollees.

E. Administration

All Federal health programs would be consolidated within a new Department of Health. The Federal Government would administer the insurance program for the aged and low-income and would contract directly with carriers or HCCs to provide covered benefits. Employer-employee plans would be administered through approved carriers or HCCs. New independent State Health Commissions would be established in each State to perform a variety of regulatory and supervisory activities. The Department of Health would assume functions of a State Health Commission in any State which failed to establish one. Private insurance carriers would administer the Comprehensive Health Care Benefits package in accordance with Federal and State guidelines on behalf of employer groups enrolling with them.

F. Financing

The Federal program for the aged would be financed through payroll taxes and general revenues with some cost-sharing for services; the program for the poor and medically indigent would be financed through general revenues with some cost-sharing and premium contributions by the medically indigent. Employers would be required to pay at least 75% of the premium cost for employee plans, with employees responsible for the remaining 25%. Federal general revenues would also be used to cover the cost of a 10% premium subsidy for anyone registering with a Health Care Corporation.

G. Cost Estimates

None available.

H. Other Major Provisions

Requires each State to develop a State plan providing for the creation of non-profit Health Care Corporations covering every geographic area within the State. Authorizes Federal grants and contracts to facilitate the planning, organizing, developing, and establishment of HCCs, and for State Health Commissions to cover all or part of the cost of developing State health plans.

National Comprehensive Health Benefits Act—H.R. 11345

(REPRESENTATIVE HARLEY O. STAGGERS)

A. General Approach

A program of comprehensive health care benefits for all U.S. residents, phased in over a six-year period. Financing would be primarily through employer (75%) and employee (25%) contributions to the costs of purchasing private health insurance providing specified benefits, and secondarily through Federal general revenues to meet the costs of coverage for the aged, poor, unemployed, and near poor. Newly-created State Health Commissions (SHCs) would be responsible for the actual administration of much of the program, with existing private health insurance carriers underwriting most of the insurance benefits. Both medicare and medicaid would continue in effect. However, since the program would, when fully operational, provide all people with benefits broader than are currently available under these and other programs, they would eventually be modified to supplement the proposed program

B. People Covered

Within two years of enactment all aged, low-income and unemployed individuals and families would be provided coverage for basic health services. Within four years of enactment, all individuals and families would be provided coverage for basic health services and the costs of catastrophic illness. Within seven years of enactment, all individuals and families would be provided coverage for Comprehensive Health Care Benefits and the costs of catastrophic illness.

C. Scope of Benefits

Initially the program would cover basic health services, including physician care, hospital care, laboratory and radiological service, limited mental health services, home health services and preventive health services. After 7 years, the legislation would require that the following Comprehensive Health Care Benefits be covered:

I. Periodic health evaluations

- (*a*) Screening tests and exams
- (*b*) All immunizations
- (*c*) Well-baby care to age 5, with number of covered visits decreasing with age of child
- (*d*) Dental services for children to age 12
  - (1) One free routine exam per year
  - (2) Extractions, fillings, etc.—20 percent copayment
- (*e*) Vision services for children to age 15
  - (1) One free routine exam per year
  - (2) Prescription eyeglasses—20 percent copayment

II. Physicians' services and ancillary health care
- (*a*) Services on an ambulatory basis in any appropriate setting (including the home) by physician or allied personnel under his supervision—50 visits per year with $3 copay per visit
- (*b*) Ambulatory diagnostic procedures—20 percent copay
- (*c*) Hospital or ambulatory center services
- (*d*) Supplies, materials, use of facilities and equipment, including drugs used or administered in connection with outpatient services
- (*e*) Ambulance services—20 percent copay
- (*f*) Voluntary family planning and infertility services

III. Other ambulatory services
- (*a*) Ambulatory institutional care program for mental illness, alcoholism, drug abuse—$2 copay per day, limited to 120 visits per coverage year.
- (*b*) Drugs, prosthetic devices, and equipment—$1 copay per prescription, 20 percent copay for devices and equipment.
- (*c*) Home health services—100 visits with $2 copay per visit

IV. Inpatient services.
- (*a*) Hospital care—60 days per 90 day benefit period, except for mental illness, alcoholism, drug abuse where limit is 45 days. Copay $5 per day.
- (*b*) Extended care services—30 days per benefit period with $2.50 copay per day.
- (*c*) Nursing home care—60 days per benefit period with $2.50 per day copay.
- (*d*) Physicians' services to inpatients—$3 copay per visit of attending physician only.

Catastrophic expense benefits would provide that, once an expenditure limit in any given year was reached, all copayments for services, limits on the number of services covered, and other restrictions and limits no longer applied and that coverage was complete. These benefits would become effective immediately for low-income persons (individuals with annual income below $2,500, a family of 4 with income under $6,500). For all others the benefits would become effective when medical expenses reached a Special Expenditure Limit graduated according to income. For example, a family of 4 with income of $10,500 would be required to incur $1,000 in out-of-pocket expenses before the benefits took effect.

D. Payment to Providers

State Health Commissions would determine premium rates to be used by private insurers and/or HMOs for mandated Comprehensive Health Care Benefit packages. SHCs would also approve, on a prospective basis, all charges for services provided by HMOs and all other health care providers. The Department of HEW would prescribe standards for providers relating to quality, safety, personnel, etc.; as a minimum, providers would be expected to meet existing medicare requirements.

Non-HMO providers would be reimbursed by private carriers underwriting the Comprehensive Health Care Benefits package. HMOs would be paid directly by enrollees or by carriers contracting with them on any appropriate prospective or prior-budgeted basis.

E. Administration

The Federal Government would administer the insurance program for the aged and low-income and would contract directly with carriers or HMOs to provide covered benefits. Employer-employee plans would be administered through approved carriers or HMOs. New independent State Health Commissions (SHCs) would be established in each State to authorize incorporation of HMOs, enforce regulations pertaining to providers, control premium rates charged by carriers, HMOs, and other providers, approve expansion of health facilities, and services, etc. The Department of HEW would assume functions of a State Health Commission in any State which failed to establish one. Private insurance carriers would issue qualified insurance policies, collect premiums, administer claims, and reimburse providers in accordance with Federal and State guidelines.

F. Financing

The Federal insurance program for the aged, poor, and near poor would be financed through general revenues with cost-sharing for services and premium contributions scaled according to financial means. Employers would be required to pay at least 75 percent of the premium cost for employee plans, with employees responsible for the remaining 25 percent. Federal general revenues would also be used to cover the cost of a 10 percent premium subsidy for anyone enrolled with an HMO.

G. Cost Estimates

None available.

H. Other Major Provisions

The development and use of HMOs would be encouraged through additional direct developmental assistance and through a 10 percent Federal subsidy of HMO premiums. Requires SHCs, carriers, and providers to undertake a variety of activities designed to protect the interests of the health consumer.

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