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2:00 p.m

THE WHITE HOUSE

WASHINGTON

May 16, 1979

MEMORANDUM FOR THE PRESIDENT

FROM: STU EIZENSTAT *Stu*  
JOE ONEK

SUBJECT: NATIONAL HEALTH PLAN

This Memorandum summarizes the HEW draft plan and the problems it raises.

I. Summary of the Draft First Phase Plan

A. Benefits

1. Catastrophic Coverage for the Employed. This is achieved by requiring every employer to provide an insurance policy with a \$2500 maximum deductible. The employer is required to pay at least 75% of the cost of the premium.

2. Catastrophic Coverage for the Low Income Worker and the Non-Employed. This is achieved first by providing a two-for-one spend-down to the income-eligibility limit of \$4200. This means, for example, that a person who earns \$5200 is eligible for full Medicaid coverage as soon as he spends \$500 on medical bills. Second, a federal program, Healthcare, will sell catastrophic coverage at a reasonable rate to all Americans who do not have coverage elsewhere.

3. Catastrophic Coverage for the Aged. Medicare beneficiaries will be provided with a ceiling of \$1250 on their out-of-pocket costs.

4. Expanded Comprehensive Coverage to the Poor. This will be achieved by enrolling all Americans with incomes below 55% of the poverty line, who are not covered by Medicaid, in a new federal program -- Healthcare. In addition, reimbursement rates for physicians under Medicaid will be upgraded to encourage physicians to serve poor patients.

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5. Improved Employer Insurance Plans. Employer insurance plans will be improved, in addition to assuring catastrophic coverage, by requiring 90-day coverage of laid-off workers and by expanding coverage for older dependent children.

6. Preventive Benefits. The plan will include a direct grant program in the prevention area.

B. Other Features

1. Medicaid will merge with Medicare in a new federal program -- Healthcare.

? — 2. There will be mandatory fee schedules for physicians in both public and private programs.

3. There will be capital expenditure limits for hospitals.

why? 4. Private insurance companies will be required to purchase reinsurance for all medical bills over \$25,000 from a federal reinsurance fund.

5. There are increases in the earned income tax credit to subsidize the costs for low income workers.

6. There are subsidies to assure that no employer pays more than 5% of his payroll for the mandated premium.

7. Competition will be enhanced by requiring employers to make equal contributions to all health insurance plans and HMOs and by making it easier for Medicare beneficiaries to enroll in HMOs.

C. Costs

The Federal budget cost of the program in 1980 dollars, without offsets, is about \$20 billion. The cost to employers in increased premiums is \$6 billion.

How to reduce by ~\$5 b.1

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## II. Problems Raised by the HEW Plan

The HEW package presents the following substantive and/or political problems. We will have a better fix on the significance of each problem after we have consulted with Senator Long and others:

### A. Size of the Package

The HEW plan calls for \$20 billion in new federal spending and \$6 billion in new employer premium costs in 1980 dollars. CBO will insist that the plan be costed in 1983 dollars which will raise the cost by some 30%.

A package this size may be viewed as inconsistent with the anti-inflation effort. On the other hand, if we cut back significantly on benefits for the poor and the aged, we may lose any hope of ultimately obtaining support from the left.

### B. Federalization of Medicaid

HEW proposes merging Medicaid and Medicare into a new federal program -- Healthcare. Federalization would require 22,000 additional federal employees and might reduce states' incentive to undertake cost containment measures. HEW believes federalization will increase efficiency and lay the groundwork for a comprehensive plan. Senator Long has, in principle, endorsed federalization.

### C. Treatment of Private Health Insurers

The HEW bill contains two features which are anathema to private insurance companies. First, HEW proposes that all private insurance companies be required to insure major risks (\$25,000 or more) with a federal reinsurance fund. Second, HEW provides a subsidy to employers if their mandated premium costs exceed 5% of payroll, but only if the employer enrolls in a federal program.

*Standardization*

*ok,*

*but costs to fed?*

*It will save*

*LA + NY # - patients*

*won't help patients*

*Why?*

The insurance industry is particularly sensitive about these features because the draft HEW comprehensive plan circulated last January transferred some 60 million Americans from private to public programs. These provisions may jeopardize insurance support for hospital cost containment.

HEW believes the reinsurance fund is necessary to provide leverage over the insurance industry and to encourage self-insurance. CEA, DPS and OMB do not believe there is significant substantive justification for the HEW provisions.

D. Mandatory Physician Fee Schedules

HEW proposes to establish physician fee schedules for both public and private programs and to forbid physicians from charging more than the fee schedule. This provision is highly unlikely to pass. It will anger providers and business groups and may cause them to expand their efforts to kill hospital cost containment. On the other hand, it will appeal to liberals and demonstrate that we are trying to reform the system.

E. Subsidies for Low-Wage Employers and Small Employers

HEW proposes a \$1.2 billion increase in the Earned Income Tax Credit to help offset the cost of mandated premiums to low-wage workers. Some may argue that a bigger subsidy is required to eliminate the regressive nature of premium financing. Similarly, small business may contend that the HEW provisions for subsidy only when premiums reach 5% of payroll is inadequate.

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*What are  
savings  
estimates?*

NHP-PHASE I MEMORANDUM

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THE WHITE HOUSE

WASHINGTON

May 16, 1979

MEMORANDUM FOR THE PRESIDENT

FROM: JOE CALIFANO  
STU EIZENSTAT  
JIM McINTYRE  
CHARLIE SCHULTZE

SUBJECT: NATIONAL HEALTH PLAN-PHASE I

This memorandum seeks your decisions on the basic architecture of the National Health Plan-Phase I.

- o Section I describes a Phase I proposal developed by HEW.
- o Section II presents the major issues for your decision at this time.
  - One critical issue is the total cost of the plan. In essence, you have to decide whether the price of universality -- albeit universal catastrophic coverage -- is worth it. OMB, CEA and Treasury believe universality can be achieved at lower cost than proposed in the HEW plan.
  - A second set of issues turns on the implications of Phase I for the future Federal role in health care. HEW extends the Federal role in the areas of benefits, eligibility, reimbursement and administration in order to lay the foundation for a universal, comprehensive plan under full Federal control. OMB, CEA and Treasury believe that the fundamental assumption in the HEW approach is mistaken and would seek a different balance between Federal, State and private efforts. Most specifically, OMB, CEA and Treasury disagree with two central features of HEW's Phase I plan:

Creation of a Federally administered public insurance program (HealthCare) that merges Medicare and Medicaid; and

Establishment of mandatory physician fee schedules for privately financed health care services. OMB, CEA and Treasury believe such fee schedules would inevitably lead to complete Federal control of health service delivery - since physicians will try to replenish their income by performing more services.

These major issues are, as noted, discussed below.

Beyond these differences, there is, however, generalized agreement about the broad goals of Phase I.

Substantively, we must combine an expansion of benefits with structural reforms to contain costs, emphasize prevention, distribute health resources more equitably, and promote competition to the greatest extent possible. We must provide protection against the costs of major illness to all Americans while at the same time improving comprehensive coverage for the poor, near poor, aged, and disabled. And we must propose a Phase I bill that is truly a foundation for universal, comprehensive health plan but that also recognizes the economic constraints of the time.

Politically, we must find a middle way between those who advocate universal comprehensive health insurance now and those who advocate a catastrophic only approach. As you know, Senator Kennedy and organized labor have just announced their large plan. Senator Long has several different proposals on the table and could move to the center to join us or could join forces with more conservative elements in support of a catastrophic only approach. (The House is not likely to consider National Health Plan legislation seriously until there is a sign of movement in the Senate.)

After you make the decisions discussed below, we will need another two or three weeks before submitting detailed specifications to the Congress: a number of second order issues must be resolved, costs firmed up, Congressional and other leaders consulted and a summary statement outlining the universal and comprehensive plan cleared. Ideally, we would send a message to the Hill in early June. But it is possible that Senate Finance will proceed to mark-up one of Senator Long's bills before then.

We think it imperative that, in the very near future, you meet with Senator Long to discuss the substance, politics and timing of the issue. He should be asked to wait until mid-June before proceeding with consideration of the National Health Plan.

I. HEW's NHP-PHASE I PROPOSAL (HEW description)

A. Basic Elements of the HEW Plan

1. Principles

The Department's Phase I proposal seeks to lay the foundation for a universal and comprehensive health plan in the future. Phase I will:

- o offer all Americans universal coverage against major medical expenses;
- o expand or improve comprehensive coverage for the aged, poor and disabled;
- o establish national standards in important areas by requiring a core benefit package, uniform definitions of providers, uniform rates of payment to providers, and standards of quality assurance for all citizens;
- o achieve cost containment by continuing hospital cost containment, establishing fee schedules for physicians and requiring mandatory assignment across public and private plans (i.e., require that all participating physicians charge no more than the scheduled fee for covered services);
- o improve management efficiency and accountability of public health insurance programs and strengthen our ability to detect and reduce program fraud abuse and error by merging Medicare and Medicaid into a new public entity -- HealthCare;
- o encourage an equitable distribution of services across all areas of the country and all population groups through reimbursement reform, resource development activities and improved coverage;
- o expand preventive services;

- o encourage competition among insurance companies, health care providers and suppliers of health care institutions through, inter alia, support of HMOs, reimbursement limits (forcing hospitals to buy more prudently/competitively), and requirements that employers pay regular group insurers and HMOs the same rate per employee.

2. Major components of NHP-Phase I

The Department's recommended plan has four structural components:

- o Employer Mandated Insurance. Employers will be required to provide all full-time employees and their families (25 hours per week for 14 weeks) with insurance protection against the costs of major illness that meets Federal standards (employees would be liable for no more than \$2500). Employers will at least pay 75 percent of the premium, employees no more than 25 percent.
- o HealthCare.
  - To assure uniformity, efficiency and accountability in the public programs and also to provide an important structure for future expansion to a larger plan, HEW's NHP-Phase I creates HealthCare, an umbrella public insurance program.
  - Medicare and Medicaid would be merged and would provide fully-subsidized comprehensive coverage for the aged, disabled, and low-income population.
  - The near poor can "spend-down" to the full subsidy level. Under the plan, all Americans whose income is less than 55 percent of poverty (\$4200 for a family

of four in 1980) will receive a full subsidy. Any individual whose medical expenses exceed 50 percent of income above 55 percent of poverty is also eligible for comprehensive benefits under HealthCare. This is called a "2 for 1" spend-down.

- Individuals not covered through employment-based insurance arrangements and small employer groups who are unable to secure private coverage at less than 5% of payroll have the option of buying into HealthCare at group rates for a \$2500 deductible policy.
- o Reinsurance Fund . As a result of the employer mandate, private insurance plans will gain an additional \$7 billion in premium revenues. The Reinsurance Fund will pool premiums for exceptionally high expenses (those over \$25,000), thus reducing the reserves required to finance the employer mandate coverage and partially equalizing premiums between high and low-risk employment groups. The Fund will additionally be the mechanism used to establish and enforce standards for private insurance plans seeking qualification for the employer mandate and for Federal tax preferences.
- o Health System Reform. Many system reform proposals have already been sent to the Congress: Hospital cost containment, mental health reform, some prevention initiatives, alterations in the planning act, to name a few. Other reforms will be sent to the Hill in the near future, such as reauthorization of health manpower legislation and HMO reimbursement reform. In the aggregate these initiatives constitute an important part of our system reform efforts. There will also be a System Reform title of the NHP-Phase I bill which will include, at a minimum, our capital control proposals and a new prevention proposal.

Each of these components is described in greater detail below.

3. Impact on Target Groups. The following chart indicates the impact of NHP-Phase I on the four key target populations.

U. S. POPULATION = 231 (1980)		
GROUP	CURRENT LAW	NHP
<ul style="list-style-type: none"> <li>● <u>Aged: 24 million non-poor aged/disabled</u></li> <li>-- aged (22 m.)</li> <li>-- disabled (2 m.)</li> </ul>	<ul style="list-style-type: none"> <li><u>Medicare covers 23 million</u></li> <li>-- limits fully-subsidized hospital days</li> <li>-- no catastrophic= unlimited cost-sharing (7 m. lack supplemental insurance)</li> <li>-- Medicaid spend-down in 30 states (1 for 1)</li> </ul>	<ul style="list-style-type: none"> <li><u>HealthCare covers 24 million</u></li> <li>-- no limits on hospital hospital days</li> <li>-- ceiling on cost sharing (\$1250 per person)</li> <li>-- improved spend-down protection (2 for 1)</li> </ul>
<ul style="list-style-type: none"> <li>● <u>Poor: 32 million low-income*</u></li> <li>-- 18 m. cash</li> <li>-- 13 m. poor not covered by welfare</li> </ul>	<ul style="list-style-type: none"> <li><u>Medicaid covers</u></li> <li>-- 18 m. cash assistance</li> <li>-- 2 m. other</li> </ul>	<ul style="list-style-type: none"> <li><u>HealthCare fully covers 31 million</u></li> <li>-- 18 m. cash assistance</li> <li>-- 13 m. other (under 55% of poverty)</li> </ul>
<ul style="list-style-type: none"> <li>● <u>Employed:</u></li> <li>-- 157 m. non-Poor Employed (Including Families)</li> </ul>	<ul style="list-style-type: none"> <li><u>Present Private Coverage:</u></li> <li>-- 100 m. with adequate insurance</li> <li>-- 57 m. with no catastrophic</li> </ul>	<ul style="list-style-type: none"> <li><u>Employer Mandate:</u></li> <li>-- 100 m. with adequate insurance</li> <li>-- 57 m. have catastrophic (\$2500 ceiling on cost-sharing)</li> </ul>
<ul style="list-style-type: none"> <li>● <u>Other: 19 m. (non-aged, non-poor, non-</u></li> </ul>	<ul style="list-style-type: none"> <li>7 m. adequately insured</li> <li>2 people eligible for state-specific spend-down (1 for 1) and .7 m. participate annually</li> <li>10 m. no coverage</li> </ul>	<ul style="list-style-type: none"> <li>7 m. adequately insured</li> <li>12 m. eligible for national HealthCare spend-down (2 for 1) and 4 m. estimate to participate annually</li> <li>1 m. buy into HealthCare</li> </ul>

\*/ Either under 55% of poverty or welfare (AFDC/SSI) eligible.

#### 4. HealthCare

As noted, HealthCare is a basic structural change that is an essential building block for future expansion to a universal comprehensive program. In Phase I, HealthCare provides comprehensive coverage to the poor, aged and disabled and makes the claim of universal coverage against the costs of major illness possible by providing optional catastrophic protection to the near poor and to certain employer groups.

The essential provisions of HealthCare are as follows:

- o All aged and disabled persons who meet the Social Security test of being totally and permanently disabled would be enrolled in HealthCare. There are two major changes from current law.
  - Cost-sharing patterns for current Medicare beneficiaries would remain the same but would be capped at \$1250 per person (\$2500 for a couple).\*/
  - An additional 1 million aged who are presently without Medicare coverage would receive full coverage under HealthCare. (Half of these are poor or near poor and half are retired public employees.)

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\*/ At present, the aged/disabled pay a first day deductible for hospitalization and then full costs after 60 days (and a 90-day lifetime reserve). They pay a premium for doctor's services and unlimited 20 percent cost-sharing.

o Low-income individuals and families would be eligible for HealthCare through one of three entitlement systems:

-- The Welfare Gate. States would certify HealthCare eligibility for all persons meeting State definitions of categorical income assistance (AFDC). The Social Security Administration (SSA) would certify SSI recipients. The income levels at which these individuals and families would be entitled to HealthCare protection will vary by State, following present State eligibility levels for cash assistance programs. This assures continued protection for all cash assistance recipients. States will finance a portion of the cost for these HealthCare beneficiaries employing the same Federal/State matching formula presently used in Medicaid.

Thus, the 18 million presently receiving Medicaid because of AFDC or SSI eligibility will receive full subsidy coverage from HealthCare. Although HEW had initially hoped to separate welfare eligibility from HealthCare eligibility, the complexity and cost of protecting present Medicaid recipients, particularly in high benefit States, was so great that the Department determined this desirable goal could not be achieved in NHP-Phase I.

-- The National Income Entitlement Gate: All individuals and families who do not meet State standards for welfare payments but whose income is less than 55% of poverty (\$4200 for a family of four in 1980) will be eligible for a full subsidy under HealthCare. 12.6 million individuals will enter HealthCare through this gate. Determination of eligibility for non-cash assistance recipients will be a Federal responsibility and the full cost of services for these beneficiaries will be paid by the Federal government.

-- The "Spend-Down" Gate. As noted, any individual or family whose medical expenses exceed 50 percent of income above 55 percent of poverty (\$4200) is eligible for fully subsidized HealthCare benefits. For example, a family whose income is \$8,000 per year and whose medical expenses exceed \$1900 (\$1900 is 50 percent of the difference between \$8000 and \$4200) would be entitled to full coverage under the plan. The "spend-down" would be financed fully by the Federal government, unless States choose to raise the spend-down level above 55 percent of poverty in which case they would share in the costs attributed to the higher level. It would replace 30 State spend-down programs. The State programs are more strict (an individual or family must pay 100 percent of income over a State standard before reaching Medicaid eligibility).

There will be no cost-sharing for the low-income population.

- o Employers and non-poor, non-aged, and non-employed individuals\*/ who cannot buy adequate insurance in the private insurance market can buy HealthCare catastrophic protection (all costs paid for by the program after an individual or family has \$2500 in out-of-pocket costs). This set of provisions entails Federal subsidies because, if the premiums are made more affordable, the premium payments will not fully cover claims incurred by the individuals (who will be higher risk than the average) entering the program in this manner.
- o Benefits under HealthCare would be comprehensive including the traditional inpatient hospital and physician services and improving benefits for outpatient care, physician office visits, mental health, home health and skilled nursing care and preventive services for pregnant women and children.

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\*/ States would also administer the existing long-term care program -- with the existing Federal match. Because of cost-constraints, NHP-Phase I does not include provisions changing long-term care arrangements.

- o The plan would be Federally administered, following the model of Medicare, with heavy reliance on the private sector for claims processing. HEW would establish policy, set standards for provider participation, determine rates of reimbursement. A competitive bidding process would be used to award contracts for administration of claims payments. States would continue to operate eligibility certification for the cash assistance population.\*/ (For more extended discussion, see page \_\_\_ below and also Tab 3.)

#### 5. Employer Mandate

The Department proposes that under the NHP all employers be required to provide their full-time workers (25 hours, 14 weeks of employment) with health insurance coverage that provides protection against expenses in excess of \$2500 per family. Employers must pay at least 75 percent of premium costs (employees can bargain for employers to pay up to 100 percent of the premium).

Provision of this level of protection will cost employers an estimated \$5.2 billion (assuming employers pay 75% of the premium on average), and will improve protection for an estimated 57 million persons (workers plus families).

Employers will purchase insurance from private companies, but must purchase plans that have been certified by the Federal government as meeting the conditions of the employer mandate. For example, the plan must offer the core NHP-Phase I benefit package.

Employer and employee premium costs presently total \$42.6 billion. Thus, the mandated coverage increases these costs by 12 percent. Like HealthCare, the employer mandate is a basic component of the Phase I foundation on which a universal, comprehensive plan would be erected: one could lower the employee cost-sharing to make the employer mandated plan more "comprehensive".

The mandate does, however, require new premium payments from some firms that presently do not provide insurance to their employees. And it also requires premium payments from some employees who do not now pay premiums (but who on average face much greater out-of-pocket costs than the cost of 25 percent of the premium). A discussion of the need to provide subsidies to low wage workers and to certain firms as a result of the mandate is found below at pp. \_\_\_\_.

6. The Federal Reinsurance Fund

As a result of the employer mandate, private employment-related insurance purchases will increase \$7 billion. The Federal Reinsurance Fund proposed by HEW is intended to serve several purposes associated with the employer mandate:

- o The Fund will pool the risk of high expenses (any cost over \$25,000 per beneficiary)
  - This will result in a degree of premium equalization between high risk firms and those whose workers have less risk of high expenditures.
  - In addition, by placing a limit on the potential cost to an employer of any individual catastrophic event, it will encourage the growth of self-insurance among medium size industries and firms. Large industries already self-insure and it is generally felt that self-insurance heightens employer concern over costs and careful planning of health resources in the community.
  - It will also encourage the growth of HMOs.

- o The Reinsurance Fund will limit the potential windfall profits which would otherwise accrue to the insurance industry as a result of the employer mandate. By pooling the reserves needed to finance extremely high expenses, through a Federal Reinsurance Fund, the investment income associated with that reserve capital can be applied to contain employer premium rates rather than increasing insurance industry profits.
  
- o The Fund is a convenient administrative device to set and enforce standards on private insurance seeking qualification to meet the employer mandate. Rather than establishing a new Federal insurance regulatory structure to supercede the State regulation now in place, the Reinsurance Fund can require all plans seeking qualification under the mandate to reinsure benefits with the Fund. As a condition of participating in the Fund, plans will be required to meet Federal standards governing such provisions as: benefits, maximum cost-sharing for consumers, reimbursement rates paid to providers, extension of coverage after termination of employment and other measures intended to protect employers and employees.

The Fund will be financed through a "surcharge" on insurance premiums. All insurance firms participating in the Fund will be required to contribute approximately 10% of their premium revenues to the Fund and be reimbursed by the Fund for any beneficiary expenses that exceed \$25,000.

Because the Reinsurance Fund will be financed entirely through private premium pooling, it could be an "off-budget" expenditure following the same precedent which has governed other Federal insurance programs that are privately financed -- the Pension Benefit Guarantee Corporation, the Federal Flood and Riot Insurance Program.

7. Reimbursement

o Physicians

The basic argument for controlling physician fees is that total expenditures on physicians have been increasing at an average of over 14 percent per year. Although real income of physicians has not increased since 1974, physician fees -- along with hospital costs -- have fueled health care inflation.

The Department's proposed NHP is designed to link together provider payment rates under HealthCare with those paid by private insurance plans. The purpose is threefold: obtain sufficient leverage over total provider payments to impose effective cost controls on physicians and other noninstitutional providers; prevent private insurance plans from payment high rates that will result in discrimination against HealthCare beneficiaries and frustrate cost control efforts; simplify the grotesquely complex physician reimbursement provisions under Medicare and Medicaid.

If you approve, this will be a controversial provision of the NHP; drawing opposition from physician groups and rivaling Hospital Cost Containment as a difficult legislative proposal. It should, however, draw strong support from organized labor, senior citizen and other consumer groups.

The basic provisions are as follows:

Fee Schedules. In the two years prior to implementation of the NHP, Medicare and Medicaid physician fees would be merged in every State, resulting in a new Statewide fee schedule for Federal programs. An average Medicare fee would be established and Medicaid fees brought up to that level.

HealthCare will pay physicians in the State according to the schedule. However, Statewide physician or other interest groups can propose alternative fee schedules if the new schedule is not estimated to increase total spending for physical services in the State.

The purpose of the schedule will be to limit the rate of increase that can occur in physician fees, and to reduce fee differentials that now exist between physicians practicing in urban and rural areas and between physicians in general practice and specialty practice.

Payment rates will be revised annually to adjust for inflation and for changes in procedures and patterns of practice. If, however, physicians have attempted to frustrate the limit on fees by increasing the volume of services billed, the increase in fee levels would be held below the actual rate justified by inflation.

Mandatory assignment. All private insurance plans which qualify for the mandate must also agree to pay physicians according to fee level established by HealthCare both for NHP-Phase I covered services and for supplementary services that employers may offer. In both HealthCare and private insurance plans physicians will be required to "accept assignment". This means that the physician cannot bill the patient for fees in addition to those permitted by the HealthCare plan.

The extension of fee controls and mandatory assignment across public and private insurance plans will provide broad authority to limit physician fees and their ability to generate higher incomes by increasing the volume of services for which they bill insurance plans.

Under the proposal, some physicians who charge very high fees today could see an actual drop in income under fee controls. However, because Medicaid fees will be raised to an average Medicare level, NHP-Phase I will result in an additional \$1.4 billion flowing to physicians in the aggregate.

HEW feels that to fail to establish controls over physician fees and to link them in the public and private sector plans will be to invite a repetition of the inflationary spiral that followed implementation of Medicare or, if controls are applied to the public plan and not to private insurance, to risk continued discrimination against the aged and particularly the poor by a majority of practicing physicians. (At present 30 percent of the nation's physicians do not treat Medicaid patients.)

o Hospitals

The hospital reimbursement policy recommended in the short term will be a continuation of the Administration's Hospital Cost Containment bill. Overtime we would recommend moving toward a more sophisticated classification system and

the negotiation of budgets with institutions, but it would be unwise to unveil a long term strategy until current cost containment legislation has been passed.

#### 8. System Reform

Many of the most serious problems in our nation's health care system will not be relieved through extensions of coverage to the uninsured or cost controls imposed through reimbursement policy. Shortages of providers in rural and inner-city areas, the absence of community-based health education and prevention services, and excessive numbers of hospital beds are all problems which require special targeted programs. The Department's proposed NHP is an umbrella designed to incorporate a variety of special health system strategies and link them closely with the insurance provisions of the HealthCare plan.

The special strategies would change over time, as the most urgent problems are ameliorated, and new issues identified. Initially, however, the following would be high priorities:

- o Strengthening the health planning (separate bill) and capital control structure (in NHP-Phase I) to reduce excess institutional beds and costly duplication of expensive equipment.
- o The new mental health legislation which, inter alia, aims to integrate the mental and general health systems.
- o Inclusion of a new prevention grant program in the system reform title of NHP-Phase I. HEW and DPS are still exploring the precise shape of this program, but they are agreed that it is necessary to include a significant prevention initiative in the Phase I bill. As your advisors are agreed that a significant universal prevention component guaranteed through public or mandated insurance would be too costly and that an important but less expensive grant program is the approach to follow. (The fully subsidized public program does include expanded preventive services for poor pregnant women and children.

- o Revising Federal health manpower policy, by eliminating support which would increase the overall supply of physicians and providing incentives for change in specialty and geographic distribution (separate bill).
- o Establishing a Resource Development and Services Program to coordinate Federal efforts to develop new delivery systems and more effectively provide direct aid to underserved populations (in NHP-Phase I). This would involve a continuation of HEW's present effort to integrate more closely the Public Health Service's grant programs with the Health Care Financing Administration's entitlement programs.
- o Increasing the efficiency and effectiveness of the health care system by assessment of new technology and procedures and extending PSRO review (more effective use of existing authority).

In addition to the above increasing competition in the HealthCare system must be a major priority. The current structure of the market for health care severely restricts the forces that hold down prices in other markets. This is largely due to the pervasiveness of third party payments and the degree of control that doctors get over what services are consumed.

To make better use of market forces in the market for health care, a national health plan should encourage competition among alternative health care packages, such as HMOs and traditional insurance plans. The proposed NHP stimulates competition in three ways.

- o It improves households' choices by requiring employers to offer all available pre-paid, comprehensive health care packages (like HMOs) as alternatives to more traditional packages.
- o It requires employers to contribute the same dollar amount on behalf of an employee whether that employee picks a pre-paid package, low-option insurance, or high-option insurance. This provision insures that employees have a financial stake in choosing among alternative packages.
- o It encourages better information for consumers about their health care alternatives.

Several of the details of these provisions still need to be worked out. For example, if an employer pays 100 percent of the cost of an expensive traditional plan, the equal-contribution requirement might involve tax-free payments to employees who choose a cheaper plan.

CEA believes that these pro-competitive measures are crucial to the success of a NHP and that they are the best method for holding down the cost of health care. Indeed NHP would be strengthened by the addition of other pro-competitive provisions. These will be explored once the major structural elements of the plan are solidified.

### 9.. Administration

The National Health Plan would assign administrative responsibilities to the Federal government, to State governments, and to the private insurance and data processing industries. Because of the priority placed on creating uniformity, efficiency and accountability under HealthCare, program policy would be set almost entirely at the Federal level. However, important administrative responsibilities will continue to be assigned to State governments, and there will be an expanded role for the private sector as administrative agent of HealthCare.

#### The Federal Government

- o HealthCare will be the primary mechanism for bringing uniformity out of the confusion and inconsistency of 53 separate Medicaid programs. Uniformity will be advanced in terms of:
  - benefits provided to the fully-subsidized populations (aged, disabled, poor): at present there is wide variation among the States as to Medicaid benefits;
  - eligibility for the 12.6 million additional low-income individuals who will receive fully-subsidized comprehensive care: although the States will continue to set eligibility for the AFDC/SSI population, we should establish the principle of uniform eligibility not related to receipt of cash assistance for the newly covered;

- reimbursement; at present there is extraordinary confusion and complexity in the 53 State programs and in Medicare.
- o HealthCare will also introduce necessary efficiencies
  - by eliminating confusion and waste created by 4 million beneficiaries enrolled in both Medicare and Medicaid; at present, there are dual structures, definitions and claims processes, making it impossible to track a patient from one system to the other;
  - by establishing a highly sophisticated reimbursement and payment system -- using private industry on a competitive bid basis -- that will serve as the fundamental public health financing administrative mechanism for the rest of the century.
- o HealthCare will ensure a much greater degree of accountability
  - efforts to provide Federal leadership are severely constrained in Medicaid because fiscal sanctions are not credible, and there is no other means of requiring compliance with standards: at present, efforts to even obtain basic program information or institute management information systems are frustrated by State non-compliance (although the Federal government is, on average, paying 55 percent of Medicaid costs and error rates on average were 9 percent in 1976).
- o HealthCare entails no greater administrative costs than perpetuation of the present dual (Medicare and Medicaid) system to handle marked increases in beneficiaries. See p. 27 for a more detailed discussion of the costs.

State governments

- o States perform intake and eligibility functions for categorically eligible persons (AFDC families) as a by-product of establishing their eligibility for welfare.
- o States would no longer be involved in physician reimbursement and other payment system functions.
- o States would continue their traditional functions in:
  - certification and licensure of health personnel
  - certification of health facilities
  - health planning and certification of need
  - hospital rate regulation in conformance with Hospital Cost Containment
  - regulation of insurance companies for solvency, reserves and other financial standards.

With the establishment of Federally-qualified plans, the areas in which the States can regulate insurance will be circumscribed. In particular, the States will not be able to impose additional benefit requirements on insurance plans, beyond those mandated in the Federal standards. This should not have a major impact on insurance commissions, since the bulk of their work is in traditional areas of financial review and fiscal responsibility of companies.

Private Insurance and Data Processing Firms

- o Private insurance firms would sell insurance to employers and administer the benefit payments under employer and individual plans. In order to qualify for the Federal mandate,

the insurance plans must participate in the Federal Reinsurance Fund and meet the conditions established by the Fund.

In addition, private insurance firms and data processing firms will bid to administer claims and data processing contracts under the HealthCare programs.

B. Costs

In the first year of implementation, the net cost of the HEW proposal (expressed in 1980 dollars) is \$18.5 billion -- \$13.3 billion Federal and \$5.2 billion private (employer) -- depending on how one counts certain offsets and cash flows within the plan. This total includes \$2.0 billion in fiscal relief for the States and localities.

The reasoning that supports this conclusion follows. A more detailed set of cost charts is found at Tab 2. Differences between OMB and HEW about how to count certain cost items and an analysis of ways in which the costs could be trimmed, if necessary, are discussed below at pp. 44-45.

1. The Basic HEW Program (1980 dollars in Billions)

POPULATION GROUP/ITEM	PROPOSAL	COST	
		Federal	Private
Aged and Medicare Disabled	Remove benefit restrictions and limit cost-sharing at \$1250 per person with spend-down (2 for 1).	\$2.6	
	Extend eligibility to aged not currently covered by Medicare.	\$1.6	
Low Income	Full subsidy to poor under 55% of poverty (includes .5 for aged under 55% of poverty).	\$6.6	
	Additional cost for present cash assistance recipients (primarily raising present Medicaid physician fees to average Medicare level).	\$1.4	
Employed	Additional cost to employers as a result of the mandate:		\$5.2
	Subsidies: <ul style="list-style-type: none"> <li>• <u>To Employers:</u> <ul style="list-style-type: none"> <li>-- Premium Subsidy of HealthCare buy-in for firms with 0-9 workers (\$\$.2)</li> <li>-- HealthCare buy-in at 5% of payroll: Option open to all firms (\$\$.2)</li> </ul> </li> <li>• <u>To Employees</u> (extend EITC to cover direct premium costs for low-wage workers (\$1.2))</li> </ul>	\$1.6	
Other (non-aged, non-poor, non-employed)	Spend-down to 55% of poverty (2 for 1)	\$3.9	
	HealthCare deficit to subsidize buy-in	\$ .3	
Prevention	Grant Program	\$ .3	
Administrative	Federal cost for aged, low-income, spend-down and HealthCare buy-in	\$1.5	
PHASE I TOTALS <u>WITHOUT</u> OFFSETS		\$19.8	\$5.2

2. Offsets

Against these costs, HEW would offer the following offsets.

OFFSETS	Costs (in billions)	
	Federal	Private
<u>Other Savings in NHP-Phase I Legislation</u>		
<ul style="list-style-type: none"> <li>• <u>Tax Savings.</u> There will be approximately a \$1 billion revenue loss due to higher employer premium payments (which can be deducted as a business expense). But this is more than offset by \$2 billion in revenue gained by raising the threshold for the medical expense deduction from 3 percent of Adjusted Gross Income to 10 percent of AGI. This latter change generates \$2 billion of revenue.</li> </ul>	- \$1.0	
<u>Savings from other Administration Legislation</u>		
<ul style="list-style-type: none"> <li>• <u>Assume passage of the Child Health Assurance Program.</u> CHAP will provide a full subsidy to some of the low-income population covered by NHP-Phase I. Costs for CHAP are already in the budget for Fiscal 1983, and should not be counted against NHP-Phase I costs.</li> </ul>	- \$0.5	
<ul style="list-style-type: none"> <li>• <u>Assume passage of welfare reform.</u> Welfare reform will decrease the Federal costs of NHP-Phase I because it will move some welfare recipients out of full Federal subsidy into joint Federal-State coverage for the poor and because it will move some individuals off welfare altogether (through provision of a job).</li> </ul>	- \$0.5	
<ul style="list-style-type: none"> <li>• <u>Savings From Hospital Cost Containment in Fiscal 1983 (discounted to Fiscal 1980 dollars).</u> In order to afford minimum benefit expansion for the four population groups, it is necessary to commit savings from Hospital Cost Containment. It is appropriate to use these health savings to finance additional health coverage for the poor, near poor and aged.</li> </ul>	- \$4.5	
<b>PHASE I TOTALS WITH OFFSETS</b>	<b>\$13.3</b>	<b>\$5.2</b>

3. Other Cash-Flows

There are several other new cash flows contemplated by the HEW proposal. But HEW would not count them as a net cost of NHP-Phase I.

CASH-FLOW	AMOUNT	
	Federal	Private
<ul style="list-style-type: none"> <li>● <u>Reinsurance Fund</u>. The reinsurance fund is created by a premium surcharge. Thus, no new premium payments are required and a portion of existing premium payments merely flow through the reinsurance fund and back to the insurance industry. There are precedents -- such as the Pension Benefit Guarantee Corporation established under ERISA -- for according the Reinsurance Fund off-budget treatment.</li> </ul>	\$2.7	
<ul style="list-style-type: none"> <li>● <u>Healthcare Premiums for 3N group</u>. The HEW proposal <u>allows</u> the non-aged, non-poor, non-employed to buy-in to HealthCare. The premium is subsidized and that subsidy cost is included in the cost of NHP-Phase I. However, the premiums voluntarily paid by the members of the 3N group are not counted as a cost of the plan.</li> </ul>	\$0.9	
<ul style="list-style-type: none"> <li>● <u>Mandated Employee Premiums</u>. Although the net premium cost to employers is counted as a cost of the plan, the net premium cost to employees (\$2 billion) is not. The rationale is that, while employees in the aggregate pay greater premium costs under the plan than at present, they will face significantly smaller out-of-pocket costs (-\$4.6 billion), and thus the net impact of NHP-Phase I on the employed population is -\$2.6 billion.</li> </ul>		\$2.0
PHASE I TOTALS WITH OFFSETS, WITHOUT OTHER CASH FLOWS	\$ 13.3	\$ 5.2

#### 4. State and Local Costs

State and local fiscal relief and fiscal responsibility under the HEW Phase I plan may be summarized as follows:

##### What is Required of States

- o States are required to pay current matching rates for the categorically eligible for those services covered by the NHP-Phase I benefit package.
- o States are required to maintain effort:
  - they cannot cut back benefits offered to the low-income population below the basic NHP-Phase I package; and
  - they cannot cut back on eligibility (thereby dumping low-income individuals into the 100 percent Federally subsidized part of the low-income program).

##### What We Give States and Localities.

- o We do not charge the States for the Medicaid fee increase (up to the average Medicare fee).
- o We continue to provide current Federal matching rates for two aspects of the present Medicaid program outside of NHP-Phase I: Long-term care and non-covered acute care services (such as dental, mental and drugs). If the States wish, HealthCare will administer the residual non-covered acute care services as part of the NHP-Phase I program.
- o We will limit the States financial exposure for future expansions of the NHP benefit package to 25 percent for the additional services.
- o The Federal government will pay 100 percent of the spend-down costs for those under 55 percent of poverty. Since 30 States now have a spend-down (with the spend-down threshold varying from

47 percent to 99 percent of poverty), this will constitute fiscal relief. However, we will give States the option of setting their own spend-down levels up to, but no higher than, their present levels. The Federal government will apply the present Federal-State match to that part of the spend-down costs due to a spend-down level above 55 percent of poverty.

Fiscal Relief

In essence, there are two types of fiscal relief under NHP-Phase I:

	<u>Cost</u> <u>(in billions)</u>
-- Reduced State spend-down costs	- \$ 0.5
-- Other reductions: primarily substitution of Federal dollars for charity care in local and county hospitals	- \$ 1.5

Total Fiscal Relief = \$ 2.0

Although we do not yet have state-by-state breakdowns of the distribution of fiscal relief, a high percentage will go to counties and localities in big states like California and New York.

Summary

A summary chart follows.

FEDERAL, STATE AND LOCAL SPENDING:  
BEFORE AND AFTER NHP-PHASE I  
(FY 80 dollars in billions)

	PRESENT LAW			NHP			CHANGE		
	S/L	Fed.	Total	S/L	Fed.	Total	S/L	Fed.	Total
<u>MEDICAID</u>									
Covered Services <u>1/</u>	\$4.7	6.3	11.0	\$4.7	6.3	11.0	\$ 0	0	0
Spend-down covered Services	.9	1.1	2.0	.4	1.6	2.0	\$-.5	+.5	0
Non-covered Services <u>2/</u> (Drugs, Dental, In-patient mental)	\$1.0	1.2	2.2	\$1.0	1.2	2.2	\$ 0	0	0
Long Term Care <u>3/</u> (SNF, ICF, Home Health)	\$3.8	4.6	8.4	\$3.8	4.6	8.4	\$ 0	0	0
<u>OTHER</u>									
Public Hospital Charity Care	\$2.0	-	2.0	\$ .7	-	.7	\$-1.3	0	- 1.3
Maternal and Child and Other Grant Programs	\$ .6	N.A.	N.A.	\$ .4	N.A.	N.A.	\$- .2	N.A.	N.A.

- 1/ Assumes State maintenance of effort for Medicaid expenditures for categorically eligible.
- 2/ Assumes continued Federal matching for these services provided to categorically eligible beneficiaries.
- 3/ Assumes continued Federal matching for these services provided to categorically eligible beneficiaries.

5. Administrative Costs

With expanded eligibility for the poor, the near poor and the aged, there will be increased Administrative costs under NHP-Phase I. The basic question is whether additional costs should be borne by the States by perpetuating the present "dual system" (Medicare and Medicaid) or whether they should be borne by the Federal government which would, in turn, make heavy use of private contractors.

The following chart compares additional administrative costs and personnel for Healthcare and for the dual system. A more extended case for Healthcare is found at Tab 3.

ADMINISTRATIVE COSTS

	Present System	Dual System	Healthcare
<u>TOTAL: STATE &amp; FEDERAL</u>			
-- Cost *	\$2.4 billion	\$3.5 billion	\$3.6 billion
-- Government employees	66,000	102,000	71,000
-- Other Non-governmental employees (on contract)	35,000	35,000	36,000
* excluding start-up			
<u>FEDERAL</u>			
-- Cost	\$2.1 billion	\$2.8 billion	\$3.3 billion
-- Federal Employees	9,000	9,000	30,000
<u>STATE</u>			
-- Cost	\$ .3 billion	\$ .6 billion	\$ .2 billion
-- State Employees	57,000	94,000	41,000
<u>START-UP COSTS</u>			
TOTAL		\$727 million	\$882 million
1980		78	52
1981		183	165
1982		466	665

The essential points are:

- o As to total cost, there is virtually no difference between Healthcare and perpetuation of the dual system: Each entails about \$1.2 billion of additional administrative cost.
- o As to total Federal cost, Healthcare costs an additional \$1.3 billion, the dual system an additional \$.8 billion. State costs decrease by \$100 million under Healthcare and increase by \$300 million under the dual system.
- o As to direct government employees: the number of Federal employees increases by 21,000 under Healthcare (primarily for intake and eligibility for the non-categorically eligible low income population) and does not markedly increase under the dual system. The number of State employees decreases by 16,000 under Healthcare and increases by 36,000 under the dual system. In short, direct governmental employees (State and federal) increases by 5,000 under Healthcare and 36,000 under the dual system.
- o As to start-up costs: they are about the same under either Healthcare or the dual system.
- o As to administrative costs as a percent of program costs, they are also about the same under either Healthcare (5.4 percent) or the dual system (5.3 percent).

As noted, however, Healthcare greatly increases the potential for achieving uniformity, efficiency and accountability in the national health financing programs.

### C. The Politics

The politics of national health insurance have been polarized in recent years. On the left, there is a committed set of interest groups pressing for universal, comprehensive reform. On the right, led by providers and other health industry interests, are those who favor a catastrophic only approach. Each holds their own position with intensity. Each opposes the other position with equal -- or greater -- intensity.

The HEW position attempts to chart a middle course. It is obviously less than universal, comprehensive reform, although it sets the stage for future expansion in that direction. It is substantially more than "catastrophic only" because of its significant expansion of benefits for the poor aged, disabled and working poor and because it seeks system and cost containment reforms.

Because the HEW proposal seeks to occupy the middle ground in a polarized situation:

- o no major interest group on the right or left will aggressively support it at the outset
- o but, if moderates in the center and to the right and left of center on the Hill decide that this is the year to act on a National Health Plan and seek a compromise position that combines catastrophic for all with improvements for the poor, aged and disabled, then the HEW NHP-Phase I bill could become the legislative vehicle for a major advance in health policy.

The key to occupying the center ground is reaching an acceptable accommodation with Senator Long -- perhaps with Senator Ribicoff playing an important role -- and moving a significant bill out of Senate Finance.

#### 1. Liberal Reaction

Liberal reaction to the bill will be led by Senator Kennedy in the Congress, and by labor and the senior citizens among the interest groups. Their reaction will most likely be as follows:

- o they will initially oppose the bill because it is not universal, comprehensive reform;

- o the intensity of their opposition will be based, in part, on their overall political relationship with the Administration;
- o it is not clear whether Senator Kennedy will participate in specific negotiations around the details of an incremental bill, although he and his supporters will privately find aspects of HEW's NHP-Phase I attractive;
- o the vast majority of liberal and moderate Senators and members may, however, support the bill. Only Senator Kennedy and a handful of others will be in a position to vote against a measure which provides catastrophic protection and substantially improves assistance for the low income population.

## 2. Conservative Reaction

The insurers, providers, and business representatives will most likely respond as follows:

- o They will be neutral to negative in their initial reaction;
- o their position as it evolves will depend in the main on their assessment of the chances for enactment of legislation. If they feel they can block passage they will attempt to do so; if they feel a bill will pass they will try to shape it to their interests.

The provider groups will be comfortable with the general approach of a first phase bill with one significant exception -- they will be strongly opposed to any reimbursement provisions which might affect them adversely.

Business also will be comfortable with a first phase approach, but they will be concerned most specifically about any burden on employers, particularly small and low wage employers.

The insurers will have the greatest impact on the Hill. Their preference as mentioned above will be to defeat any legislation. If they feel that legislation will pass, they will be generally comfortable with (and in fact have proposed themselves) an incremental approach. In this case they will fight to protect their self interest in the incremental context and they will pay particular attention to the following:

- o attempting to strengthen the role of the States versus the role of the federal government in regulation. They are convinced that they can have greater effect in neutralizing State regulatory efforts than they can federal regulatory efforts;
- o using State-private insurance pools versus a federal program of last resort for people who are unable to purchase regular insurance coverage. Again they would rather take their chances on their ability to dominate the arrangements established by the State government;
- o opposing any reinsurance provisions as they see these as a direct attack on the one role -- namely insuring against large risks -- which they feel is central to their reason for existence. They also fear its possible expansion to cover more and more bills;
- o opposing any provisions which will address the mechanism by which they set their rates. Obviously, their flow of revenue is of paramount importance to them.

### 3. Senator Long

Senator Long appears ready to move in one of two directions:

- o forging a conservative coalition with conservative democrats, republicans, insurers and providers to pass a very restrictive, low cost, catastrophic only, piece of legislation. Such legislation would contain very high catastrophic deductibles (on the order of \$15 to \$20,000 a year), little or no assistance for the poor, and few in any cost control or system reform provisions; or
- o forging a centrist coalition with the Administration's support to pass a bill similar to HEW's Phase I measure which would include catastrophic protection (with deductibles in the \$2,500 range) along with substantial assistance for the poor and a series of cost control and system reform provisions.

Senator Long will choose the latter course only if the Administration makes it clear to him that we want him to make such a choice and will cooperate in passing such legislation. In other words, we cannot refuse to deal with Senator Long and still obtain this more favorable outcome.

## II. ISSUES FOR DECISION

In this section, we seek your guidance on the major outlines of the NHP-Phase I.

First, we discuss major design issues that you should consider apart from their cost. These involve major choices about the future Federal role in our health care system.

Second, we then discuss the total cost of the plan to seek your decision on an overall cost constraint.

We have tried to keep the number of issues for decision to the first-order questions that will, in large measure, control the shape of the rest of NHP-Phase I.

### A. Major Design Issues

#### 1. HealthCare

All your advisors agree on a number of HEW's proposed changes to Medicaid:

- o an improved mandated benefit package
- o Medicaid fees brought up to Medicare levels
- o for providers, participation in Medicaid as a condition for participation in Medicare.

There are two major areas of disagreement.

#### Administration

OMB, CEA, and Treasury do not believe that it is necessary to replace Medicare and Medicaid with a new Federal program for the poor and elderly in order to accomplish the desired changes for the poor. HEW believes that creation of HealthCare is an essential step for effective program management and for further expansion to a larger plan.

- o OMB, CEA and Treasury argue that uniform eligibility and benefit standards do not require Federal intake (through the Social Security system). Currently, the States perform intake and eligibility determinations for food stamps and unemployment insurance under strict Federal guidelines.

HEW argues that a separate eligibility gate for those newly subsidized under NHP-Phase I (i.e. those under 55 percent of poverty not receiving AFDC and SSI and those who "spend-down" into a full subsidy program) is an essential building block for a universal, comprehensive plan -- it separates health care coverage from welfare coverage and begins the vital process of ending two-class care in this nation.

HEW also argues that it is politically untenable to think that the States will be willing to pick up additional financial responsibility for the newly eligible when we are, in essence, requiring them to continue their present cost-sharing for the categorically eligible population. This being so, it is highly undesirable to give the States administrative responsibility for intake and eligibility for the newly eligible since they would have no incentive for efficient management. The high error rates in Food Stamps -- a State run, federally financed program -- are substantially higher than those in AFDC which has joint State-Federal financing.

- o OMB, CEA and Treasury argue that Medicaid programs in each State currently provide all benefits to eligible poor persons. HEW would use Healthcare to provide most acute care services. Some acute services (e.g., drugs and dental) now provided through Medicaid in the States would be available either through HealthCare or, at State option, through a special program. Long-term care would be provided by States with Federal cost sharing only for old Medicaid eligible persons.

HEW has not demonstrated the efficiencies of fragmenting benefits for the poor into three programs. While, for cost reasons, eligibility for long-term care may have to be limited in some way, those limitations could be introduced in existing Medicaid programs.

HEW argues that it is vital to introduce sound and uniform management techniques into Medicaid claims and reimbursement processes. Under HealthCare these functions would be competitively bid and performed by private industry. There would be no fragmentation with respect to acute care services, because Healthcare would handle claims processing and reimbursement, at State option, for non-covered acute care services (i.e. for the residual acute care Medicaid program).

- o OMB, CEA and Treasury argue that experience shows that private insurers pay claims more efficiently than government. Currently under Medicare HEW picks an intermediary in each State. Competitive bidding, although allowed under law, is not used. Some states, however, do currently use competitive bidding for selecting claims processors under Medicaid. Given this history there is no reason to assume that better claims payment follows from Federal assumption of the claims payment process.

HEW emphasizes that claims processing and reimbursement would be conducted by private contractors under HealthCare. At present, less than a third of the States contract out for Medicaid claims processing and reimbursement. Moreover, HEW argues that HealthCare will allow creation of an integrated claims processing system for the 4 million who receive both Medicaid and Medicare.

#### State/Federal Financial Roles

OMB, CEA, and Treasury agree that it may be necessary politically to assume a major portion of the added costs for the poor and near poor. However, this diminishes the services which can be provided with scarce Federal resources.

More importantly, if each State's additional burden is assumed by the Federal government, the state financial participation will be substantially reduced at the margin. We believe that State financial risk is critical to State efforts in improving planning and cost containment. This view is supported by HEW evidence which shows effective cost containment programs have been undertaken in States with large financial commitments to Medicaid (e.g., New York, Massachusetts, Maryland and New Jersey). In addition such "hold-harmless" provisions reward those States that have kept benefits low and the eligible population small. HEW's plan will reward States for failing to take adequate care of their poor population and punishes more generous States.

Finally, if a State's financial risks is substantially diminished, the incentives to improve management of health care programs also disappear. As virtually all major innovations in cost containment (hospital rate commissions and catastrophic insurance programs, for example) have been developed and refined at the State level before being adopted and disseminated by the Federal government, a major source of ideas for program improvement would be lost.

HEW argues that, as noted, its proposal does keep State money in at the margins for the welfare-eligible population: the present matching system would remain in place for that population. This -- plus the general interest of the States in keeping health care costs down for all their citizens -- will provide incentives for continued experimentation in health system reform. Finally, HEW underscores the basic political point: the States will not accept a greater financial burden for medical care for low-income individuals.

\_\_\_\_\_ Approve HealthCare (DPS and HEW recommend)

\_\_\_\_\_ Disapprove and design plan that continues dual Medicare and Medicaid structure (OMB, CEA, and Treasury recommend)

3. The Employer Mandate . The employer mandate is the mechanism for ensuring coverage of the full-time employed population. It is also the mechanism for ensuring a major role for the private insurance industry and for incorporating premium financing as a central feature of the NHP-Phase I. And it is, as noted, an essential design feature for future expansion because it is the vessel for converting a universal, catastrophic plan for the full-time employed into a universal, comprehensive plan -- by initially mandating a core benefit package and then lowering the cost-sharing from \$2500 in subsequent years.

Your advisors are generally in agreement that an employer mandate with the following basic characteristics should be at the center of NHP-Phase I.

- o employers must offer coverage to all full-time workers (25 hours per week for 14 weeks) and their families
- o the coverage must include at least the basic NHP-Phase I benefit package
- o cost-sharing arrangements are flexible, but no family can face more than \$2500 out-of-pocket spending under an approved plan
- o coverage generally would be provided by private insurers at appropriate group-rated premium costs
- o employers must, at a minimum, pay 75 percent of the premium costs.

A mandate of this size will have minimal one-time employment and inflation effects. It could result in 50,000-100,000 unemployed, and might add 0.1-0.2 percentage points to the CPI.

DOL, on the other hand, prefers an earnings-related approach as embodied in the recent Kennedy/organized labor proposal on the grounds that it is more progressive than conventional premium financing and minimizes other undesirable side effects. There is no doubt that such an approach has some advantages over conventional premiums as a method of financing. However, it was rejected by your other advisors for political and administrative reasons since:

- o earnings-related premiums are simply a payroll tax by another name;
- o they, in principle, should appear on-budget to the Federal government, and would not do so only as the result of a transparent obfuscation; and
- o they are basically incompatible with traditional private health insurance and lead to complex administrative arrangements in order to retain a substantial role for private insurers.

It is therefore recommended (by CEA, DPS, HEW, Treasury, OMB) that you adopt the employer mandated approach described above. (The next section presents some decisions regarding subsidies to compensate for the undesirable consequences of the employer mandate on certain low wage workers and small businesses.)

\_\_\_\_\_ Approve

\_\_\_\_\_ Disapprove

#### 4. Low-Wage Employees and Small Businesses

The premium which employers and employees must pay under the mandate will cost approximately \$600-\$700 annually for workers with families and \$250-\$300 for individual workers. With a 75-25% employer-employee split, the employers' share will be \$450-\$575 for workers with families and \$188-\$225 for individual workers. The employees' share will be either \$150-\$175 (family) or \$62-\$75 (individual).

In fact, economists agree that these premium costs understate the true long run economic consequences for many workers and overstate them for many firms, since firms generally will be able to offset much of this new payroll cost by increasing wages over time by less than they otherwise would. It is even possible that future increases in the minimum wage would be deferred because of the mandated coverage.

These mandated costs may be undesirably high for certain firms and lower wage workers. Your advisors generally favor subsidies to deal with these problems. Without them, we will be open to strong attack from the Kennedy/Labor forces.

##### a. Employee Subsidy

The premium costs for workers with relatively low incomes present two specific problems.

- Premium costs represent a significant percentage reduction in their income. For example, a worker with family earning 120% of the minimum wage (\$7,440 in 1980) would face a direct premium cost of 2-3% of take-home pay. As noted, the true costs to such a worker actually could be two to three times this amount because of reduced wages.

- Premium costs may be viewed as inequitable since families at equivalent income levels not covered through the employer mandate (a family with two part-time workers, for example) will receive equivalent insurance coverage through the spend-down provision without incurring any premium costs.

HEW proposes to expand the Earned Income Tax Credit by \$1-\$1.2 billion to help offset employee premium burdens for low income workers. The EITC covers only families, but it is workers with families who are most heavily hit by the mandated premiums.

Expanding the Earned Income Tax Credit by this amount would utilize more fully an existing tax subsidy scheme to aid working poor families. This amount of money is sufficient to provide an additional subsidy of \$200-\$300 to a family whose primary source of income is a full-time low wage job. Thus, it will more than offset any direct premium costs that such families might face as a result of the mandate.

If you decide to provide this employee subsidy, the exact design of this expansion will be coordinated with the smaller one already included in the welfare reform proposal.

b. Employer Subsidy

For the vast majority of employers the premium cost of the mandated catastrophic coverage will be no more than 1%-2% of payroll. However, for smaller firms with a high proportion of low wage workers who require family coverage, these costs could run as high as 7-8%. Although it is not clear that the mandated employer costs will have an adverse impact on more than a small number of firms, they may be perceived as doing so and could, thus, create major political problems.

HEW proposes to subsidize firms for the premium costs in excess of 5% of their payroll. HEW would allow firms to buy into Healthcare, but DPS, OMB and CEA are concerned that the subsidy be designed to that firms with premium costs above 5% could buy private insurance and still receive the subsidy. This proposal would entail additional federal subsidy costs of \$0.2 billion annually. If all the firms whose premium costs might exceed 5% of payroll exercised this option, 3.8 million workers and their families would be involved.

By insuring that firms do not have to incur any costs in excess of 5% of payroll as a result of the mandated coverage, we prevent the extreme cases from influencing the political debate over the desirability of this basic approach to financing catastrophic coverage for the employed population.

Further discussion. The HEW solution will still mean that the financing of coverage for low income workers is regressive. Furthermore, some small employers will regard a 5% increase in their payroll as significant.

It may be necessary, therefore, to consider other alternatives. One possibility is to exempt firms with a small number (49 or less) of employees. Small employers would, therefore, be relieved of the burden of mandated coverage. Low wage workers in low income families would still be covered by the spend-down before incurring medical expenditures in excess of \$2500. Workers with incomes \$5000 or more in excess of 55% of the poverty level could purchase catastrophic insurance at a reasonable price from either private insurance or Healthcare.

There are several problems with this approach. First, it would increase budget expenditures by about \$1.5 billion since all low wage workers would be covered only by the spend-down provision and not at all by private insurance. Second, fewer workers would be protected from catastrophic illnesses, since many workers with incomes \$5000 or more in excess of 55% of the poverty level would not purchase catastrophic insurance. Third, it would not put in place a system which can later be expanded into a comprehensive plan since one-third of the labor force is in firms of size 49 or less.

Another possibility is to retain mandated employer coverage but increase the subsidy to both low wage workers and small employers. The disadvantage of this approach is simply that it increases on-budget costs. For example, to expand the EITC to offset the full family premium costs and to cap firms' liability at 3% of payroll would cost an additional \$4-\$5 billion.

Decision

\_\_\_\_\_ Approve \$1-\$1.2 billion EITC expansion for low-wage employees and subsidy for firms whose premium costs exceed 5% of payroll. (HEW and DPS recommend)

\_\_\_\_\_ Disapprove

## 5. Physician Reimbursement

HEW has proposed that all medical payments to physicians, those made by both public programs and private insurers, would be based on statewide fee schedules and that all physicians would be required to accept these fees as payment in full for services rendered.

HEW argues that the purpose of the schedule would be to limit the inflationary rate of increase in physician fees that has been occurring and to reduce fee differentials that now exist between physicians practicing in urban and rural areas and between physicians in general practice and specialty practice. The mandatory schedules would apply to private payers as well as the public plan to prevent continued discrimination against the aged and particularly the poor by a majority of practicing physicians.

Fee schedules raise two key substantive issues for OMB, CEA and Treasury.

- o Although these offices are sympathetic to the purposes of fee schedules, they believe that the HEW's cure is worse than the disease. Evidence from the 1971-73 price controls suggests that effective fee controls lead doctors to provide unnecessary services in order to sustain their incomes. They believe that it is bad policy to encourage this type of misallocation of resources.
- o The mandatory fee schedules would apply to private payors as well as the public plan in order to discourage continued discrimination against the aged and particularly the poor by a majority of practicing physicians. OMB, CEA, and Treasury believe that discrimination is based on many factors besides fee differences and that equalizing fees would by no means eliminate discrimination. As an alternative way to combat discrimination we suggest that providers not receive any reimbursements, including those for Federal employees unless they accept all federally connected patients.

Given the experience of Hospital Cost Containment in Congress and the fact that mandatory fee schedules are much more threatening than hospital reimbursement limits, it is clear that mandatory fee schedules will face a very, very hard fight, and their chances of survival are not high. One must therefore discuss not only the merits of fee schedules but also the politics.

The strategy of this issue must be judged from several perspectives.

- o Cost Containment and System Reform. Failure to seek to reduce physician fee increases and to effect mandatory assignment will be strongly criticized by labor and senior citizen groups and leave us open to the charge from Senator Kennedy that we are not serious about bringing health costs under control and that we are freezing in place existing incentives for specialty care and discouraging practice in rural and inner-city areas. Although HMO's and other pro-competitive reforms should help hold down costs in the long run, there seems to be no good alternative to fee schedules in the short run.
- o Price Controls. CEA, DPS and OMB are concerned that mandatory assignment and fee schedules will establish price controls on hundreds of procedures and will have to be linked to controls on volume increases. This move will run against the Administration's general position on wage/price controls, although it could be justified, as Hospital Cost Containment has been, on the ground that the health sector is different. There is a danger of losing insurance support and general business neutrality on cost containment if price controls are placed on physicians. HEW argues that there is no good alternative to fee schedules and mandatory assignment -- otherwise we are simply giving physicians a blank check. (As it is, physician income will increase \$11 billion under NHP-Phase I.)
- o Importance of a Loss on the Issue. DPS is concerned that this issue will receive inordinate attention when the NHP-Phase I plan is announced and that it will then be difficult to adopt a fall-back position, having argued forcefully for the need for controls.

HEW believes that it is a good cause, worth waging, and that, at the least, it should be our going in position. HEW notes that we can fall back to a modified position which would be fee schedules for both public and private plans but mandatory assignment only in the public plan. Qualified private plans would have to pay at the fee schedule. Companies could agree to pay additional fees but would not deduct those extra fees as a business expense.

\_\_\_\_\_ Approve physician fee schedules and mandatory assignment in both public and private plans as going-in position. (HEW and DPS recommend.)

\_\_\_\_\_ Approve physician fee schedules and mandatory assignments in public plans (OMB, CEA and Treasury recommend).

6. The Reinsurance Fund. HEW has proposed a reinsurance fund that will pool the risk of high expenses (any cost over \$25,000 per beneficiary) in order to equalize premium costs between high risk and other firms, to encourage self-insurance and thereby cost containment among businesses and to help HMO's. The Fund will also set and enforce standards on private insurance seeking qualification to meet the employer mandate.

CEA, DPS and OMB oppose the Reinsurance fund, on both substantive and strategic grounds.

Substantive arguments:

- o DPS argues that there is no economic justification for the Fund since large firms do not require reinsurance (due to the size of the work force) and there appears to be little evidence that small firms have trouble buying such reinsurance protection. HEW notes that small firms are not buying such reinsurance and are not self-insuring.
- o DPS argues that there will be little equalization of premiums under the fund because the expenses that it covers are so high (\$25,000). HEW maintains that, on average there will be a 5 percent equalization, and that, in high risk industries like chemical production or mining, the equalization effects could be higher.

- o DPS argues that, with reinsurance, private insurance companies will have little incentive to worry about the costs of major illness. HEW argues that, with a level of \$25,000 and with insurance companies picking up 20 percent of the costs of illness over that level, such an incentive exists.
- o CEA and OMB argue that the Reinsurance Fund is not necessary to regulate private insurance: standards can be enforced through favorable tax treatment or simply as a condition of complying with the employer mandate.
- o DPS and OMB argue that the Reinsurance Fund will increase the cost of NHP-Phase I because the \$2.7 billion in outlays -- even though derived from a premium surcharge -- must be counted "on-budget." HEW argues that there are precedents -- primarily the Pension Guarantee Fund under ERISA -- for counting the Fund's outlays "off-budget."

Strategic arguments.

DPS and OMB argue that we will needlessly alienate the insurance industry by proposing the Reinsurance Fund. The insurance companies are not likely to oppose our plan strongly, in the absence of the Reinsurance Fund, and their relative neutrality will be an important factor working in our favor on the Hill.

HEW argues that we should propose the Fund as a going-in position. We inevitably get involved in a bargaining situation with Senator Long -- and it is critical that we have something to give up. The Reinsurance Fund, which involves an industry that is close to Senator Long, is an excellent bargaining chip.

\_\_\_\_\_ Approve Reinsurance Fund  
(HEW recommends)

\_\_\_\_\_ Disapprove (CEA, DPS and OMB  
recommend)

B. Cost

1. HEW Position: The Need for Minimal Equity and Universality.

As noted (see pp. 20 to 23 above), HEW argues that its plan can be costed out at (in 1980 dollars) at 18.5 billion: \$13.3 billion net new Federal cost and \$5.2 billion net new employer cost. This net cost turns on assumptions about offsets -- most importantly \$4.5 billion from fiscal 1983 savings due to passage of Hospital Cost Containment -- and the method for counting certain cash flows.

Without the Hospital Cost Containment offset (but excluding the cash flows), the cost of the HEW NHP-Phase I plan is \$18.8 billion in net new Federal dollars.

This cost is the price of equity and universality: equity in extending comprehensive, fully-subsidized protection to all poor individuals and families under 55 percent of poverty (and those near poor who spend-down to that level) and universality in making available to all 231 million Americans protection against the costs of major illness.

HEW believes that this is the minimum package for a credible NHP-Phase I. The only way to cut Federal costs -- eliminating full coverage for singles and childless couples (savings of \$3.3 billion), dropping coverage for the 1 million aged presently without Medicare protection (savings of \$1.6 billion) or reducing the "spend-down" from "2 for 1" to "1 for 1" (savings of \$1.5 billion) -- would seriously compromise either the equity or the universality of the plan.

2. OMB Comments.

HEW's cost estimates for Phase I clearly overrun the public commitment of \$10-\$15 billion in additional health spending. OMB projections indicate that HEW's plan (using HEW cost estimates, but appropriate budget accounting principles) would involve Federal outlays of \$32.5 billion in FY 1983. HEW will make a programmatic case for this level of Federal spending.

To gain a common ground for this discussion, we have agreed with HEW that cost estimates would be done using 1980 dollars, populations, employment and program level assumptions.

However, while OMB believes that the level of resources committed to Phase I is a critical question, there are two major problems with HEW's cost estimation procedures.

First, there are differences between OMB and HEW on what constitutes a "cost" of the plan. For example, HEW's current draft Phase I plan has "net costs" of \$25.8 billion, a figure OMB bookkeeping would increase by about \$5 billion to reflect (1) the employees' share of increased premiums for mandated catastrophic coverage and (2) the cash flow through the reinsurance fund. It is unlikely that agreement on an appropriate set of "costs" can be reached at the staff level before May 17.

Second, and more importantly, the cost estimates are now very soft. The costs of particular components have changed substantially (and inexplicably) in the last several weeks and OMB's initial assessment of the current numbers suggests that some items may be very high and others too low. HEW has been unable to provide adequate back-up information for their estimates and has not yet provided explanations of the variation between their costs and independent estimates of costs for similar coverage.

It may be that most of the eligibility and benefit expansions HEW wants to provide under their Phase I approach could be implemented with \$15 billion (1980 dollars). However, the large uncertainty about costs leads OMB, CEA, and Treasury to build on a base of programs with which we have experience, rather than undertaking a large, new, untested program.

\_\_\_\_\_ Approve \$18.8 NHP-Phase I Federal costs  
(without offsets) proposed by HEW (DPS  
and HEW recommend)

\_\_\_\_\_ Disapprove (OMB, CEA and Treasury recommend)

### III. NEXT STEPS

Given your guidance on the issues discussed above, we will develop complete specifications of NHP-Phase I. We

we also begin selective consultations with key Congressional leaders, and complete a 15-page description of a fully implemented National Health Plan.

We will then report back to you on our progress.

As noted, it is important that you discuss NHP-Phase I with Senator Long at your earliest convenience.



TAB 1: SUMMARY SPECIFICATIONS FOR PHASE I OPTION

A. Introduction

The Phase I Option will offer every resident of the United States an opportunity to be insured under a comprehensive health insurance plan that includes coverage of all ambulatory care medical services, hospital care, outpatient X-rays and diagnostic services as well as limited provision of mental health and some preventive health care services. In addition to offering this comprehensive range of services, the plan will place a limit on out-of-pocket spending for health care (protection against "catastrophic costs").

The system reform and cost containment features of the Plan will seek to reduce increases in health care spending through both enhancing competition in the health sector and providing mechanisms through which the HealthCare program can set limits on payments to institutional and non-institutional providers.

There will be four major institutional components of the Phase I Option:

- o HealthCare. A Federal insurance program for the aged, disabled, poor and others with extremely high expenses (through a spend-down). In addition to providing protection for these beneficiaries the HealthCare Administration will negotiate provider reimbursement rates. It is proposed that these payment rates also apply to private insurance plans which qualify for participation in the Reinsurance Fund.
- o Employer Mandated Coverage. Insurance for the working population and their dependents.
- o Reinsurance. A Federal program to reinsure extremely high medical expenses in employer financed group coverage and to set standards for participating private insurance plans.
- o System Reform Initiatives. A variety of programs aimed at improving health resources, enhancing competition in the health sector and reducing excess capacity in hospitals.

Each of these institutional components is described in more detail in the following sections, with a discussion of the specific plan feature recommended, and alternatives not recommended.

The combined impact of these two eligibility provisions is to continue the current Federal/State match in financing HealthCare coverage for welfare recipients (including those newly entitled by virtue of our welfare reform proposal). This has the advantage of providing a straight-forward means of capturing the bulk of current State Medicaid expenditures.

The added coverage extended to persons not now eligible for cash assistance (with incomes below 55% of poverty) will be financed entirely with Federal funds. The uniform Federal standard at 55% of poverty, although far below that which would be considered adequate protection for the poor, would allow a base for future program expansions to phase coverage up to the full Federal poverty standard.

- c. All other individuals or families will be eligible for coverage if their expenses for covered medical services exceed 50% of the difference between their income and 55% of poverty (2 for 1 spend-down)
- d. Any individual or employer with less than 10 workers can buy into HealthCare at a premium rate which is approximately 150% of the average premium for large employment groups.
- e. Any employer can buy into HealthCare at a premium set at 5% of payroll.

2. Benefits

a. Benefit Package

- o Inpatient hospital (unlimited).
- o Physician and other ambulatory services (excluding dental and psychiatric) (unlimited).
- o Preventive services for pregnant women and children
- o Mental health, alcohol, drug abuse (psychiatrist, psychologist, organized centers)
  - 20 days inpatient hospital
  - \$1,000 in outpatient
- o 100 home health visits
- o 100 days skilled nursing care
- o Laboratory services, X-ray and other miscellaneous services -- identical to Medicare benefit package.

b. Cost-Sharing

- o The aged and disabled will maintain their current cost-sharing configuration but will be protected against out-of-pocket costs in excess of \$1250 per person.
- o Persons below the Federal LIS (low-income standard) will not face any cost-sharing.
- o Others will be protected against all expenses which exceed 50% of the difference between their income and the LIS.

3. Reimbursement

Reimbursement policy will link the rates of payment for physicians, hospitals and other health care providers under HealthCare with the rates paid by qualified private insurance plans sold to employers. The mechanisms for setting provider payment rates under HealthCare are described below. The link to private employer financed plans is described in the section dealing with the employer mandate.

a. Physicians

Initially, Statewide fee schedules will be established, statistically based on current Medicare fees.

Medicaid fees will be phased-up to the Statewide fee schedules. Physicians with "reasonable charges" (the current Medicare payment allowance) above the schedule will be "held harmless" for an initial two year period. Specialty differences would not be recognized in the calculation of Statewide fees. The Secretary would have the option to establish subState or multiState schedules.

The process thus far sets a uniform Federal fee schedule which is State-wide in its application and which serves as the starting point for negotiations between the HealthCare plan and physicians in the State.

An organization representing a majority of physicians in the State can then propose an alternative schedule of fees, so long as the total expected expenditure under the alternative schedule does not exceed that which would result from the HealthCare promulgated schedule. HealthCare can accept the alternative schedule, or conduct negotiations with the physician representatives to alter that schedule. In future years a National Advisory Committee on physician reimbursement would be established to serve as the physician reimbursement subcommittee of an NHP Reimbursement Negotiating Board.

Physicians who accept HealthCare patients must accept assignment and cannot bill any beneficiary for fees in addition to those paid by HealthCare.

b. Hospitals

The hospital reimbursement provisions will be an extension and elaboration of HCC proposal.

4. Financing

- a. Aged. The current Medicare Part A payroll tax will continue and will subsidize a portion of costs for the aged and disabled. The aged and disabled will, in addition, be required to pay a premium equivalent to the current Part B premium.
- b. Low-Income. The States and the Federal government will continue to finance the cost of care for welfare recipients, using the current Medicaid matching formula. States will control the income eligibility level set for AFDC recipients by virtue of controlling the level set for cash assistance. This means that States will have increased expenditures over time for this group of HealthCare beneficiaries, comparable to what their expenses would have been under Medicaid.

Non-categorical individuals, those not on welfare, whose income is less than 55% of poverty will be financed entirely at Federal expense. Funds will be drawn from general revenues.

5. Administration

HealthCare will be administered by DHEW using the general approach of Medicare. The Department will establish policy, determine rates of payment to providers under the program (as described in Reimbursement section). Claims payment operations will be handled by fiscal agents chosen through competitive bidding.

Eligibility determination will be split between the States and the Federal government. States will determine eligibility for the welfare families at the same time they determine their eligibility for cash assistance. All other persons will enter the program through an eligibility determination process administered by SSA/HCFR local offices. SSA will handle eligibility determination for the aged and SSA-disabled plus SSI beneficiaries.

States will continue to handle their traditional functions in certification and licensure.

C. Employer Mandated Coverage

1. Eligibility

Employers must provide coverage meeting minimum Federal standards to all full-time employees (25 hours per week, 10 weeks of employment) and their immediate (nuclear) family. Children will be covered under an employer-financed plan until they are age 21, or 26 if in school full-time. Employees can decline coverage only if they document enrollment under a spouse's insurance plan.

2. Benefits

Plans meeting minimum standards must provide the basic HealthCare benefit package.

Cost-sharing arrangements are flexible, but no family can face more than \$2500 in out-of-pocket spending under an approved plan.

3. Financing

The employer must pay at least 50% of premium costs for the mandated benefit package.

In order to protect employers from excessive burdens due to premium costs, two subsidies are offered:

- o Employers with less than 10 employees can buy HealthCare at the individual premium rate.
- o Any employer can buy HealthCare at a premium equal to 5% of payroll.

4. Administration

Private insurance plans would continue to market and administer their insurance plans. However, in order to be qualified to meet the requirement of the employer mandate, the plans must meet Federal standards governing benefits, maximum cost-sharing, and reimbursement policy.

5. Reimbursement

Payment rates for physicians and hospitals under qualified private plans must be the same as those specified under the HealthCare plan. Mandatory assignment of physician claims is required under private plans as in HealthCare. Physicians will be permitted to bill patients an amount in addition to the approved rate although they will be required to inform the patient in advance if they intend to bill at a higher rate.

All insurance plans will pay hospitals on the per diem rate specified for that hospital under the HealthCare plan. No additional patient billing will be permitted by hospitals.

D. Federal Reinsurance Fund

A Federal Reinsurance Fund will be established and all insurance plans seeking qualification for the employer mandated coverage must reinsure benefits with the Fund. In order to qualify for participation in the Reinsurance Fund insurance plans must meet standards specified by the Fund including:

- o benefits and cost-sharing arrangements
- o reimbursement rates
- o other administrative standards such as continuation of coverage after employment terminates, waiting periods, exclusions, etc.

The Reinsurance Fund will be financed through a surcharge on employer premium payments.

E. System Reform Initiatives

In addition to reforms in the reimbursement system, the following steps would be included in NHP to complement insurance provisions:

1. Increasing competition through expansion of HMOs and seed money for innovative service models, such as hospices and ambulatory surgicenters.
2. Ensuring that the neediest of the underserved populations receive preventive and primary care through expansion of the National Health Service Corps, Community and Migrant Health Centers, and nurse practitioner clinics.
3. Implementing the new Community Mental Health Systems Act, with emphasis on State roles in serving the chronically mentally ill, development of community services for underserved groups and linkages between health and mental health care.
4. Implementing the capital controls provisions of HCC.



4/16/79  
C. F. ...

TABLE 1: THE DEPARTMENT'S PHASE I OPTION

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- LAYS THE STRUCTURAL FOUNDATION FOR A UNIVERSAL, COMPREHENSIVE HEALTH PLAN
- SUBSTANTIALLY IMPROVES COVERAGE FOR THE MOST VULNERABLE GROUPS
  - THE AGED, POOR AND DISABLED
- OFFERS EVERY AMERICAN FAMILY PROTECTION AGAINST CATASTROPHIC COSTS
- INSTITUTES IMPORTANT SYSTEM REFORMS TO IMPROVE ACCESS AND CONTROL COSTS
- PROVIDES A FRAMEWORK WITHIN WHICH EFFECTIVE COST CONTROLS CAN BE IMPOSED
- ENHANCES COMPETITION AMONG HEALTH CARE INSURERS AND PROVIDERS
- ASSURES THAT PRIVATE INSURANCE PLANS OFFER AN ADEQUATE STANDARD OF PROTECTION AND COVER A FULL RANGE OF SERVICES
- IMPROVES THE MANAGEMENT EFFICIENCY AND ACCOUNTABILITY OF PUBLIC HEALTH INSURANCE PROGRAMS

TABLE 2: STRUCTURAL OVERVIEW

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TO ACCOMPLISH THESE OBJECTIVES, THE PLAN WILL HAVE FOUR MAJOR ELEMENTS:

- HEALTHCARE -- THE FEDERAL INSURANCE PLAN FOR THE AGED, DISABLED, POOR, NEAR-POOR AND HIGH RISK EMPLOYMENT GROUPS
- EMPLOYER MANDATE -- ALL EMPLOYERS ARE REQUIRED TO PROVIDE INSURANCE FOR FULL-TIME WORKERS (25 HOURS PER WEEK, 10 WEEKS)
- REINSURANCE FUND -- QUALIFIES ALL PRIVATE INSURANCE PLANS AND REINSURES PRIVATE COSTS THAT EXCEED \$25,000
- SYSTEM REFORMS -- (CAPITAL CONTROLS, HMOs, PREVENTION INITIATIVE)

TABLE 3: IMPACT ON MAJOR POPULATION GROUPS

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THE FOLLOWING CHARTS SHOW THE IMPACT OF NHP ON MAJOR POPULATION GROUPS:

- THE AGED AND MEDICARE DISABLED
  
- THE POOR
  - THOSE ON CASH ASSISTANCE
  
  - OTHERS (SINGLE INDIVIDUALS AND CHILDLESS COUPLES)
  
- EMPLOYED PERSONS AND THEIR FAMILIES
  
- THE NON-AGED, NON-EMPLOYED, NON-POOR\*\*\*

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\*\*\*Examples of the 3-N population are early retirees not yet eligible for Medicare, widows, divorced women who no longer have children at home, the partially disabled who have not yet qualified for disability benefits under Social Security, persons who have never worked, for example, the mentally retarded.

TABLE 4: IMPACT OF NHP ON THE AGED/MEDICARE DISABLED

	<u>CURRENT LAW</u>	<u>NHP</u>
ELIGIBILITY:	ELIGIBLE FOR MEDICARE WITH 40 QUARTERS SOCIAL SECURITY COVERAGE (APPROXIMATELY 1 MILLION AGED DO NOT QUALIFY, NUMBER GROWING). MEDICAID ELIGIBLE IF ON SSI OR MEET SPEND-DOWN REQUIREMENTS	ALL AGED AND MEDICARE DISABLED ENROLL IN HEALTHCARE.  COVERAGE FOR ADDITIONAL 1 MILLION
COST SHARING:	<u>HI MEDICARE</u>  1 DAY HOSPITAL DEDUCTIBLE FOR EACH SPELL OF ILLNESS: CO- INSURANCE FROM 61st DAY  <u>SMI MEDICARE</u> \$60 DEDUCTIBLE; 20% CO-INSURANCE ON ALL SERVICES, NO MAXIMUM	RETAIN PART A & B CONFIGURATION, LIMIT OUT-OF-POCKET TO \$1250
FINANCING:	HI PAYROLL TAX ON NON- GOVERNMENT EMPLOYERS/ EMPLOYEES: SMI PREMIUM PAID BY BENEFICIARY	HI PAYROLL TAX EXTENDED TO <u>ALL</u> WORKERS, ALL NON- POOR AGED PAY PREMIUM EQUIVALENT TO SMI PREMIUM

TABLE 5: IMPACT OF NHP ON THE POOR

	<u>CURRENT LAW</u>	<u>NHP</u>
ELIGIBILITY:	<p>STATES SET INCOME AND ASSET TESTS FOR CATEGORICALLY ELIGIBLE PERSONS. (AFDC FAMILIES) FEDERAL GOVERNMENT SETS SSI ELIGIBILITY LEVELS</p> <p>OTHERS (SINGLE INDIVIDUALS AND CHILDLESS COUPLES NOT ELIGIBLE)</p>	<ul style="list-style-type: none"> <li>○ <u>WELFARE GATE</u> STATES CONTINUE TO SET INCOME AND ASSET TESTS FOR CATEGORICALLY ELIGIBLE PERSONS (AFDC, AFDC-U) FEDERAL SSI STANDARDS</li> <li>○ <u>INCOME GATE</u> ALL PERSONS ELIGIBLE WITH INCOME UNDER 55% POVERTY</li> <li>○ <u>SPEND-DOWN GATE</u> SPEND DOWN TO 55% ON 2 FOR 1 BASIS</li> </ul>
COST SHARING:	NONE (EXCEPT SOME NOMINAL CO-PAY REQUIREMENTS FOR DRUGS)	NONE
FINANCING:	FEDERAL/STATE	<p>FEDERAL/STATE SHARE CATEGORICALLY ELIGIBLE</p> <p>FEDERAL FINANCING OF ALL OTHERS AND SPEND-DOWN</p>

TABLE 6: IMPACT OF NHP ON EMPLOYED PERSONS

	<u>CURRENT LAW</u>	<u>NHP</u>
ELIGIBILITY:	ARRANGEMENTS (IF ANY) AS AGREED BY EMPLOYER/EMPLOYEES. 8 MILLION FULL-TIME WORKERS (AND DEPENDENTS) HAVE NO INSURANCE	ALL FULL-TIME EMPLOYEES MUST BE COVERED UNDER PRIVATE PLAN
COST-SHARING:	VARIES WIDELY. OF EMPLOYEES AND DEPENDENTS WITH COVERAGE, 48 MILLION HAVE INADEQUATE CATASTROPHIC PROTECTION.	EMPLOYEE LIABILITY CANNOT EXCEED \$2500
FINANCING:	MOST EMPLOYERS WHO OFFER INSURANCE PAY AT LEAST 88% OF PREMIUM	EMPLOYER MUST PAY AT LEAST 75% OF PREMIUM; CAN PAY A HIGHER PERCENTAGE

TABLE 7: IMPACT OF NHP ON 3-N GROUP

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	<u>CURRENT LAW</u>	<u>NHP</u>
ELIGIBILITY:	PURCHASE PRIVATE INSURANCE AT RATES SET BY INSURANCE PLANS. MANY IN GROUP ARE "UNINSURABLE" AND CANNOT OBTAIN COVERAGE. 12 MILLION DO NOT HAVE ADEQUATE INSURANCE AGAINST HIGH COSTS	CAN PURCHASE HEALTHCARE AT SUBSIDIZED PREMIUM RATE (140% OF LARGE GROUP RATE)  OR  ENTER HEALTHCARE THROUGH SPEND-DOWN
COST-SHARING:	VARIES WIDELY (ALL PAYMENTS MAY BE DENIED FOR PRE-EXISTING CONDITIONS)	\$2500 DEDUCTIBLE: NO CO-INSURANCE
FINANCING:	BY INDIVIDUAL	INDIVIDUAL PREMIUM WITH FEDERAL SUBSIDY

TABLE 8: GROUPS HELPED BY NHP

GROUP	CURRENT LAW	NHP
o 24 MILLION AGED/DISABLED NON-POOR	MEDICARE COVERS 23 MILLION	HEALTHCARE COVERS 24 MILLION
-- AGED (22 MILLION) -- DISABLED (2 MILLION)	-- LIMITS HOSPITAL DAYS -- NO CATASTROPHIC -- MEDICAID 1 FOR 1 SPEND-DOWN	-- NO DAY LIMITS -- CEILING ON COST SHARING -- IMPROVED SPEND-DOWN PROTECTION (2 FOR 1)
o 31 MILLION LOW-INCOME	MEDICAID COVERS 20 MILLION	HEALTHCARE COVERS 31 MILLION
-- 18 MILLION CASH ASSISTANCE -- 13 MILLION POOR NOT COVERED BY WELFARE	-- 18 MILLION CASH ASSISTANCE -- 2 MILLION OTHER	-- 18 MILLION CASH ASSISTANCE -- 13 MILLION OTHER
o 157 MILLION NON-POOR EMPLOYED INCLUDING FAMILIES	100 MILLION WITH ADEQUATE INSURANCE	100 MILLION FULLY INSURED
	57 MILLION WITH NO CATASTROPHIC	ALL HAVE CATASTROPHIC
o 19 MILLION OTHER	7 MILLION ADEQUATELY INSURED	SEVEN MILLION FULLY INSURED ONE MILLION PEOPLE BUY INTO HEALTHCARE
	SOME FAMILIES ELIGIBLE FOR STATE-SPECIFIC SPEND-DOWN (1 FOR 1)	ALL PEOPLE PROTECTED BY NATIONAL HEALTHCARE SPEND-DOWN (2 FOR 1)

TABLE 9:  
OVERVIEW OF NET COSTS BY POPULATION GROUPS  
(FY 80 DOLLARS IN BILLIONS)

	FEDERAL	PRIVATE	
<u>AGED AND MEDICARE DISABLED</u>	+ \$2.6		REMOVE BENEFIT RESTRICTIONS AND LIMIT COST-SHARING AT \$1250 PER PERSON WITH SPEND-DOWN
Current Total - \$39.8			
	+ \$1.6		EXTEND ELIGIBILITY TO AGED NOT CURRENTLY COVERED BY MEDICARE. COULD BE FINANCED BY EXTENDING PART A PAYROLL TAX TO FEDERAL, STATE AND LOCAL EMPLOYEES; PAYROLL TAX RAISES AN ESTIMATED \$2 BILLION IN REVENUES.
<hr/>			
<u>LOW INCOME</u>	+ \$6.6		FULL SUBSIDY TO POOR UNDER 55% OF POVERTY (INCLUDES \$0.5 BILLION FOR AGED UNDER 55% OF POVERTY)
Current Total - \$5.8			
	+ \$1.4		ADDITIONAL COST FOR CASH ASSISTANCE RECIPIENTS (PRIMARILY PHYSICIAN FEE UPGRADE)
<hr/>			
<u>EMPLOYED</u>		+ \$5.2	NET COST TO EMPLOYERS
Current Total - \$67.3			SUBSIDIES
	+ \$0.2		--PREMIUM SUBSIDY OF HEALTHCARE BUY-IN FOR FIRMS WITH 0-9 WORKERS
	+ \$0.2		--HEALTHCARE BUY-IN AT 5% OF PAYROLL: OPTION OPEN TO ALL FIRMS
	+ \$1.2		--TO EMPLOYEES (EXTEND EITC)

TABLE 9 CON'T

OTHER (Non-aged)	+ \$ 3.9	SPEND-DOWN TO 55% OF POVERTY (2 FOR 1)
Current Total - \$22.7	+ \$ 0.3	HEALTHCARE DEFICIT BUY-IN
PREVENTION	\$ 0.3	GRANT PROGRAM
ADMINISTRATIVE COST	\$ 1.5	FEDERAL COST FOR AGED, LOW-INCOME, SPEND-DOWN AND HEALTHCARE BUY-IN
Current Total - \$11.4		
SUB-TOTAL	\$19.8	ON-BUDGET FEDERAL COST
Current Total - \$147.4	\$ 5.2	EMPLOYER COST
	\$25.0	NEW FEDERAL AND EMPLOYER COSTS WITHOUT OFFSETS
OFFSETS	\$ 4.5	TOTAL HCC: FEDERAL SAVINGS IN '83 (DEFLATED TO 1980 DOLLARS)
	\$ 0.5	CHAP
	\$ 0.5	WELFARE
	<u>\$ 1.0</u>	TAX SAVINGS
	\$13.3	TOTAL FEDERAL WITH OFFSETS
	\$18.5	TOTAL FEDERAL/PRIVATE WITH OFFSETS

TABLE 10: SOME POTENTIAL ADD-ONS  
(FY 80 DOLLARS IN BILLIONS)

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	<u>FEDERAL COSTS</u>
DRUGS FOR THE AGED	
-- \$250 DEDUCTIBLE AND 20% CO-INSURANCE	+ \$2.0
-- \$500 DEDUCTIBLE AND 20% CO-INSURANCE	+ \$0.6
LEAVE CURRENT MEDICARE COST-SHARING PATTERN FOR AGED, BUT PROVIDE \$1250 PER PERSON CAP ON OUT-OF-POCKET	NEGLIGIBLE FIRST YEAR COSTS; OUT YEAR COSTS WOULD INCREASE BY \$1.7 BILLION (1980)
PREVENTIVE CARE	
-- FULL PREVENTION PLAN FOR ADULTS	+ \$2.9

TABLE 11: SOME POSSIBLE DELETIONS FROM PLAN  
(FY 80 DOLLARS IN BILLIONS)

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	<u>FEDERAL SAVINGS*</u>
NO CONTINUING PAYMENT FOR PRESENT FEDERAL SHARE OF NON-COVERED ACUTE CARE SERVICES (PRIMARYLY DRUGS AND DENTAL)	- \$1.3
NEGOTIATE INCREASE IN MEDICAID FEES TO MEDICARE LEVEL WITHOUT AGGREGATE INCREASE	- \$1.4
RAISING MAXIMUM DEDUCTIBLE TO \$3500 FOR 3N BUY-IN GROUP	- \$ .04
DROPPING COVERAGE OF AGED CURRENTLY INELIGIBLE FOR MEDICARE	- \$1.6
REDUCING SPEND-DOWN FROM 2-FOR-1 TO 1-FOR-1	- \$1.5
DROPPING COVERAGE OF NON-AGED, SINGLE INDIVIDUALS AND CHILDLESS COUPLES	- \$3.3

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\*Savings not necessarily additive because of overlap of groups affected by changes.

TABLE 12: TAX EXPENDITURES  
(FY 80 DOLLARS IN BILLIONS)

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INCREASE THRESHOLD FOR EXPENSE DEDUCTION FROM 3% - 10% OF INCOME	+\$2.0
REVENUE LOSS DUE TO HIGHER EMPLOYER PREMIUM PAYMENTS	-\$1.0
NET REVENUE	+\$1.0

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TABLE 13:  
STATE AND LOCAL SPENDING FOR COVERED  
SERVICES, BEFORE AND AFTER NHP  
(FY 80 dollars in billions)

	PRESENT LAW	NHP	CHANGE
<u>TOTAL</u>	<u>\$13</u>	<u>\$11.0</u>	<u>\$ -2.0</u>
<u>MEDICAID</u>			
COVERED SERVICES <u>1/</u>	\$ 5.6	\$ 5.1	\$ -0.5
NON-COVERED SERVICES <u>2/</u> (DRUGS, DENTAL, INPATIENT MENTAL)	\$ 1.0	\$ 1.0	\$ 0
LONG TERM CARE <u>3/</u> (SNF, ICF, HOME HEALTH)	\$ 3.8	\$ 3.8	\$ 0
<u>OTHER</u>			
PUBLIC HOSPITALS AND HEALTH CENTERS -- FACILITY DEFICITS	\$ 2.0	\$ .7	\$-1.3
MATERNAL AND CHILD HEALTH AND OTHER GRANT PROGRAMS	\$ .6	\$ .4	\$- .2

- 1/ Assumes State maintenance of effort for Medicaid expenditures for categorically eligible; some fiscal relief for spend-down.
- 2/ Assumes continued Federal matching for these services provided to categorically eligible beneficiaries.
- 3/ Assumes continued Federal matching for these services provided to categorically eligible beneficiaries.

TABLE 14:  
METHODS OF PROVIDING STATE AND LOCAL FISCAL RELIEF  
(FY 80 DOLLARS IN BILLIONS)

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TOTAL STATE AND LOCAL FISCAL RELIEF IN NHP	<u>\$ -1.5</u>
Facility deficits and grants	<u>\$ -1.5</u>
 POSSIBLE ADDITIONS TO FISCAL RELIEF	 <u>\$-1.2 to -1.4</u>
<u>5% decrease State match for Medicaid</u>	- .2 OR
<u>10% decreased State match for Medicaid</u>	- .4
<u>Relief for reducing spend-down costs</u>	- .5 - 1.0
 POSSIBLE REDUCTIONS IN FISCAL RELIEF	 <u>\$ +.7</u>
<u>Bill States for increased Medicaid fees</u>	<u>\$ .7</u>

TABLE 15: EMPLOYEE IMPACT  
(in billions)

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	PRESENT LAW	NHP	CHANGE
EMPLOYEE PREMIUM PAYMENTS	\$ 7.5	\$ 9.0	\$ + 1.5
OUT-OF- POCKET COSTS	\$15.4	\$10.8	\$ - 4.6
TOTAL IMPACT ON EMPLOYED POPULATION	\$22.9	\$19.6	\$ - 3.1

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TABLE 16: DETAILS AND OPTIONS FOR EMPLOYER MANDATE

PLAN CHARACTERISTICS			ADDITIONAL COSTS FOR THE EMPLOYED POPULATION (in billions)		
DEDUCTIBLE	COINSURANCE	MAX OUT-OF-POCKET	PER WORKER COSTS	EMPLOYER COST 75% SHARE	EMPLOYER COST 50% SHARE
\$ 0	50%	\$1500	\$634	\$11.5	\$7.7
0	50	2500	601	10.4	7.0
100	50	1500	571		
1500		1500	483	9.2	6.2
2500		2500	373	5.4	3.6
3000		3000	350	4.3	2.9
3500		3500	318	3.3	2.2

TABLE 17: TREATMENT OF SMALL FIRMS

DEDUCTIBLE	Average Premium	Employer Share	Average Premium	Employer Share	Average Premium	Employer Share
	2500		3000		3500	
ALL FIRMS	\$373	\$280	\$350	\$263	\$318	\$239
LARGE FIRMS*						
INDIVIDUAL	\$213	\$160	\$200	\$150	\$182	\$137
FAMILY	\$611	\$458	\$573	\$430	\$521	\$391
SMALL FIRMS**						
INDIVIDUAL	\$253	\$190	\$237	\$178	\$216	\$162
FAMILY	\$725	\$544	\$680	\$510	\$618	\$464

\* MORE THAN 50 WORKERS

\*\* 10-49 WORKERS

TABLE 18: FEDERAL REINSURANCE FUND

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FUNCTIONS

- REINSURE QUALIFIED PRIVATE PLANS FOR COVERED BENEFITS EXCEEDING \$25,000 PER FAMILY PER YEAR
- IMPLEMENT STANDARDS IMPOSED UNDER THE EMPLOYER MANDATE
- CERTIFY ANY INSURANCE PLAN SEEKING QUALIFICATION FOR PREFERENTIAL TAX TREATMENT

RATIONALE

- REDUCE PREMIUM DIFFERENCES AMONG EMPLOYER GROUPS: ADVANCE EQUITY
- STIMULATE SELF-INSURANCE AMONG EMPLOYERS: PROMOTE COST CONTAINMENT
- LIMIT INCREASES IN INSURANCE INDUSTRY RESERVES AND PROFITS DUE TO EMPLOYER MANDATE
- ENCOURAGE COMPETITION AMONG INSURANCE COMPANIES
- PROVIDE FINANCIAL COMPONENT TO FEDERAL REGULATION OF QUALIFIED PLANS

TABLE 19: HEALTHCARE DEFICIT FOR 3N BUY-IN

PLAN CHARACTERISTIC	SINGLE INDIVIDUAL	PREMIUM FAMILY OF FOUR	COST <u>*/</u>
50 PERCENT COINSURANCE \$2500 CEILING	\$526	\$1577	\$ .6
\$1500 DEDUCTIBLE	\$423	\$1200	\$ .4
\$2500 DEDUCTIBLE	\$326	\$ 926	\$ .3
\$3000 DEDUCTIBLE	\$297	\$ 837	\$ .3
\$3500 DEDUCTIBLE	\$270	\$ 754	\$ .26

\* Assumes 2 for 1 spend-down and is cost over the spend-down.

TABLE 20: ADMINISTRATIVE STRUCTURE OF PHASE I

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MAJOR FUNCTIONS

- ENROLLMENT
- PROVIDER REIMBURSEMENT

OPTIONS FOR ORGANIZING AND ADMINISTERING

- DUAL STRUCTURE
- HEALTHCARE

CRITERIA FOR CHOICE

- ACCOUNTABILITY
- EFFICIENCY
- CONSISTENCY
- POLITICAL CONSIDERATIONS

TABLE 21: ENROLLMENT FUNCTION

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ENROLLMENT FUNCTION

- HEALTHCARE
  - CASH RECIPIENTS ENROLL THROUGH CURRENT CASH STRUCTURES (STATE WELFARE AND SSA)
  - ADDITIONAL ELIGIBLES ENROLL THROUGH HCFA/SSA DISTRICT OFFICE
- DUAL STRUCTURE
  - ELDERLY AND DISABLED ENROLL THROUGH SSA
  - LOW INCOME ENROLL THROUGH STATE WELFARE OFFICES
- KEY DIFFERENCE -- NEW PHASE I FEDERAL RESPONSIBILITY UNDER HEALTHCARE, STATE RESPONSIBILITY UNDER DUAL STRUCTURE
- ADVANTAGE OF HEALTHCARE OVER STATES
  - EQUITABLE NATIONWIDE ADMINISTRATION OF NEW UNIFORM POLICY
  - EFFICIENT AND ACCURATE ELIGIBILITY PROCESS
  - SINGLE SYSTEM RATHER THAN 53 STATE SYSTEMS
  - SETS STAGE FOR FUTURE NHP PHASES

TABLE 22: REIMBURSEMENT FUNCTION

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REIMBURSEMENT FUNCTION

- HEALTHCARE
  - CONTRACT WITH INSURERS OR DATA PROCESSING FIRMS
  - FIXED PRICE BASIS
  
- DUAL SYSTEM
  - MEDICARE THROUGH PRIVATE CONTRACTORS
  - MEDICAID BY STATES, IN-HOUSE OR SUBCONTRACTED
  
- ADVANTAGE OF HEALTHCARE OVER STATES
  - GREATER ACCOUNTABILITY, AUTHORITY
  - GREATER LEVERAGE ON SYSTEM THROUGH COMBINED PURCHASING POWER
  - ONE FISCAL AGENT FOR PROVIDERS TO DEAL WITH
  - MAXIMIZE NEW TECHNOLOGY
  - CONSISTENT NATIONAL IMPLEMENTATION
  - CONSISTENT WITH FURTHER NHP PHASES

TABLE 23: THE CASE FOR HEALTHCARE

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ACCOUNTABILITY

- DUAL SYSTEM RETAINS STATE POLICY CONTROL, STATE RESPONSE TO INTERNAL POLITICAL AND BUDGETARY PRESSURES
- FEDERAL FINANCING, ACCOUNTABILITY MUST BE ACCOMPANIED BY AUTHORITY OVER CONTRACTORS; FEDERAL AUTHORITY INCOMPATIBLE WITH STATE ROLE
- STATES HAVE NO FINANCIAL STAKE IN NEW ELIGIBLES

EFFICIENCY

- HEALTHCARE ELIMINATES DUPLICATIVE ARRAY OF PROCESSORS
- HEALTHCARE ELIMINATES CROSSOVER CLAIM PROBLEM
- HEALTHCARE ALLOWS REVIEW OF ALL PROVIDER/BENEFICIARY CLAIMS

CONSISTENCY

- HEALTHCARE PROVIDES CONSISTENT IMPLEMENTATION AMONG COMPONENTS
- HEALTHCARE CONSISTENT WITH EXPANSION IN SUBSEQUENT PHASES

TABLE 24 - ADMINISTRATIVE COSTS OF NHP  
(\$ in millions)

	<u>Current Programs (Medicare &amp; Medicaid)</u>		<u>Current Programs with New Enrollees</u>		<u>HealthCare</u>	
	<u>Dollars</u>	<u>Staff*</u>	<u>Dollars</u>	<u>Staff*</u>	<u>Dollars</u>	<u>Staff*</u>
TOTAL	\$2,415	100,590	\$3,453	137,268	\$3,576	106,795
<u>Direct Federal Costs/Federal Employees (HCFA/SSA)</u>	\$454	8,628	454	8,628	992	30,000
<u>Federal Cost - Contracted Service/ Non-Federal Staff (Medicare/HealthCare)</u>	845	36,612 <sup>1</sup>	870	37,312 <sup>1</sup>	1,774	38,050 <sup>1</sup>
<u>Medicaid Costs/State &amp; Local Employees</u>	1,117	55,350	2,129	91,328	809	38,745
Federal funds	782	41,000	1,512	67,650	574	28,700
State funds	335	14,350	617	23,678	235	10,045
<hr/>						
Total Federal funds Increment	\$2,080 —		\$2,836 + 756 (+36%)		\$3,341 +1,261 (+61%)	
Total State Funds Increment	\$335		\$617 + 282 (+84%)		\$235 - 100 (- 30%)	

\* Estimated full-time equivalent

<sup>1</sup> Includes 2,000 State employees doing provider certification activities for Medicare/HealthCare

TABLE 25: COMPETITION UNDER THE NATIONAL HEALTH PLAN

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THE NATIONAL HEALTH PLAN PRESERVES COMPETITION WHERE IT EXISTS AND PROMOTES COMPETITION WHERE NONE CURRENTLY OCCURS.

o COMPETITION IN HEALTH INSURANCE:

- EMPLOYER MANDATE EXPANDS THE GROUP HEALTH INSURANCE MARKET
- MULTIPLE CHOICE PROVISIONS ENHANCE COMPETITION AMONG HMOs AND IPAs, AND INCREASE COMPETITION BETWEEN HMOs AND IPAs AND QUALIFIED TRADITIONAL FORMS OF INSURANCE PLANS
- EMPLOYERS FREE TO INNOVATE AND EXPERIMENT WITH PLAN DESIGN AND BENEFIT CONFIGURATION
- SELF-INSURED PLANS AND SMALL CARRIERS ARE ENCOURAGED TO PARTICIPATE IN THE GROUP HEALTH INSURANCE MARKET
- INSURANCE COMPANIES AND ADMINISTRATIVE SERVICES CONTRACTORS WILL COMPETE FOR PUBLIC AND PRIVATE ADMINISTRATIVE SERVICES CONTRACTS
- EQUAL EMPLOYER CONTRIBUTION TO ALL HMOs, IPAs OR INSURANCE PLANS WILL CREATE INCENTIVES FOR EMPLOYEES TO JOIN COST-EFFECTIVE PLANS

o COMPETITION AMONG PROVIDERS:

- SYSTEM REFORMS INCREASE COMPETITION WITH THE MORE EXPENSIVE, TRADITIONAL HEALTH CARE PROVIDERS
- INDUCE ECONOMIC DECISION MAKING IN THE PLANNING AND MANAGEMENT OF BUSINESS OPERATIONS THROUGH BUDGET CONSTRAINTS AND CAPITAL LIMITATIONS

TABLE 26: TOTAL HEALTH EXPENDITURES, NATIONAL HEALTH PLAN, BY SOURCE OF REVENUE  
 FY 1980 (AMOUNTS IN BILLIONS)

	CURRENT LAW	NHP-1	CHANGE
<u>TOTAL</u>	<u>\$147.2</u>	<u>\$165.2</u>	<u>\$18.0</u>
FEDERAL TAX REVENUES	44.1	63.9	19.8
STATE AND LOCAL TAX REVENUES	8.2	6.7	-1.5
PREMIUMS			
EMPLOYERS	42.6	47.8	5.2
EMPLOYEES	7.5	9.0	1.5
INDIVIDUALS	11.0	13.5	2.5
DIRECT PATIENT PAYMENTS	26.9	18.9	- 8.0
OTHER	6.8	5.3	-1.5

TABLE 27: FEDERAL COST, NATIONAL HEALTH PLAN, BY TYPE OF SERVICE  
 FY 1980 (AMOUNTS IN BILLIONS)

	CURRENT LAW	NHP-1	CHANGE
<u>TOTAL</u>	<u>\$44.1</u>	<u>\$63.9</u>	<u>\$19.8</u>
HOSPITAL AND EXTENDED CARE SERVICES	30.6	35.9	5.3
PHYSICIAN AND OTHER AMBULATORY SERVICES	11.6	21.8	10.2
MENTAL HEALTH	.5	.9	.4
PREVENTION	.1	.9	.8
SUBSIDIES TO EMPLOYED	.0	1.6	1.6
ADMINISTRATION	1.4	2.9	1.5

TABLE 28: POOR PERSONS COVERED BY NHP-1  
[IN MILLIONS]

	Total Below 55% of Poverty or on Cash Assistance	Currently on Medicaid*	Non-Cash Assistance Below 55% of Poverty
<u>TOTAL</u>	<u>30.9</u>	<u>20.3</u>	<u>10.6</u>
Children	15.1	9.0	6.1
Females, Age 22-44	3.3	2.6	.7
Pregnant Females	.8	.7	.1
Females, Age 45-64	1.1	.3	.8
Males, Age 22-44	1.8	.9	.9
Males, Age 45-64	.6	.3	.3
Disabled, Non-Medicare	3.1	2.6	.5
Aged and Medicare Disabled	5.0	3.8	1.2

\*Includes 18.4 million on cash assistance, and 1.9 million other Medicaid recipients below 55% poverty.

Table 29: POPULATION COUNTS, 1980  
(AMOUNTS IN MILLIONS)

	Total	Poor (under \$4100 or cash assistance)	Near Poor (up to \$7100)	Blue Collar (up to \$10,100)	Higher Income
<u>Total U. S. Population</u>	<u>231.0</u>	<u>30.9</u>	<u>18.7</u>	<u>18.7</u>	<u>162.9</u>
<u>Aged and Medicare</u>					
<u>Disabled</u>	<u>28.8</u>	<u>5.0</u>	<u>7.5</u>	<u>5.4</u>	<u>10.9</u>
Male aged 65 and over	10.4	1.1	1.8	2.2	5.3
Female age 65 and over	15.4	2.7	5.1	2.9	4.7
Medicare Disabled	3.0	1.2	0.6	0.3	0.9
<u>Employed Families</u>	<u>164.4</u>	<u>7.7</u>	<u>5.9</u>	<u>8.9</u>	<u>142.0</u>
Children under 22	62.5	4.5	3.6	4.2	50.2
Males 22 - 44	34.2	0.9	0.8	1.5	30.9
Males 45 - 64	16.8	0.3	0.3	0.5	15.7
Females 22 - 44	30.5	1.1	0.7	1.4	27.3
Pregnant Females	2.8	0.2	0.1	0.2	2.4
Females 45 - 64	15.3	0.2	0.3	0.8	13.9
Disabled, Non-Medicare	2.3	0.2	0.1	0.2	1.7
<u>Non Employed Families</u>	<u>37.9</u>	<u>18.3</u>	<u>5.2</u>	<u>4.4</u>	<u>10.0</u>
Children under 22	17.3	10.6	2.3	1.6	2.8
Males 22 - 44	3.7	0.9	0.6	0.6	1.5
Males 45 - 64	2.3	0.3	0.2	0.3	1.5
Females 22 - 44	4.3	2.2	0.5	0.5	1.1
Pregnant Females	0.8	0.5	0.1	-	0.1
Females 45 - 64	4.9	0.8	0.8	0.9	2.3
Disabled, Non-Medicare	4.6	2.9	0.7	0.4	0.7

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