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THE WHITE HOUSE
WASHINGTON

November 9, 1977

Hamilton Jordan

The attached was returned in the President's outbox. It is forwarded to you for appropriate handling.

Rick Hutcheson

cc: Jim Gammill

RE: BOARD FOR INTERNATIONAL FOOD AND AGRICULTURE DEVELOPMENT

THE WHITE HOUSE
WASHINGTON

	FOR STAFFING
	FOR INFORMATION
✓	FROM PRESIDENT'S OUTBOX
	LOG IN/TO PRESIDENT TODAY
	IMMEDIATE TURNAROUND

ACTION	FYI	
		MONDALE
		COSTANZA
		EIZENSTAT
✓		JORDAN
		LIPSHUTZ
		MOORE
		POWELL
		WATSON
		McINTYRE
		SCHULTZE

	ENROLLED BILL
	AGENCY REPORT
	CAB DECISION
	EXECUTIVE ORDER

Comments due to Carp/Huron within 48 hours; due to Staff Secretary next day

		ARAGON
		BOURNE
		BRZEZINSKI
		BUTLER
		CARP
		H. CARTER
		CLOUGH
		FALLOWS
		FIRST LADY
		HARDEN
		HUTCHESON
		JAGODA
	✓	GAMMILL

		KRAFT
		LINDER
		MITCHELL
		MOE
		PETERSON
		PETTIGREW
		POSTON
		PRESS
		SCHLESINGER
		SCHNEIDERS
		STRAUSS
		VOORDE
		WARREN

THE PRESIDENT HAS SEEN.

THE WHITE HOUSE

WASHINGTON

November 8, 1977

MEMORANDUM FOR THE PRESIDENT

FROM: HAMILTON JORDAN H.J.

SUBJECT: Board for International Food and Agriculture Development

The Board for International Food and Agricultural Development is an independent seven member commission. At least four of the seven members must be selected from universities. Currently, there is one vacancy.

The purpose of the Board is to review and evaluate research grants for studies in the areas of food, nutrition and agriculture conducted primarily by Black land grant institutions. OMB has recently finished a review of the Board's activities and recommends that it should not be changed by Reorganization.

For the present vacancy, I recommend the appointment of Ms. Johnnie Watts Prothro. Ms. Prothro is a professor of Nutrition at Emory University. Before coming to Emory, she had been affiliated with the Center for Disease Control in Atlanta and with Tuskegee Institute.

The Agency for International Development oversees the operation of the Board. Governor Gilligan agrees that Ms. Prothro would be a good addition to the Board.

RECOMMENDATION:

Appoint Johnnie Watts Prothro as a Member of the Board for International Food and Agriculture Development.

APPROVE ✓ DISAPPROVE _____

IAB B

40543

NAME: Johnnie Watts Prothro

HOME ADDRESS: 919 Falcon Drive, S.W., Atlanta, Georgia 30311

HOME TELEPHONE: (404) 753-2910

EMPLOYER: Emory University, Division of Allied Health Professions, Dietetics Program

BUSINESS ADDRESS: 1712 Aidmore Drive, N.E., Atlanta, Georgia 30322

BUSINESS TELEPHONE: (404) 329-6130 ~~377-2411, Ext. 7795~~

DATE OF BIRTH: February 26, 1922, Atlanta, Georgia

EDUCATION:

B.S.	Spelman College, Atlanta, Georgia	1941
M.S.	Columbia University, N.Y., N.Y.	1946
Ph.D.	University of Chicago, Chicago, Ill.	1952

EMPLOYMENT:

1975- Present	Professor, Emory University
1973- 1975	Professor, Tuskegee Institute
1972-1973	Nutrition Advisor, Center for Disease Control, Atlanta, Georgia
1968-1972	Head, Department of Home Economics and Food Administration, Tuskegee Institute Tuskegee, Alabama
1963- 1968	Associate Professor, University of Connecticut Storrs, Connecticut
1952- 1963	Professor, Tuskegee Institute, Tuskegee Institute, Alabama

SCIENTIFIC SOCIETY AFFILIATIONS:

1. Society of Nutrition Education
2. American Dietetic Association
3. American Institute of Nutrition
4. American Home Economics Association
5. The Society of the Sigma Xi
6. Nutrition Today Society

FELLOWSHIPS RECEIVED:

1. Borden Award, American Home Economics Association, University of Chicago, 1950-59.
2. Special Fellow, National Institutes of Health, UCLA, Affiliate in Research, 1958-59.
3. OEEC Fellow, National Medical Research Institute, London, England Affiliate in Research, Summer 1961.

THE PRESIDENT HAS SEEN.

9:00 AM

THE WHITE HOUSE

WASHINGTON

November 8, 1977

C

BILL SIGNING
S.717 - FEDERAL MINE SAFETY AND HEALTH AMENDMENTS
AND
H.R.6010 - AVIATION ALL-CARGO DEREGULATION
Wednesday, November 9, 1977
9:00 a.m. (15 Minutes)
The Roosevelt Room

From: Frank Moore F.M.

I. PRESS PLAN

Full Press Coverage

II. TALKING POINTS

Prepared by Jim Fallows

III. PARTICIPANTS

The President

The Vice President

Cabinet

Brock Adams
Ray Marshall

Senate

Harrison Williams
Jennings Randolph
Wendell Ford
Ted Stevens

Senate Committee Staff

Michael Goldberg, MESA bill
Bob Ginther, Air Cargo bill

House

Carl Perkins
James Oberstar
Glenn Anderson
Norm Mineta

William Harsha

House Committee Staff

Paul Dwyer, MESA bill
Cliff Madison, Air Cargo bill

Other

Joan Davenport, Assistant Secretary, Interior
Robert Barrett, Administrator, MESA
Robert Lagather, Deputy Solicitor, Dept. of Labor
Arnold Miller, United Mine Workers (tentative)
Jack Sheehan, United Steelworkers
Alfred Cohn, Chairman, CAB
Terry Bracy, Department of Transportation

THE PRESIDENT HAS SEEN.

THE WHITE HOUSE

WASHINGTON

Eizenstat / OMB / McIntyre comments

MEMORANDUM FOR: THE PRESIDENT

FROM: STU EIZENSTAT Stu
JOE ONEK
JIM McINTYRE Jim McIntyre

SUBJECT: National Health Insurance

1. Background. On Wednesday, November 9, you will receive a one-hour briefing on National Health Insurance, conducted primarily by Secretary Califano. HEW's briefing memorandum, which is a thorough and thoughtful overview of NHI issues, is attached.

   The purposes of the November 9th meeting are:

   -- to introduce you to HEW's approach to NHI issues;
   -- to initiate the NHI dialogue between yourself, HEW, OMB, your staff, and other affected Cabinet-level officials, some of whom will be in attendance;
   -- to permit you to make known any initial substantive guidance you have on NHI issues; and
   -- to establish the timetable for the development and presentation of the Administration's NHI program.

2. PRM. We strongly recommend that, in addition, you take this opportunity to initiate the PRM procedure with regard to National Health Insurance. Although HEW may object, National Health Insurance is the ideal domestic issue for which to use the formal Policy Review process. As attendance at the Wednesday meeting will make clear, several federal departments will be directly involved in the NHI policy formulation process, including Labor, Treasury and Commerce. In addition, other agencies will be involved to a slightly lesser extent, including VA, DOD, the Federal Insurance Administration, and the Civil Service Commission.

We suggest that you designate HEW as the lead agency for the PRM process at the Wednesday meeting. Our staffs will work closely with HEW in preparing the necessary documents to institute the process.

3. Estimating the Costs of NHI. It is essential that a consensus be developed among your advisors on the methodology and assumptions used in estimating the costs of National Health Insurance options. OMB's experts believe that:

   -- Consistent with budget practices, the costs of alternative NHI proposals should be developed and presented in current dollars for the initial years of implementation;

   -- Cost estimates should include a state-by-state breakdown of payment sources before and after the implementation of NHI;

   -- Analysis of alternative benefit packages should be broadened; for example, the "minimal" benefit package presented in HEW's briefing memorandum appears to be more comprehensive than Blue Cross's and Aetna's well-regarded Federal Employee's low option plan.

   In addition, analysis should include the cost implications of a system similar to Canada's, in which the federal government's financial contribution would be fixed and open-ended supplementary coverage would be provided by the states.

   As HEW's memorandum makes clear, the successful initiation of these analytical efforts will permit guidance from you on the amount of federal expenditures and taxes the Administration should propose for our National Health Insurance initiative.

4. National Health Policy and NHI. As HEW's memorandum makes clear, the Administration's NHI plan -- regardless of its nature -- will focus primarily on the financing and delivery of medical care.

However, there is expert consensus that the health of our people will be less enhanced by incremental increases in medical care expenditures than by increases in expenditures for upgrading the environment, improving workplace safety, and encouraging Americans to alter their lifestyles. Our NHI proposal will provide an unparalleled opportunity for you to educate the American people to this reality, and for us to present specific health policy initiatives sensitive to this reality.

During the HEW meeting you should make it clear that our development of an NHI program is being conducted with a view toward taking advantage of this opportunity. This approach not only makes sense from a health standpoint, but will perhaps reduce the inevitable criticism from labor and the left that our National Health Insurance proposal does not spend enough federal money.

5. The Role of the Federal Government in Administering NHI. One of the fundamental NHI issues is the extent to which the federal government, the states, and private insurance companies share administrative responsibility under the program. There will be substantial political opposition -- from private insurance companies, the business community, Governors, and health care providers -- to a significant increase in the federal administrative role. The Administration's general policies also militate against massive increases in the federal bureaucracy and federal regulation. In this instance, the crucial question is whether a major increase in the federal administrative role is required to meet our objectives:

-- For eliminating financial barriers to access, or for ameliorating the financial hardship of health care expenses, a number of schemes -- not necessarily involving increased federal administration -- can be devised, including giving every American a voucher with which to purchase private health insurance.

-- For assuring adequate physician services in rural and ghetto areas, probably no NHI plan under serious consideration -- regardless of its federal

adminitrative role -- can be relied upon; more targeted programs, such as the National Health Service Corps, will continue to be required.

-- For containing costs and improving the delivery system, a number of differing approaches have been advanced, including establishing a total national health budget, regulating the supply of physicians and hospital beds, and creating competitive markets for insurance companies and HMOs; the requirements for federal administration will vary greatly depending upon which of these approaches is adopted.

Thus, the test of whether an expanded federal administrative role is required must be whether it will contribute to a more efficient and a less costly medical care system.

6. The Role of the Federal Government in Financing Medical Care. The advantages of increased reliance on federal financing, as opposed to continued or increased reliance on private financing, are fully detailed in Secretary Califano's memorandum. It is important to stress, however, that the federal government could increase its financing without increasing its administration of medical care. For example, the government could make tax credits available to enable persons to enroll in health insurance or HMO plans. The Federal Employees Health Benefit Program works on a similar principle -- the federal government subsidizes employee enrollment in approved health insurance or HMO plans. An HEW-commissioned study explores the possibility of extending this federal employee approach to the entire population.

Attachment

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

NOV 3 1977

MEMORANDUM FOR THE PRESIDENT

FROM: Joe Califano by [illegible]

SUBJECT: National Health Program

Califano memo

I. Introduction

National Health Insurance will be among the most complex and bedeviling policy initiatives of your Administration. The majority of Americans may favor a National Health Insurance plan, yet Presidents since the time of Truman have been unsuccessful in enacting such a plan. In addition to the emotional biases and built-in federal/state conflicts inherent in both welfare reform and NHI, a health insurance program will also confront strong, entrenched economic interests in the $139-billion (1976) health-care system -- which has mushroomed during the past ten years into the country's third largest industry behind construction and agriculture.

To enact national health insurance will not only require the sensitive drafting of an imaginative and sound proposal with meticulous attention to detail, but also a sustained commitment to a massive political effort -- probably extending over several Congressional sessions. You will need to draw on all the resources of your own skilled advisers and staff in orchestrating this initiative.

The timing of NHI will need to be carefully considered in light of the schedule of your other legislative programs on the Hill and the pressures from those who favor NHI. At present, we intend to follow the same pattern that we used in welfare reform: first, a statement of principles; second, a tentative plan; and third, a final plan and legislation.

Its timing must also be coordinated with the progress of the Program for Better Jobs and Income through the Congress. One of the major unresolved issues with regard to the Program is Medicaid eligibility. We must develop detailed proposals on how we intend to handle Medicaid eligibility before the Congress takes final action on our welfare reform proposal. Consequently, either our NHI plan has to be completed on a schedule consistent with Congressional action on welfare reform, or we will be forced to develop a separate Medicaid reform plan that could be put forth as the initial phases of National Health Insurance.

Purpose of This Memorandum

The purpose of this memo (and the briefing to follow) is to describe the process we have established to prepare an NHI proposal, to provide brief background material on the current problems in health care and financing, and to seek preliminary guidance from you on some of the major decisions that lie ahead -- to get a sense of your intuitive views on this subject.

I need to get any early, tentative sense you have about the problems that a national health plan should seek to address. Various groups see national health insurance as a means of achieving different objectives:

-- Improving health;
-- Protecting Americans against financial devastation from illness;
-- Making health services more accessible to all, but particularly to the low-income, inner-city or rural population;
-- Making the health care delivery system more efficient (or at least less costly) and more effective.
-- Changing the health care system from its current acute care orientation to be more responsive to other needs such as mental health and preventive services.

The extent to which we focus on each of these objectives will profoundly affect our ultimate proposal.

It will also be valuable to get any sense you have of the overriding issues central to the financing mechanism that must lie at the heart of any NHI proposal. The major issues here involve:

-- Overall federal costs
-- Role of private insurance companies
-- Nature of cost and quality controls on the health care industry
-- Role of the states
-- Phasing of the program

We will need to return to you in December to begin considering the fundamental approach we should adopt in developing a proposal.

HEW's Efforts

We have made a concerted effort to obtain the views of every group that will be affected by national health insurance as well as the views of the general public across the country. We have also sought to incorporate into our decision-making, lessons to be learned from our experience with health care financing both in this country and abroad.

- o I have solicited systematically the views of all members of Congress, all Governors, Mayors of all the larger cities, other state and local health officials, and more than 2,000 experts and organizations knowledgeable about National Health Insurance.

- o By November, the Department will have conducted more than 100 regional hearings -- with at least one hearing in each state -- to obtain the views of individuals and organizations throughout the Nation. To kick off this effort, I personally held an all-day hearing in Washington on October 4th and heard more than 60 witnesses.

- o Since April, an Advisory Committee on National Health Insurance Issues, chaired by Under Secretary Hale Champion, has explored a wide range of NHI issues. It has held public hearings and made site visits to underserved communities throughout the United States. Composed of outstanding individuals from business, labor, consumer groups, the health industry, and State and local governments, this Committee will provide us with its views beginning this month.

- o To obtain first-hand knowledge of the strengths and weaknesses of national health systems in other countries, we are also surveying foreign health insurance systems. I visited Canada in September and will be going soon to examine the British and German systems.

We have also put together at HEW an extraordinarily able and diverse team to help develop our NHI proposal. As individuals, they have worked on virtually every one of the major NHI bills introduced in recent years. Thus, all the perspectives we will have to contend with when your program goes to the Congress will be represented forcefully around the table as we draft our proposal.

The Carter Foundation of NHI Development Activities

Our drafting of a national health insurance proposal will begin with a consideration of the following principles contained in your speech to the National Student Medical Association:

-- Coverage must be universal and mandatory. Every citizen must be entitled to the same level of comprehensive benefits.

-- We must reduce barriers to early and preventive care in order to lower the need for hospitalization.

-- Benefits should be insured by a combination of resources; employer and employee shared payroll taxes, and general tax revenues.

-- Uniform standards and levels of quality and payment must be approved for the Nation as part of national health planning. Incentives for reforms in the health care delivery system and for increased productivity must be developed.

-- Effective cost and quality controls and the necessary machinery for monitoring the quality of care must be established.

-- Rates for institutional care and physician services should be set in advance, prospectively.

-- Freedom of choice in the selection of a physician and treatment center will always be maintained.

-- Consumer representation in the development and administration of health programs should be assured.

-- Resources must be set aside to encourage development of alternative approaches and to spur redistribution of health personnel.

-- National priorities of need and feasibility should determine stages of the system's implementation.

-- Incentives for the reorganization of the delivery of health care must be built into the payment mechanism.

-- A basic concern shall be for the dignity of the person, not for the individual's wealth or income.

If you want us to give particular emphasis to any of these principles, it would be helpful to receive early guidance from you.

II. Background

The Health Industry

Health has become the third largest business in the Nation behind only agriculture and construction. Health expenditures last year rose to $139 billion -- 8.6 percent of the GNP -- up nearly $100 billion in ten years, and presently rising at 15 percent per year. In 1966, health expenditures were $42 billion, only 5.8 percent of GNP. Nearly half of the 1976 expenditures -- some $66 billion -- went to pay for institutional care in more than 7,000 hospitals ($55.4 billion) and 16,000 skilled nursing homes ($10.6 billion). Another $26 billion was paid by Americans to 375,000 doctors. Today five percent of the entire work force (4.8 million people) now work in the health care field.

Behind these national expenditures lie dramatic increases in the expenditures that every American family is making for health care. Health care costs are rising at a rate 2-1/2 times the CPI. An average hospital stay today costs more than $1,400. In the last ten years per capita spending on hospital care in real terms has more than doubled.

The causes for these increases are: a non-competitive industry; new and expensive technology; open-ended tax subsidies and public insurance programs (Medicare, Medicaid); and perverse incentives created by laws that only reimburse for more expensive care; by the fee-for-service compensation system for doctors; by cost-reimbursement for hospitals; and by the presence of third-party payers (Medicare, Medicaid, private insurance) that insulate doctors who order services and consumers from cost concerns -- it usually seems that someone else is paying the bill.

The expensive system we have built seems overused and misused. Since 1966, surgery is up 24 percent. In addition, wide variations in the use of health service are not always related to differences in health status. Hospitalization rates of elderly patients enrolled in prepaid health plans (Health Maintenance Organizations) -- where the incentive to "over treat" does not exist -- are 30 to 60 percent lower than for other patients. HMOs reduce medical costs for the elderly patients surveyed from 10 to 40 percent. Sixty-one percent of all physicians are specialists, but only 20 percent of visits to physicians require specialized care.

With a shortage of primary care physicians and with costs skyrocketing, the current system both fails to provide care to segments of the population and often does not offer the type of care that is needed:

-- Inner city and rural citizens cannot get care or must rely entirely on hospital emergency rooms. There are 800 doctors per 100,000 people in Manhattan, while Mississippi has fewer than 80; Nevada only 60.

-- Acute care continues to be emphasized over preventive care: we miss opportunities to reduce premature deaths and preventable disabilities.

Health Financing System

Eighteen million Americans do not have any health insurance or access to free care through the VA or the Public Health Service. Of those who have health insurance, 19 million mostly low-income families have only costly and inadequate policies purchased individually (not, for example, through an employer-subsidized group policy), usually without major medical coverage. More than one-half of all Americans do not have adequate health insurance coverage for catastrophic expenses.

Moreover, existing health insurance is strongly skewed towards coverage of acute care and hospitalization, often omitting entirely primary, preventive and outpatient care. Such coverage strengthens the incentives for the doctor to rely on the most expensive acute care treatment available -- which is usually the service covered by insurance. By reimbursing physicians and hospitals retrospectively on the basis of their costs or normal fee, insurance companies have provided the medical community with an incentive to raise costs and fees — and little incentive to economize.

Federal Involvement in Health Care

The Federal Government is already heavily involved in health care with projected expenditures of almost $51 billion for FY 1978. In that same year health related "tax expenditures", will reduce Federal revenues by an estimated $7 billion as the result of tax exemptions for employer contributions to health insurance and the personal income tax deductions for health insurance premiums and medical expenses.

The Federal Government's complex array of health programs falls into four categories:

- o Direct care programs for some special populations provided either directly through its own operations (Public Health Service, Veterans Administration, Department of Defense) or through a grant program;
- o Programs designed to regulate the supply of medical resources or improve the quality of services;
- o Federal programs to pay for medical care services -- Medicare, Medicaid, CHAMPUS;
- o Programs to fund medical research, public health activities and ensure the safety of drugs and medical devices.

Direct Provision of Health Care

The Federal Government provides health services directly to 11.3 million citizens at a cost of $7.3 billion. The vast majority of these people are military personnel and their dependents, and veterans. The Veterans Administration provides hospital and medical care to service disabled veterans, veteran pensioners, veterans 65 and over, and any other veteran who he is unable to pay for the cost of care. DoD directly provides care to active duty military personnel and their dependents, and HEW provides medical services to the Coast Guard, Merchant Seamen, and Indians.

Primarily as a result of the VA system, some 5.3 percent of short-term hospital beds are in federally-owned or operated hospitals. The VA system will spend about $4.0 billion this year for medical care; the Department of Defense $2.7 billion. In addition, the Federal Government operates a variety of programs (migrant health, community health centers, maternal and child health program) that directly fund health services.

Federal Regulation, Planning, and Development

During the past decade, a series of Federal programs aimed at regulating or changing the health delivery system have been enacted into law. Three are most significant:

The Health Planning Program was designed to plan, develop, and regulate the supply of health care resources in local communities. This program establishes local Health Systems Agencies (HSAs) in each State; 205 have been conditionally designated by HEW. They are consumer-controlled, generally non-profit private agencies responsible for developing regional health care plans and for approving new hospital capital investment in their region. A statewide planning agency consolidates the local HSA plans into a single State plan and makes final decisions on hospital capital expenditures. HEW establishes national guidelines that recommend standards for determining a community's need for health care resources.

The program is based on the belief that the increase in health care costs is due, in part, to a surplus of hospital beds and equipment which are expensive to maintain and tend to be used unnecessarily. The Administration's Hospital Cost Containment legislation would strengthen the planning program by limiting the projects that can be approved.

The Professional Standards Review Program (PSRO) seeks to control excessive use of health care resources and maintain the quality of health services provided under Medicare and Medicaid. Poor-quality care and excessive and unnecessary utilization of resources plague these two programs. The PSRO program has established 195 physician-sponsored organizations across the Nation. HEW has approved the areas that these organizations regulate, has approved the local sponsorship of each PSRO, and funds PSRO operations. Each PSRO establishes a staff consisting of physicians and nurses to review and approve all Medicare and Medicaid hospital admissions in every hospital that receives these patients.

The Health Maintenance Organization (HMO) program is charged with changing the health delivery system towards a greater emphasis on pre-paid group practice, and away from fee-for-service practice. Pre-paid group practices (or HMOs) deliver care far more efficiently (10-40 percent lower cost than fee-for-service; 30-60 percent less hospitalization) because they have no incentive to over-use services and have strong incentives to keep their enrollees healthy and out of the hospital. The HMO program makes Federal grants and loans, and provides technical assistance to local organizations interested in developing HMOs. And once HEW has approved one or more HMOs as "qualified" to serve a particular area, federal law requires any employer that offers employees traditional

health insurance to also offer the opportunity to enroll in at least one of the approved HMOs. We have given this program the highest priority and are committed to a major expansion of HMOs throughout the country. I have recently written the Presidents of the Fortune 500 companies urging them to form HMOs for their employees and to assist the formation of these pre-paid group health plans in their communities.

Federal Payments for Medical Services

Medicare is operated entirely by HEW to finance health services for the aged. It covers 26 million aged and disabled people at a cost (FY 78) of $26.2 billion. Coverage focuses on hospital and physician services. Other services such as drugs, most mental and preventive services, and long term care services are not covered. Medicare covered hospital services are financed from Social Security taxes. Physician and other non-institutional services are financed through individual premiums ($7.70 per month) and Federal general revenues.

Medicaid is a joint Federal-State program to finance health care for certain low income citizens. Medicaid covers 24 million low income people who are either aged, blind, disabled or in families with only one parent. Many other low income persons, primarily single individuals or intact poor families are not covered. Medicaid is financed with Federal and State money (55 percent Federal, 45 percent State), and is administered by the States. Total Medicaid costs are $21.2 billion (FY 78) of which the Federal share is $11.9 billion. Benefits and eligibility definitions vary from State to State.

Champus is a Federal insurance program similar to Medicare which provides comprehensive health insurance to dependents of active service military personnel and military retirees.

Biomedical Research and Other Public Health Activities

The National Institutes of Health fund about 75 percent of all biomedical research. To a substantial extent, it is our funding priorities and policies that determine the development of the majority of new treatment technologies.

The Center for Disease Control in Atlanta responds to outbreaks of communicable diseases, conducts a wide variety of epidemiological studies across the country, and supervises an extensive program in occupational safety and health. The Federal Food and Drug Administration regulates the safety of drugs and medical equipment and devices. Expenditures by these agencies amount to $3.1 billion.

III. Major Problems in the U.S. Health Care System

Access

As the result of financial barriers or the absence of providers in a given area, millions of Americans have difficulty obtaining health care when they need it.

Many individuals do not have the financial resources to afford needed health care and are not covered by health insurance. And at least to some extent because adequate services are not always readily available, many minority groups and persons living in inner-city or rural areas are much less healthy than the general population:

- Infant mortality rates are 51 percent higher in urban poverty areas than in the Nation as a whole.

- Death rates within the U.S. vary widely by race with life expectancy for blacks being five years less than for whites.

- The life expectancy of migrant workers is 49 years.

- The rate of many chronic diseases is significantly higher among low-income people -- 64 percent higher for hypertension, 85 percent higher for hearing impairments, more than double for diabetes and heart conditions, for persons age 45 to 64.

Other barriers to access result from the paucity of physicians in rural and inner-city areas as well as the tendency of physicians to enter speciality practice rather than the general practice of family medicine.

Threat of Financial Ruin

Catastrophic medical expenses brought on by severe or prolonged illness or by the need to place aged or disabled persons in nursing homes for long periods of time have become a threat to the financial well being of many Americans. About 7 million American families will have uninsured medical expenses which exceed 15 percent of their income, at an aggregate cost of about $6.3 billion. Thus, a very small number of Americans bear a disproportionate burden of privately paid health expenses due to the illness or age of one or more members of their family.

Cost of Medical Care

Beyond those Americans with catastrophically high medical expenses, increases in medical care costs are increasingly becoming a drain on the pocketbooks of everyone as well as on limited social resources. Those costs hit middle-income Americans particularly hard.

Prices of health care services have increased 12.7 percent annually, on average, over the past decade, more than twice the 5.7 percent increase of all consumer prices. If this trend continues, health expenditures which currently consume 8.6 percent of GNP will exceed 9 percent of GNP by 1980. Already the average American must work one month per year to pay for medical care costs.

Responsiveness of the Health System

Our current health system does not respond well to health care needs of many Americans, and provides inappropriate -- and overly expensive -- care to others. Too frequently individuals do not know what kind of care they need, and the present system provides them no easy way to find out. People without a family physician or who are not enrolled in an organized group health plan are often confused as to whether they should seek medical care, and if so, what type of care. Some studies strongly suggest that many people visit physicians who do not need medical care, and many people who need medical care do not go to the doctor until long after they should.

Moreover, the current system does not make available the wide variety of medical services that many people need, such as mental health and preventive services. As a result, many people seek out a doctor or receive expensive acute care when more routine service or counseling could be provided. Our existing system has not developed needed capacity in many respects to respond most effectively, more appropriately, and most efficiently to the real needs of many Americans.

Health Status

The rapid advance in our scientific knowledge and medical technology has neither ended preventable disease in this country nor produced a nation that is as healthy as it could be. Many diseases are far more prevalent here than in other countries. But the vast majority of early deaths and much disability in this country is caused, not by an inability to obtain medical services, but rather as the result of life-style (smoking, drinking, driving, tension, obesity, lack of exercise); occupational hazards; environmental poisons; unsafe communities; and poor diet and nutrition.

A brief caveat concerning health status:

Expert analysis, as reflected in a recent Rand Corporation report on national health insurance, properly emphasizes that

> "improving health is unlikely to be substantially furthered by any (national health insurance) plan. Although this may seem strange to the layman, mortality rates from the major killers of the day — cancer, heart disease, stroke, accidents, homicide — are unlikely to be much reduced by further extension of personal medical care services."

As the Rand report reflects, more general discussion often mistakenly assumes that a national health insurance proposal will necessarily address the full range of the Nation's health problems. NHI proposals, though a necessary foundation on which to build any broader program, focus on financing health care services and on the problems of access, catastrophic expense, and control of rising costs. Only a national health program in its broadest sense could even attempt to affect the health status of most Americans. To do so, such a program would have to focus on health and nutrition education, occupational and environmental hazards, life-style changes, and other factors not directly addressed by the provision of personal medical care services.

IV. Objectives of National Health Insurance

The various plans that have been proposed are generally based on either one of two quite different views of national health insurance:

- That NHI should be narrowly focused, aimed at preventing financial hardship and ensuring financial access to all persons who need medical care;

- In addition to these objectives, that NHI should encourage certain changes in the organization and delivery of health care services, such as developing services in rural and inner-city areas, helping consumers use health care services appropriately, stimulating innovative low-cost approaches to the delivery of services, enforcing standards of quality, cost control, and efficiency, and promoting health prevention.

V. Fundamental Approaches

A. Financing Mechanisms vs. Broader National Health Program

Broader-based NHI plans may need to go beyond incentives in a financing plan to achieve their objectives, including for example:

- Direct Federal grants programs to ensure primary-care programs for disadvantaged persons in underserved areas including out-reach, transportation, and home care;

- Additional controls on the number and type of medical specialists through regulation of residency training and licensing;

- Measures designed to control the number of hospital beds and reduce unnecessary and duplicative capital expenditures by hospitals.

- Health education programs to encourage more healthful life-styles and to improve patterns of consumption of health care;

- Public health services such as disease prevention and control, which benefit communities rather than individuals; (in addition, certain mental health, drug abuse and alcoholism services have components that may pose problems of quality control if private providers are reimbursed);

- More emphasis on direct promotion of (1) new ways of organizing care (community health centers and HMOs) and (2) alternatives to institutionalization such as coordinated home health services; and

- Strict cost controls over hospital operating expenses and prices of other medical services.

B. Alternative Proposals for Federal Role in Financing

The extent of the Federal Government's role is perhaps the most important feature distinguishing past health insurance proposals. Such proposals can be viewed against a spectrum running from a greater to a lesser Federal role.

Complete Federal Operation of Health Care Facilities -- At one end of the spectrum lies a federally operated health system analogous to the British National Health Service which has been proposed in legislation submitted by Congressman Ronald Dellums.

Federal Financing/Private Ownership -- Under this approach, all financing would flow from the Federal Government, eliminating the need for private health insurance. Current private ownership of health facilities would be retained. The Kennedy-Corman Health Security bill adopts this approach and emphasizes the Federal Government's potential leverage to achieve cost control, quality control, and delivery system reform. Organized labor and many consumer groups support the Health Security approach.

Mixed Public/Private Financing with Increased Public Regulation -- Other proposals retain a role for private health insurance companies, while substantially increasing public regulation of the private sector. These proposals mandate private insurance coverage, or provide roles for private companies in the provision of supplementary insurance or the administration of

public programs. These proposals generally call for greatly increased regulation (either State or Federal) of the health system which can include regulation of premium rates, policy provisions, reimbursement to facilities and practitioners, and quality of care provided. Plans of this type include Kennedy-Mills, the Nixon Administration's CHIP proposal, and the Health Insurance Association of America's bill.

Limited Federal Intervention to Assist the Poor and Families with Catastrophic Expenses -- This approach would limit Federal action to high priority patient groups. It would expand coverage to all of the poor through a federally operated Medicaid program and to families with catastrophic medical expenses. While establishing some voluntary standards for private insurance, it would not impose cost or quality controls beyond those in present Federal regulations. This approach has been favored by Senators Long, Ribicoff, and Talmadge.

Private Market Incentives -- Some have called for a reversal of the present trend toward increased Federal regulation of health care, with an attempt to build a market system to provide health services. In this case, the Federal Government would provide neutral financing through issuance of tax credits or vouchers to be spent on health care. The American Medical Association has supported a plan containing a voucher or tax-credit approach that would retain the current pricing system but would provide subsidies, on a sliding scale according to income, for private health insurance.

More recently, at my request, Stanford Business School Professor Alain Enthoven has developed a private market tax-credit plan that attempts to encourage consumers to join HMOs and that would re-focus the Federal role toward attempts to structure the private market to encourage competition in ways that would produce more efficient and lower cost delivery systems.

VI. Major Health Insurance Issues

The precise nature of the Administration's national health program will depend upon decisions on several specific issues. These include:

A. Eligibility
B. Covered benefits
C. Reimbursement Methods/Cost Controls/Quality Controls
D. Methods of Financing
E. Administration
F. Phasing

A. Issue: Eligibility/Entitlement

- Who should be covered by national health insurance?

You have consistently called for "universal" and "mandatory" insurance coverage. Accordingly, we plan to draft a national health insurance proposal that will ultimately cover the entire population.

Universal coverage is most easily assured in a publicly-financed plan. In an employer insurance plan, by contrast, where an employee's eligibility and the payments for coverage depend on the relationship to the employer, some people (e.g., the unemployed, self-employed, seasonal worker, etc.) may fail to obtain coverage. Any approach to NHI through employer plans, therefore, must contain a residual public plan to cover those outside the work force or others excluded from private insurance plans (e.g., such as poor health risks).

B. Issue: Benefits

- Which services (e.g., dental care, optional plastic surgery) will be eligible for reimbursement under the insurance plan, and which practitioners (e.g., psychologists, chiropractors) will be permitted to deliver those services?

- Will patients be required to make any payment toward covered services (e.g. deductibles, co-insurance)?

- Should patient payment requirements be lowered or eliminated for the poor? If so, how should this be integrated with the Program for Better Jobs and Income? How do we define poor?

Services to be Insured. A broad consensus exists over benefits to be included under NHI. Commonly accepted benefits include all acute care services (physician, hospital, laboratory and X-ray), a limited amount of drug therapy, and certain preventive services for children and mothers. There is less agreement whether the following services should be included:

- o Long-Term Care. Long-term care for the aged and disabled is among the most costly and controversial services which might be included in national health insurance. Currently, Medicare covers only 100 days of post-hospital skilled nursing care; Medicaid currently provides unlimited coverage, but only for the totally destitute. While long-term care services could be covered by NHI, financing long-term care services through a Federal grant program might allow greater control over appropriate placement than would be possible if the elderly were "entitled" to insurance benefits for such care.

- o Preventive Care. Coverage of preventive services can add substantially to the immediate total cost of the NHI program. Some of these costs may be offset later by improved health of the population. The cost of providing preventive services varies significantly by the type of insurance mechanism chosen, the level of reimbursement, and the types of health professionals permitted to provide these services. Typical preventive services might include pre-natal care, family planning services, early cancer detection examinations, and immunizations.

- o Mental Health Services. The issue of what types of mental health benefits will be provided under national health insurance and which types of mental health professionals will be permitted to claim payment for providing care will be one of the most difficult decisions in the benefits area. We do not know the cost of insuring mental health services on the same basis as other types of care.

- o Dental Care. Despite the health gains from covering dental services, full coverage would be prohibitively costly because of the large backlog of demand for dental care -- unless

methods of delivering dental services undergo a radical change. Experience under the Canadian national health insurance system suggests that it may be necessary to begin with limited benefits, such as a nationwide dental service for children provided in schools by dental nurses.

Patient Payments (Cost-Sharing). Most private insurance (as well as Medicare) requires the patient to make some initial payment for many services. Those who favor cost-sharing argue that making patients pay some fee both reduces program costs and also can make patients and doctors sensitive to the cost of health services and to the need to economize by using costly services only when necessary. Considerable uncertainty exists as to how much cost-sharing reduces utilization, and whether the reduction occurs in needed or unneeded services. Cost-sharing can add significantly to administrative expense and the complexity of the program.

Most people agree, however, that cost-sharing should be reduced or eliminated for low-income persons. Labor vigorously opposes any cost-sharing for anyone.

C. Issue: Reimbursement/Cost Controls/Quality Controls

- How will providers (hospitals, physicians, nurses, laboratories, and others) be paid? To what extent will changes in reimbursement mechanisms be used to control the costs of health care, to change the distribution and organization of services, and to improve access?

Several changes in reimbursement policies have been widely discussed:

-- To fix reimbursement rates for physicians and for institutions prospectively in order to control costs;

-- To set uniform rates for equivalent services in all locations. While such a change might improve geographic distribution and attract more doctors to family practice, it also might lead to excessive incomes for some physicians.

-- To establish reimbursement policies that encourage more efficient health maintenance organizations and community health centers. These organized health care centers employ the skills of lower cost health professionals such as nurse practitioners.

Current NHI plans have also proposed a variety of other cost control measures. Two examples:

o Area-Wide health budget. A defined region would be allotted a fixed, prospectively-established budget. Within each area, budgets for hospitals or other institutional providers could be determined, and fixed sums could be set aside for reimbursement of physicians and other independent health professionals.

o Fixed-budgets for institutional providers. Most industrialized nations with comprehensive health plans have set pre-approved budgets for hospitals and other institutional facilities. Any NHI plan must create strong incentives for efficiency in hospital reimbursement controls.

Physician reimbursement. The physician is the key health care decision-maker; he directs at least 70 percent of the $139 billion in health costs. Change in physician reimbursement will not come easily or quickly. There are only some 7,000 hospitals, but more than 375,000 physicians. Attitudes toward physicians as individuals are quite different from attitudes toward hospitals as organizations. Actions, for example, that restrict the income of individuals may be less acceptable than actions that restrict the income of institutions.

Physicians may be reimbursed

-- on a fee-for-service basis;
-- by salary, or
-- through fixed payments per patient.

Because most physicians will continue for some time to be paid on a fee-for-service basis, NHI must contain a structure by which fees are determined. The main issues in designing a physician reimbursement/cost-control scheme under NHI include:

-- whether fees should be set or negotiated, and how;
-- whether the approved fee must be the total fee;
-- how fees should be changed over time;
-- whether the fee schedule should be an instrument for injluencing the geographical and specialty distribution of physicians;
-- how fees can, and whether fees should, be used to promote organized ambulatory care settings and more efficient methods of delivering services.

Quality Assurance -NHI should assure the quality of care provided by hospitals and physicians. We do not do as well at this currently as we should, but a successful NHI plan must contain forceful, effective provisions to prevent abuse of the system. Greatly increased accountability of providers will be necessary to meet this goal. Alternative mechanisms include:

-- Establishing strict standards for certification of hospitals, physicians, etc., to limit NHI financing to honest and competent providers.

-- Creating an efficient, administrative structure to assure effective fraud and abuse detection.

-- Strengthening the accountability and effectiveness of the current PSRO program by setting national utilization standards, focusing review on overused procedures (such as hysterectomies) or on individuals with excessive delivery patterns, and broadening the make-up of PSRO boards to include non-physician providers and consumer members.

-- Strengthening State licensure programs by requiring periodic recertification and effective sanctions applied to incompetent professionals. Data developed by PSROs could be made available to licensure programs.

-- Grievance and complaint processes for consumers; local ombusdmen or councils armed with investigatory and disclosure power could assist in this area.

D. Issue: Financing

o Should NHI be financed through tax revenues alone or in combination with premiums? Should all NHI funds be paid to the federal government, or should employer-employee payments go to a quasi-public corporation or through private insurance companies to a quasi-public corporation? What mix of federal taxes is appropriate? Should the federal government levy all taxes or share responsibilities with the States?

The major alternatives -- with a list of possible variations -- for financing health insurance are:

o A Tax-Financed Plan. A plan financed exclusively through public revenues could draw upon any of the following sources in a variety of combinations:

-- Federal general revenues
-- Special Federal excise taxes on alcohol, tobacco and other harmful substances
-- Payroll taxes
-- Repeal of "tax expenditures" by eliminating or reducing (1) tax exemptions for employer contributions to health insurance or (2) the personal income tax deductions for health insurance premiums and medical expenses
-- State and local taxes
-- Tax credits

- o A Mandated Employer Plan and Residual Public Plan. Under such a plan, employers would be required to purchase all or part of private health insurance (or to provide a certain level of coverage or care) for their employees. The government would provide public financing for those not covered by employer plans.

Either type of plan could require consumers to finance a portion of the plan's cost through premium contributions.

The costs of tax-financed plans, other than those paid directly by consumers, would be a normal expense on the Federal budget. Premiums paid by employers in employer plans, however, do not appear on the Federal budget if employers deal directly with providers and insurance companies.

Among the often discussed variations are mandatory premiums or taxes that might flow directly to a quasi-public corporation whose income and expenditures would be not in the Consolidated Federal Budget. Such a public corporation could contract with private insurance companies to perform either underwriting or administrative functions. Under another alternative, employers could be taxed but would receive a credit for outlays on comparable private insurance.

Some past proposals, such as the American Medical Association Medicredit Plan, have suggested credits to the personal income tax to offset the burdens of premiums or large medical expenses. Tax credits are administratively simple, do not show up on the budget and are not subject to regular Congressional appropriations approval. Tax credit plans reduce the opportunity to use the financing mechanism as a means to influence the cost or quality of medical care.

Impact on Families of Differing Income. The way in which national health insurance is financed will also affect the distribution of the cost burden of national health insurance among the poor and the well-to-do.

All financing alternatives, including the use of premiums, payroll taxes, and/or general revenue raised by income taxes, will have to be carefully structured to avoid any excessively regressive impact that would impose a financial burden on the poor. Excise taxes, such as alcohol and tobacco taxes, would make consumption of physically harmful substances more expensive.

Employment Effects. The financing method can affect the demand for and supply of labor. The cost of employer paid fringe benefits such as health insurance is likely to be borne by the employee in the form of lower real wages. However, employers can not reduce the real wages of an employee already at the minimum wage level. For these employers, a premium is much the same as an increase in the minimum wage. As a result, the demand for low wage workers is likely to decline. Employers would also have a strong incentive to hire good health risks or those who decline the insurance, if employee participation is voluntary. The problem may be especially acute in a plan financed through experience-rated premiums based on expected health utilization rates by employees.

Shifting Tax Burdens. Depending on how extensive the proposal, a Federal plan covering health care, financed through personal income taxes, or credits to the personal income tax, would free:

-- State and local governments of up to $19 billion in 1978 health expenditures, and

-- Employers of up to $34 billion in group health insurance premiums.

On the other hand, a plan which requires all employers (including State and local government employers) to provide comprehensive coverage to all employees, and which requires State governments to share with the Federal government the cost of expanding public coverage to all low-income individuals could substantially increase employer and State government payments.

E. Issue: Administration

- What should be the respective roles of the Federal government, State governments, the insurance industry, and local agencies such as areawide health planning agencies (HSAs)?

The administration of national health insurance -- one of the most emotionally and politically charged issues that must be decided -- is closely tied to financing the program.

Choices must be made about the appropriate role of the Federal government and the roles of the States, local governments, the Health Systems Agencies, and private insurers. Defining the appropriate role (if any) for private insurers is the most difficult and controversial of these issues; but its resolution may be the key to securing passage of a national health insurance bill in the Congress.

Private Insurance Companies

At present, the health insurance industry performs three functions:

- Enrollment (sales)
- Underwriting (risk-taking)
- Claim payment (reimbursement of providers and beneficiaries)

Each of these tasks will change under national health insurance. At one extreme, private insurers would have no participation in NHI. Their role would be limited to providing coverage not included in the NHI program (this is the system which has been adopted in Canada). At the other extreme, their role in at least underwriting and claim payment could expand markedly.

Organized labor has advocated the exclusion of private insurance companies from any participation in NHI. Senator Kennedy's Health Security Bill reflects this position. The Nixon Administration, the Health Insurance Association, and the American Medical Association all mandate purchase of private insurance or provide tax credits for the purchase of private insurance. Under some of these plans the private insurance industry would expand by up to 50 percent.

In addition to the politics of passage, the role for private insurance companies either as underwriter or as administrative agents of a public plan hinges on several considerations:

-- the extent to which effective cost and quality controls can be built into privately-underwritten and administered plans;

-- the weighing of economies of scale in centralized plans against greater flexibility and innovation in privately administered plans; and

-- the dislocations caused by substantial changes in the size of the private health insurance industry.

The States

The administrative role of State governments involves consideration of the following items:

-- Provision of benefits for low-income people (e.g., State operation of a residual Medicaid program);

-- The State's financial contribution to the program;

-- Implementation and monitoring of cost containment provisions;

-- Regulation of the private insurance industry's participation in the program;

-- Licensure and certification of providers.

At the present, State governments have significant policy and administrative responsibilities in most of these areas. The extent to which the State role is expanded or diminished will depend, in part, on the degree of federal centralization in policy determination and management.

F. Issue: Phasing

You have consistently stated (and I have repeatedly echoed) that your long-range objective is a universal and comprehensive National Health Insurance system, but that such a program would have to be phased in as revenues permit and in a manner consistent with the attainment of a balanced budget in 1980. A variety of different phasing options are feasible, and depend in large measure upon two factors:

-- The design of the ultimate national health insurance plan;

-- The available amount of new Federal funds for each phase.

Two broad approaches exist for phasing National Health Insurance. We could introduce a comprehensive health insurance bill that delays the effective dates for various portions of the program, so that coverage of certain groups, or benefits would be phased in over a period of time. Some have suggested, alternatively, an incremental approach towards a National Health Program. While the outlines of an ultimate program would have to be developed, supporters of this approach urge that only a few initial steps be submitted to the Congress at the present time. Whichever approach is adopted, there are three basic means, with infinite variations, of phasing in National Health Insurance coverage:

-- By population groups;

-- By range of services covered;

— By the degree of patient cost-sharing required.

Population Groups

We could replace Medicaid with coverage for the entire low-income population, improve Medicare for the aged and disabled, and perhaps extend coverage to pregnant women and children as well. In some ways our Child Health Assessment Plan (CHAP), which expands Medicaid coverage to all low-income children under six, is a baby step toward National Health Insurance. We are currently requesting that this proposal be expanded to include all low-income pregnant women.

Beginning NHI by providing a broad range of services to all the poor has considerable initial appeal. This method of phasing may prove to be essential to ensure coordination of

health services for the poor with the Program for Better Jobs and Income. But it also has drawbacks:

- Covering all the poor in the first phase of National Health Insurance would involve a substantial increase in Federal budget cost. Costs could be reduced by serving only low-income children and pregnant women at first, followed by other age categories in later phases.

- This approach would not directly benefit the middle class, might suffer from the poor reputation of the Medicaid program (and its cost implications for the States), and might rigidify a two-class health care system.

Another phasing alternative that is often suggested would cover all children and pregnant women regardless of income. This approach would devote considerable resources to the care of middle and upper income children and women who already receive adequate health care. It would not meet the needs of low-income adults, nor the problems of the middle class faced with catastrophic health care expenses.

Services Covered

Specified benefits could initially be provided to the entire population. Phase one might pay for hospital services, and then include physician services. The Canadian National Health Insurance plan began in this manner. The first phase creates an unfortunate incentive toward hospital care and away from preventive care services and essential dental, mental health and long-term services.

Cost Sharing

Another approach to phasing would require patients to pay very high percentages of their bills in the early stages. In the first phase, the plan could require patients to pay, say, 50 percent of the cost of all services up to a maximum annual family payment of $1,000. These amounts could be adjusted for families below the poverty level. The patient coinsurance could be gradually reduced, as revenues permitted, and the low-income subsidies extended to all near-poor as well as poor families.

VII. Cost of National Health Insurance

The cost of health care is high and going up fast. That fact has deterred the public, and their elected officials, from moving quickly into a national health insurance scheme which would require major tax increases and accelerate inflation of health care costs. Key Congressional committees still remember under-estimates of the budgetary costs of Medicare and Medicaid, and the inflation in health care expenses following their introduction is painfully apparent. To obtain widespread public and political support, National Health Insurance must embody effective cost controls and insure that the American family is not faced with substantially higher payments for health care (including taxes and out-of-pocket expenses) than it would face in the absence of a plan.

A. Cost Dimensions of NHI

There are three elements that should be considered in analyzing the cost of National Health Insurance:

- -- Total spending on health services (which may be affected by an NHI plan)
- -- Overall cost of NHI services which includes both federal costs and payments that State governments, employers, and/or employees may be required to make under NHI to qualified private health insurance plans
- -- Cost to the federal government budget

Total Health Spending in the U.S. In the absence of a National Health Insurance Plan, total health expenditures are expected to be at least $202 billion by 1980 (in 1978 dollars). The effect of an NHI plan on the nation's total spending on health care is somewhat uncertain:

- -- National Health Insurance can help hold health costs down if it has tough provisions to contain costs.

- -- At the same time, removal of the financial barriers to health care for all low-income families regardless of family composition, employment status, or geographical location should also result in greater use of the health care system. Some increases in total health expenditures would indicate that the plan was filling a previously unmet need.

-- A national health insurance plan with inadequate or ineffective cost control provisions could lead to a general increase in costs due to expanded waste, inefficiency, and inflation.

Total Federal Cost

Two major influences on federal costs are relatively obvious: the comprehensiveness of the benefit package and the amounts patients must pay themselves.

A third factor is somewhat more complex. Currently about $55 billion is paid in private health insurance payments. How these private expenditures are handled by NHI greatly affects both the real and perceived impact on the federal budget. An NHI plan can treat these private expenditures in several ways:

- o NHI can "capture" (through taxes) the amounts currently paid for private health insurance expenditures and pay for most or all health insurance in federal dollars;

- o NHI can require by law that private expenditures continue to be made (and set standards for these private expenditures); the federal government would then pay only for coverage of low-income families and others not covered through the work place;

- o NHI can "pay" for insurance indirectly through tax credits and incentives for private insurance plans.

The impact (in terms of gross revenues and expenditures) on the Federal budget of the same insurance plan (i.e., same benefits, coverage, etc.) can, therefore, differ markedly depending upon how much of the insurance coverage is provided directly by the Federal government and how much Federal law requires or encourages the private sector to provide.

The choice between a publicly-financed plan and a mixed public/private plan does not, however, necessarily affect the net Federal budget costs. Increases in federal expenditures for persons currently covered under private plans would be offset by an increase in federal revenues by taxing back an amount equal to private expenditures formerly devoted to private insurance coverage. Primarily at stake in the choice between a public plan and a mixed public/private one is a potential increase in the absolute size of the Federal budget in the range of two-three percentage points of GNP.

The decision whether to replace private health insurance payments with a tax to support a public NHI plan is difficult. Retaining employer-employee payments in the private sector would minimize any increase in the size of the Federal budget. But it may be difficult to obtain other objectives (cost controls, quality control, administrative efficiency) of a national health program in a plan which relies on private coverage coupled with a residual public plan for those outside employer and other group plans.

On the other hand, a major public education effort would be required to explain that the higher absolute Federal budget costs would be in large part offset by federal "capture" of current employer-employee premium payments.

B. Model Cost Estimates

Table 1 presents federal budget cost estimates of model plans with three different benefit packages varying in the extent of comprehensiveness and with three different types of patient cost-sharing requirements:

- o Benefits:
  - — a comprehensive benefit package,
  - — a moderately comprehensive plan (excludes some preventive and mental health services and all dental and long-term care services), and

— a minimal benefit plan (excludes most prescription drugs, preventive care, mental health, long-term care, and dental services).*

o Patient Payments (Cost-Sharing):

— no patient payment,
— patients required to pay 25 percent of all charges up to a $1,000 ceiling per family,
— patients required to pay 35 percent of all charges up to a $1,000 ceiling per family.

In those plans with some cost-sharing required of patients, these amounts are eliminated for all families with incomes below the income security breakeven level ($8400 for a family of four in 1978), and some partial subsidies are extended to all families earning within $3300 of the breakeven level.

The table also shows the effect of a plan that captures private health insurance payments in the federal budget and of a plan that assumes that private health insurance pauments are part of NHI, but not paid to the Federal treasury.

*Minimal Plan includes:	Inpatient, Outpatient; Surgery with prior authorization X-rays; Prescription drugs (50% total costs; Durable equipment; Ambulance: SNF/HHA only if post-hospitalization; Outpatient Mental Care limited to 20 visits in CMHC.
Moderate Plan includes:	All the above plus Drugs (85% total); Some Preventive Ambulatory mental health in CMHC unlimited; Psychiatric Inpatient care limited to 30 days.
Comprehensive Plan includes:	The moderate plan plus Dental services for children (18 years or less); Dentures; Eyeglasses for children; Broad preventive care services; Limited Outpatient psychiatric care outside of organized settings; Mental services in CHMC, HMO, CHC.

TABLE 1: FEDERAL INCREMENTAL COST FOR MODEL NATIONAL HEALTH INSURANCE PLANS BASED ON PRICES AND POPULATION PROJECTED FOR 1980*
(Expressed in billions of 1978 dollars)

	Comprehensive	Moderate	Minimal
Type I Plans			
No Coinsurance	$121.9	$105.3	$ 86.2
25% Coinsurance	103.6	93.2	69.8
35% Coinsurance	94.7	77.7	60.5
Type II Plans			
No Coinsurance	67.0	50.4	31.3
25% Coinsurance	48.7	38.3	14.9
35% Coinsurance	39.8	22.8	5.6

*Type I Plans assume current private health insurance payments of $54.9 billion are transferred to the Federal budget.

Type II Plans assume current private health insurance payments of $54.9 billion are diverted to NHI through off-budget mechanisms.

In all plans, it is assumed that State payments for health care services continue at current rates. Strict cost controls in the form of the Administration's Hospital Cost Containment plan and physician fee schedules are assumed to be in effect.

THE WHITE HOUSE
WASHINGTON

Nov. 8, 1977

The Vice President
Hamilton Jordan
Frank Moore
Jody Powell
Jack Watson
Charles Schultze

The attached is forwarded to you for your information.

Rick Hutcheson

NATIONAL HEALTH INSURANCE

THE WHITE HOUSE

WASHINGTON

November 8, 1977

MEMORANDUM FOR THE PRESIDENT

FROM: JIM FALLOWS

SUBJECT: Mine Safety Bill

Jerry Doolittle has prepared these suggested talking points for your November 9 signing of the Federal Mine Safety and Health Amendments Act of 1977 (S. 717).

1. Much of the nation's economy depends on the labors of miners. Their health, safety and welfare are therefore of crucial concern -- particularly as we expand production of coal and other needed minerals.

2. S. 717 extends to non-coal miners the same protection coal miners already receive under the 1969 Coal Mine Health and Safety Act, so that all miners will finally be covered under one comprehensive mine safety and health law.

3. Non-coal mines are less dangerous than coal mines -- but still had 113 fatal and 7,443 disabling accidents last year. One fourth of non-coal miners have impaired hearing, and their death rates from illness are much higher than normal.

4. The new law contains provisions aimed at preventing such tragedies as the Scotia Mine explosion, where 26 persons died last year even though 62 ventilation violations had been

issued the preceding two years. The law's enforcement provisions profit from our operating experience with the 1969 coal act; many flaws have been corrected.

5. The bill transfers the mine health and safety program from Interior to Labor, where it can be better coordinated with other occupational health and safety programs.

6. This bill is the product of close cooperation between the Administration and both Houses of Congress. You particularly want to recognize the efforts of Senator Williams of New Jersey and Congressman Carl Perkins of Kentucky.

# # #

THE PRESI[illegible] HAS SEEN.

THE CHAIRMAN OF THE
COUNCIL OF ECONOMIC ADVISERS
WASHINGTON

November 5, 1977

MEMORANDUM FOR THE PRESIDENT

From: Charlie Schultze CLS

Subject: Mine Safety Legislation

I recently sent you an "inflation scorecard." Among other things, it concluded that:

- the government takes many actions, to meet desirable social objectives, which have inflationary consequences;

- unless such proposals are developed we should give high priority to finding ways of meeting such objectives at lower inflationary costs; and

- where that is impossible, we should examine the proposals carefully to make sure the gains are worth the costs.

A classic example of when this was not done has just come to my attention, in the Federal Mine Safety and Health Act Amendments for 1977, an Enrolled Bill which will shortly be before you for signature.

This legislation does two things:

1. Transfers responsibility for mine health and safety from Interior to Labor.

2. Substantially enlarges the regulatory and enforcement power of the mine safety agency and extends its authority from coal to all mines.

In reviewing the documents provided me by Rick Hutchinson, I learned that all of the discussion revolved solely around

the transfer issue, and at no time were you presented any analysis of the important regulatory provisions. A review of Administration correspondence with the Congress indicates that we supported both aspects of the bill as it proceeded to passage.

My staff and the staff of COWPS, believe that, at least potentially, there are substantial inflationary problems in the bill.

First, several sections of the OSHA legislation are inserted into mine safety legislation. These standards considerably enlarge the range of health hazards subject to regulations. More importantly, a key phrase in the OSHA legislation that has been used to require OSHA to pay at least limited attention to economic considerations was omitted from this bill. (In the standard setting language, the phrase "to the extent feasible" was dropped.) Other changes with similar impact were also made.

Second, the bill expands the already large powers for the mine safety agency to close all or part of mines -- whenever violations occur -- and requires companies to continue paying miners their full wages during such a period. Under the bill individual miners or union representatives can demand inspections, and require the Labor Department to justify in writing that violations are not occurring. Where longer term health and safety requirements are involved -- not imminent danger problems -- many mines are likely to have at least minor violations on frequent occasions. It is possible, given the bitter labor relations in this industry, that the combination of all of these provisions could be used as a way to launch wildcat strikes while still collecting pay.

Third, these health and safety rules are extended from coal mining to all mining.

The economic consequences of these rules will depend in large measure on precisely how the law is interpreted by the agencies responsible and the Courts. Experience with the prior mine safety act, however, suggests that the impact could be large.

One clear possibility is that tighter work rules and provisions for mine closings could sharply reduce mine productivity. In 1969, the coal industry was subjected to the requirements of the earlier mine safety act; the copper

industry was not. The attached chart vividly indicates the course of productivity in the two industries since 1969. The 46 percent decline in coal mine productivity is attributable largely to the impact of the safety rules.

I expect that the result of this legislation could be continued declines in productivity in coal that could undermine the objectives of the energy program. Similar difficulties will emerge for the first time in copper and other mining industries. There also is evidence that -- in a worst-case situation -- anti-nuclear groups could use the new health hazard rules of these amendments to argue in court that all uranium mines should be closed. Their legal case could be a strong one.

I am not arguing that improvements in health protection workers are undesirable, nor that we should be unwilling to forgo some productivity in the interests of health and safety. But we should carefully examine legislation in these fields, explicitly consider the costs as well as the benefits, and try to reduce the inflationary consequences. We are not mining experts at CEA. Other members of the Administraton would surely have had different views and assessments of the impact of this legislation. But internal debate would at least have flushed out the issues.

I have not recommended veto of this legislaton because the Administration supported it throughout its development.

You may want to consider, however issuing a signing statement commending the bill's objectives but urging the agencies involved to recognize the need to carry out its provisions in a way which takes into account other important concerns such as employment, inflation, and the energy program. The mines must be kept economically viable if we are to keep employment in mining industries high, and achieve growing levels of output -- particularly in energy-related fields -- at reasonable cost. If you wish, we would be glad to work with Jim Fallows to draft such a statement.

MINING PRODUCTIVITY INDEXES (1967=100)