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A current medical reimbursement practices and prospects for national health insurance

Wallace D. Kinney

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CURRENT MEDICAL REIMBURSEMENT PRACTICES
AND
PROSPECTS FOR NATIONAL HEALTH INSURANCE
BY
WALLACE D. KINNEY

A thesis submitted in partial fulfillment
of the requirements for the degree of
MASTERS OF PUBLIC ADMINISTRATION

CALIFORNIA STATE COLLEGE, SAN BERNARDINO

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Approved by:

[Signatures and dates]
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Although various individuals have provided data for this thesis, full responsibility for facts and opinions, and especially for the interpretation thereof, expressed in the following pages, rests with the writer alone.
# TABLE OF CONTENTS

**Chapter**

1. **INTRODUCTION**
   - SCOPE OF STUDY 1
   - HISTORY 4
   - BACKGROUND 8
   - PURPOSE 13

2. **NATIONAL HEALTH INSURANCE** 16

3. **IMPACT OF NATIONAL HEALTH INSURANCE ON COUNTY MEDICAL FACILITIES** 23

4. **BASIC PLAN FOR A NATIONAL HEALTH INSURANCE PROGRAM** 37

5. **ANALYSIS OF MAJOR LEGISLATION COVERING NATIONAL HEALTH INSURANCE PLANS** 51

6. **INEFFECTIVENESS OF CURRENT PROGRAMS AND PROPOSED SOLUTIONS** 81

7. **BENEFITS AND CONSEQUENCES OF NATIONAL HEALTH INSURANCE** 93

8. **FINDINGS AND RECOMMENDED SOLUTIONS** 107

**BIBLIOGRAPHY** 126
Chapter 1

INTRODUCTION

Scope of Study

For many years health care services and the payment thereof have been problems facing this nation. In the last decade, health care services have been covered under the Medicare and Medi-Cal Programs, which began in 1966. These two programs pay the health care bills of the elderly and the needy. They have become major elements in federal, state, and local government expenditures. Many new public and private organizations have been created to monitor the quality of health care, to plan for and allocate health resources, and to improve the efficiency and effectiveness of health care services.

However, the new organizations have been unable to eliminate many deficiencies that exist in the health care services system. There exists a need for a national health care policy which could be supported by the enactment of legislation providing universal national health insurance coverage for every citizen in this nation. There have been many national health insurance bills proposed and introduced in Congress, and the proposals are so numerous and differ in their approach and detail that many citizens are bewildered, confused, and have little, if any, concept of how the proposed programs would affect them and their families.
To clarify health care issues, services and patient choices, this study is organized into eight chapters which outline scope of study, health care history, background and purpose; the creation of proposals for universal national health insurance; impact of national health insurance as county medical health facilities; basic issues in national health insurance; analysis of major legislation covering national health insurance; proposed solutions; benefits and consequences of national health insurance; and the author's findings and recommended solutions for a national health insurance program.

Chapter 1, the introduction, provides the scope of study, history, background, and purpose of national health insurance, as undertaken by the author. Chapter 2, outlines the role of the federal government--its contribution, responsibility, and the coverage to be provided by a universal national health insurance program. Chapter 3, presents the impact, in the author's view, of national health insurance on county medical facilities. Chapter 4, presents basic issues in national health insurance--who and what services should be covered, how the adopted plan should be financed, how hospitals, physicians, and other providers should be paid. Chapter 5, covers analysis of major legislation covering national health insurance plans that have been submitted to Congress. Chapter 6, states, in the author's view, the ineffectiveness of current health care services programs--Medicare and Medi-Cal, and proposed solutions. Chapter 7, describes the benefits and consequences of national health insurance. Chapter 8, is a brief summary of the author's findings and recommended solutions for a universal national insurance program to meet the needs of Americans requiring health care services.
The author is not endorsing any one plan, but there are specific features outlined in each which will best meet the objectives of national health insurance by insuring access to medical care for all Americans. A national health insurance program could reduce financial hardships created by health care services and catastrophic illnesses while improving health care services to all Americans.
History

American medical science has made great advances in curing disease, easing human distress and prolonging life. Yet, still unavailable to many, due to high costs, are the services required for adequate health care. The United States is nearing the point where decisive action must be taken to resolve the problems of our health care system.

The subject of national health insurance has been a publicly debated issue in the United States for nearly fifty years. Perhaps, one of the most outstanding changes in attitudes among those traditionally resistant to the acceptance of national health insurance is the recognition that government financing is not necessarily associated with undesirable restrictions on good medical practice or professional freedom. The United States is the only major industrial nation without a comprehensive national health insurance plan. For years, politicians, the health-care industry, organized labor, and ordinary consumers of health care have debated whether such a plan was needed. Those who have been pressing for national health insurance, especially groups affiliated with the Committee for National Health Insurance, continue to work for enactment in 1977.¹

The cost of every product and service in the United States has steadily increased during the current inflationary period, but the costs of health care services have risen greater than most of the consumer indexes. There seems to be few, if any, disagreements that the

health care services costs have risen to such heights that many Americans have become virtually eliminated from access to adequate care. Limited accessibility, restricted coverage, co-payments and deductibles have combined to prevent millions of Americans from receiving proper medical care. The American public is identifying its need for first-class medical health care as an inalienable right.²

Many Americans, at every income level, are forced, because of medical costs, to mortgage their family's future, sell their homes, give up their childrens' college education and even declare bankruptcy. Many Americans are hounded by collection agencies hired by hospitals and doctors to pay for medical services for which they do not have the funds. Many have their salaries garnished; some are even sued. Four out of five Americans have health insurance of some kind, but most are surprised when they find out too late that their policy covers much less than they thought, or that their policy excludes the particular health problem with which they are faced, or has lapsed because, for example, they were laid off or changed jobs or didn't realize that their payments were no longer being made. Millions of Americans who are sick or injured get no help at all from doctors and hospitals. Many are turned away because they can't pay. There are many areas in the country and the city that have been abandoned by doctors, and finally there are many other Americans who have simply given up trying

to get care because they know they can't afford it, or they know they will be insulted or abused by the "charity" care which is the only kind that is offered to them. One out of five Americans has no health insurance at all because he can't afford it, or has a health problem that makes him uninsurable. 3

Good health care should be a right for all Americans. Health is so basic to a man's ability to bring to fruition his opportunities as an American that each person should guarantee that health care is provided to everyone at a cost they can afford. Health care is not a luxury or an optional service one can do without. The fact that disease and injury deprive many Americans of the opportunity to fulfill these rights because they were born in the wrong place, or because their families could not pay the price, denies our belief that men are created equal and should have equal opportunity. The American people have the knowledge, wealth and ability to insure that every American gets the health care he needs without being faced with financial ruin in the process. Americans have the ability to guarantee each other good health care. Their problem is to determine if they have the will to provide good health care to all Americans. If they have the will, they can assure each other lives of greater opportunity and dignity. 4


4 Ibid., p. 18.
The American people are becoming increasingly aware of the inadequacies of the present health care system in the United States, particularly concerning the aspects of increased costs and unavailability of timely service brought on by the lack of practicing physicians. Changes of major significance seem imminent and inevitable. The kind of system adopted will have important effects on the access of health care and resulting effects upon the quality of services provided and the number of physicians available to provide services. There are numerous National Health Insurance Acts or Programs being considered in Congress at the present time. If any one of these programs is adopted, which provides free access to physicians services without cost to the individual, it is feared that the demand for health services will increase at such a rapid rate that the supply of physicians will not be available in proper proportions to the demand which will result in inefficient and low-quality health care. As stated by Osler Peterson, "Any National Health Insurance that will make needed care more accessible, must assure enough physicians are engaged in giving primary care to meet most of the demand promptly with minimal constraints on the patient seeking help."\(^5\)

In the future, it may be possible to measure and project the increased demand for services with some accuracy. At that time, proper action must be taken to train enough new physicians to meet expected demands. The demands by Americans for health care services are often limited to their individual ability to pay for the services.

Background

The evolution of National Health Insurance in the United States started with the medieval guilds. Through the eighteenth, and well into the nineteenth centuries, the source of medical care was provided by local doctors making house calls, and there were very few hospitals. Doctors were paid by those who could afford to pay, and hospitals received their funds from charities. Health care services progressed slowly during the 1800's. Health care ideas were changing with regard to the types of health services to be provided and the role hospitals played in its delivery. The first compulsory national "Sickness Insurance Act" became law in Germany on June 15, 1883. It was written and drawn up by Chancellor Otto von Bismarck. Germany's initiation of the social insurance concept in 1883 was the first in Europe. Austria adopted compulsory health insurance in 1888, and Hungary adopted compulsory health insurance in 1891. The British enacted old age pensions and a compulsory health insurance law in 1911. These and other significant events later influenced plans in the United States. The first extensive social insurance legislation in the United States was enacted by the State of New York, with its Industrial Injury Compensation Program.

During the years 1912 through 1934, the health insurance program did not disappear; however, it came virtually to a standstill.

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with the Great Depression in the 1930's. The only program to assist the industrial worker was Workman's Compensation, which stood alone for a quarter of a century until the New Deal and Social Security of 1935, which was enacted under President Franklin D. Roosevelt.  

Social insurance, as the term was quite generally employed, consisted of the following subdivisions: compulsory health insurance, old age pensions, widows and orphans, and unemployment pensions or doles. 

Under the Act, President Franklin D. Roosevelt stated that the Social Security Act was only the cornerstone and the beginning of a much more extensive program. Under the study, "Provisions" of the Social Security Act, the Social Security Board was to continue the research and investigation for National Health Insurance. 

In 1943, Senators Robert F. Wagner and William H. Murray, and Congressman John D. Dingell came forth with a new National Health Bill which proposed establishment of a single national health insurance fund, in the model of the Old Age Pension System. This fund would support the costs of comprehensive services to all working people and their dependents. It would be financed by insurance contributions from employers and workers and administered through a network of Federal Offices. The Wagner-Murray-Dingell Bills received a lot of opposition from private medical professionals and insurance companies. 

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8 Ibid., p. 34. 


Their bills were never voted on, but they had an enormous effect by pos-
ing a threat to the voluntary health insurance movement. They stimu-
lated its growth at a robust rate. By the mid-1950's, some 70% of the
nation's population was protected with some degree of private health
insurance.¹¹

The great majority of voluntarily health insured people were
covered through their place of work. Therefore, when they were un-
employed or retired, they lost the protection of their health insur-
ance. The most serious problem was the aged American who did not
always have insurance coverage, and who because of biological reasons
had a greater volume of serious sickness than other Americans. With
the election of President Lyndon B. Johnson in 1964, the Medicare Bill
was enacted in July 1965, which provided medical care insurance for
the aged; and it greatly expanded the accessibility of old people to
medical care, but did almost nothing to modify the health care services
system in America. President Lyndon B. Johnson signed the Medicare
Bill on July 30, 1965. He paid tribute to Harry S. Truman as the
first Chief Executive to endorse health insurance under Social Security.
The debate on the Medicare Bill had started 60 years before.¹²

There were other legislative enactments in late 1965, the
Regional Medical Programs for Heart Disease, Cancer and Stroke (RMP);
and in 1966, there was the Comprehensive Health Planning Act (CHP).

¹¹Corning, Peter A., The Evolution of Medicare...from Idea to
Law, U. S. Department of Health Education and Welfare, Social Security
Administration, Office of Research and Statistics, Research Report

¹²Goodman, Raymond D., M.D., M.P.H., Ed., National Health
Insurance, Monograph (California: The Regents of the University of
California, 1975) p. 11.
In July 1969, a conservative White House declared that the nation faced a serious breakdown in its whole medical care system, and leaders from all political areas spoke of the "health care crises," that urgently required corrective action.13

There were many National Health Insurance proposals introduced in the early 1970's. Senator Edward M. Kennedy made the first introduction in August of 1970; and in January of 1971 he proposed a new bill for comprehensive health insurance which would have covered the entire national population. It was called the Health Security Bill. In February 1971, President Nixon sent Congress a message on "Building a National Health Strategy." It called for, not only mandatory health insurance—the first such program by a Republican leader—but modifying the fee-for-service system through encouragement of "health maintenance organizations" (HMO). Within eighteen months, a dozen other health insurance bills had been introduced in Congress, including measures sponsored by the American Medical Association, the commercial insurance industry, and the Republican administration itself. There has been separate legislation on Health Maintenance Organizations (HMO), Professional Standard Review Organizations (PSRO), on national health planning, and on other aspects of the health service industry.14

The experience of Medicare and Medi-Cal over the past ten years has fully substantiated that more than a financial solution is required if the United States is to provide a sound system for delivery

13 Ibid., p 12.

of health care to all who require such services, regardless of their financial or social standing in the country. This brief review of the evolution of national health insurance in the United States points out that the costs of medical care, accessibility to medical care, and the control of its quality and quantity, have all become primary political issues. At the same time, it is quite evident the whole system of delivering medical care services to all people in the United States requires major overhaul and establishment of realistic goals. Implementation of established goals will require support and financing by the Federal, State and County governments.

Government can supplement the effort of the individual patient. It can do this by helping to finance the deficit between the total cost of care and what the patient can pay. It is self-evident that first rate medical care must be appropriate to the needs of the patient medically, socially, economically, and psychologically. Under such a system, it is possible to control quality; for the patient would help control quality through his role as the person who selects and pays for his care, and the professions help control it through the use of their professional skills. Government programs and voluntary programs must be supports only—supports to the patient when costs exceed means.  

The programs, governmental and voluntary, must be financed by the prepaid method of payment. The patients must retain the freedom of choice of physicians and hospitals without the possibility of losing their benefits. Patients who desire special services must pay for them.

Purpose

The National Health Insurance Program would establish comprehensive health care benefits and services to all United States citizens. It would be Federally financed and administered by the U.S. Government. State and Local governments would also assist in developing the methods and means for organizing the delivery of medical care and developing health resources to meet the demands of the public for more and higher quality health care.

The National Health Insurance Program would help to curtail the rapidly escalating cost of medical care, eliminate incomplete and partial protection for those people who have private health insurance that does not provide full protection. It would eliminate inadequate protection against the cost of medical care associated with catastrophic illness or disease. It would eliminate the uneven distribution of health resources and services, and create more interest from the providers of health care. It would create incentives to improve the efficiencies and effectiveness for utilizing scarce health care resources.16

The private insurance companies which will provide the insurance coverage for all citizens, will be required to prepare standardized insurance packages, and price competition will become very important. This will create two beneficial results--administrative costs will be held to a minimum, and selling costs will be held to the socially efficient level.

There are, however, several tempering factors. For one thing

16 Ibid., p. 110.
if all existing insurers are of minimum, efficient size, the industry will be significantly more concentrated than it is now. With far fewer insurance firms, collusive behavior is more likely; of course, if the firms collude, then there is no reason to expect that society will enjoy the benefits of efficient management. For another thing, consumer confusion will not be totally eliminated by the standardized packages.

One of the most difficult issues to resolve in a national health insurance plan is how the provider will receive reimbursement for the services he has provided to patients. Cooperation on the part of the providers, hospitals, physicians, and others, is essential and mandatory if the plan is to be successful. At the same time, the filing of claims for reimbursement of services, or to receive authorization to obtain the required health care services, must not be confusing, complex or lengthy. If they are, it will discourage patients, or providers, from having any desire to participate in the plan. This would create hardships on all parties and would lead to failure of the plan to fulfill its goals or objectives to provide health care services to all Americans.

National health insurance payments could be made to insurers or health maintenance organizations on a capitation basis rather than on a premium basis. Use of a repetitive procedure could determine the capitation fee. This type of payment would serve to internalize the incentives for efficiency just as it is done in presently existing health maintenance organizations. Insurers, thus, would have strong
internal incentives to assume an advocacy role. 17

This brief review of the evolution of National Health Insurance clearly establishes that the costs of medical care, accessibility to medical care and the control of its quality have all become political issues. There is a great involvement both of the Federal Government and the State and Local Governments; and with the pressures being placed upon the representatives of the people, one can expect that a National Health Insurance Program of some sort will be adopted to protect the public and to provide general health service to all of the citizens of the United States in the near future.

Chapter 2

NATIONAL HEALTH INSURANCE

During the past thirty years, Congress has considered a succession of legislative proposals intended to substantially alter the role of the Federal Government in providing personal health care services to the American people. These various measures are loosely classified as "National Health Insurance" which include specific proposals having the endorsement of widely diverse groups and representing a variety of philosophies. Each of the separate plans would give the National Government more responsibility, in varying degrees, for the financing of care, the regulation of health providers, and in some instances, the organization of the health delivery system.\(^\text{18}\)

To establish alternative approaches to National Health Insurance requires decisions about a multitude of issues. The plan must be designed so that it not only meets today's needs, but also is flexible enough to adjust to the demands of changing medical technology. Deciding which of the many possible features of a National Health Insurance Plan should be included, is not always a clear-cut choice. In most cases, some trade-off must be made between one set of advantages and another. The first choice to be made in designing a National Health Insurance Plan is as to the extent of population coverage. National Health Insurance aims primarily at assisting people with low incomes.

or high medical bills. Yet a National Health Insurance Plan that attempts to meet only their needs may fail to do so. Demands on the medical care system by higher income people, who are excluded from the plan but covered under private insurance, may divert resources away from the poor. Physicians may find treatment of higher-income patients financially more attractive than serving the poor, and, moreover subject to fewer constraints on their methods of practice. The supply of resources available to low-income persons is thus inevitably interlocked with patterns of medical care for others.¹⁹

Therefore, the major goals of National Health Insurance cannot be achieved so long as there are segments of the population that do not have adequate protection against the high cost of medical care. Universal coverage without regard to family compensation, employability or Social Security contribution history seems to provide the most equitable solution.²⁰

The National Health Insurance Program should cover a wide range of necessary health services required to meet the needs of every American citizen, and services that should be considered as high priorities are: (1) medical services that reduce mortality or increase productivity, hence benefiting all Americans as a whole; (2) medical services that add substantially to the financial burden for an individual;


²⁰Ibid., p. 57
(3) medical services that are so essential they will be sought regardless of cost; (4) medical services that constitute acceptable lower cost substitutes for covered services. 21

National Health Insurance must cover the care in a doctor’s office as well as hospital care. It must cover treatment for illness as well as services to prevent illness, such as Well Baby Care and Physical Examinations. It should cover prescription of drugs, eye glasses, hearing aids, and it should even phase-in coverage of dental care, starting with children. The elderly and disabled must have improved health security and homemaker services must be covered, meals on wheels, and other services aimed at helping people who are unable to care for themselves to remain as independent as possible in their own homes. 22

American medical science has made great advances in curing disease, easing human distress, and prolonging life. Yet, medical services are still unavailable to many United States citizens, due to the high cost of the medical services required to provide adequate health care. The point has been reached in the United States where decisive action must be taken to remedy the problems of the health care system. The citizens of the United States need a program of National Health Insurance. There are some sixty million people in the United States who have little or no protection against the cost and perils of poor

21 Ibid. p. 58.

health. "The American people want National Health Insurance," and in a few short years it will be a Federally funded and necessary program.  

The National Health Insurance Program is essential to all of the citizens of the United States; and when they get it, it is essential that it be a plan that preserves and builds on the strengths of the existing system of health care. The present system is not perfect, and it has a lot of room for improvement. It presently exists with lots of problems; however, many of the problems are that too many citizens of the United States have no health insurance at all, and others have spotty or unbalanced coverage. That puts too much emphasis on hospitalization and too little on home health care, physicians visits, or prescription drugs. The United States needs to plug those gaps in health coverage—plugging the gaps in the National Health Services field can be done very effectively without throwing out, or totally altering the whole system. The existing system for health care delivery provides the best doctors, the finest research, and the finest health institutions in the world. Presently, the government has been kept from interfering with the relationship between the patient and his doctor. The majority of the American people agree that a need exists to progress from the present method of health care services delivery with support from a National Health Insurance Program.


24 Ibid., p. 2.
The National Health Insurance Program must define the proper role of physicians, hospitals, and paramedic responsibilities, and the proper role of social workers and health educators, nutritionists and psychologists to insure that a meaningful program is developed and implemented. The program must improve and protect the health of all Americans while maintaining health expenditures within reasonable limits.  

The National Health Insurance Program must insure that the United States government's and each American family's health care dollars are spent wisely, carefully and less wastefully. National Health Insurance has become a major issue today because of the rapid and uncontrollable increases in medical costs under the existing programs and system of controls. A major objective must be to stop the rampant inflation in health care costs and maintain health expenditures within reasonable limits.  

The National Health Insurance Program for the United States citizens is an issue today because the present method of getting and paying for health care is dangerously near total collapse. Too much is being spent for health care, and the quality of health care is not what it should be, and the health care is not available to many who need it.


26 Ibid., p. 18.
most. Present health insurance pays less than one-third of the health bill for those covered. Millions of Americans are not covered. The predominant evidence for the failure of health care services to reach many who need it most is found in the following widely accepted statistics: the poor have twice as much illness, four times as much chronic illness, three times the heart attacks, and five times the eye defects, and five times as much mental retardation.

Private health insurance has failed to come close to meeting the nation's needs for adequate coverage. In fact, private health insurance pays less than one-third of the health costs. The rest comes either out of private pockets or is paid by the government. Many millions of Americans have no health insurance. Millions of additional working people, and their families, do not have the security of knowing their hospital and medical costs will be paid during lay-offs and periods of unemployment.

The United States cannot afford to wait for solutions that the private health insurance industry is incapable of providing. Therefore, the National Health Insurance Program will have to provide incentives to help maintenance organizations and all medical foundations to insure that they operate at their peak and in the most efficient and effective manner. Physicians must receive incentives to become members of the primary health care teams to insure that they establish good working relationships with specialists and with patient care resources, such as hospitals, skilled nursing homes, and home health facilities. They should be reimbursed for the cost of such linkages and be encouraged
to extend their services throughout such support arrangements.  

Once the National Health Insurance Program is adopted and implemented, there should be a continuing requirement that the governmental agencies support continuing studies of new and promising methods of organizing and delivering health care services.

The National Health Insurance Program would be administered under the Social Security System, similar to Medicare, and paid for out of payroll and other taxes. By using taxes, rather than a flat insurance premium, American families can be assured that they will have to contribute to the cost of their care on the basis of their income, rather than on the basis of their past medical history or any other factor.

The administration of the system through Social Security will provide controls on costs, create incentives for greater efficiency in health care, and keep health care costs down to a price the nation can afford. The program will assure every American of his right to receive good health care, just as he is assured an opportunity to get a good education. The program will provide every American the opportunity to obtain preventive medical care. The young and old, who are crippled at birth or in old age, will be provided good medical care without causing them to become charity patients because of catastrophic expenses which they cannot afford to pay.

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27 Ibid., p. 102.

Chapter 3

THE IMPACT OF NATIONAL HEALTH INSURANCE ON COUNTY MEDICAL FACILITIES

County medical facilities for many years operated as public charity hospitals. Their purpose was to provide adequate medical treatment to the indigent population of the various counties. The services provided by the public charity hospitals, at that time, covered 90% of the indigent patients, both inpatient and outpatient. The reimbursement for costs was paid by the state and county tax funds at taxpayers' expense.29

In 1965, the Social Security Act was amended with what is commonly known as the Medicare Program (federal) and (state) Medi-Cal Program, known throughout the country as Medi-Cal, or in California as Medi-Cal. Since that time, there have been two significant trends which have greatly affected the hospital industry. First, the Medicare and Medi-Cal Programs have provided many indigent patients with the means to purchase medical services from private hospitals and physicians; therefore, drawing indigent patients away from the county medical facilities. Secondly, since the Medi-Cal reform laws for California took effect in late 1972, there has been a legal requirement

for public hospitals to decrease the length of inpatient stay and provide more services. 30

These changes and the certain advent of a national health insurance program have redirected the county medical facilities' emphasis to care through outpatient clinical services. The health care services system has been created as programs developed, and has had hastily prepared regulations established for it by the federal and state governments. County medical facilities are presently looking for more concrete regulations for obtaining fiscal reimbursement which will offset the continuing program changes. It is believed that the more aid and assistance an indigent (destitute) patient receives, the more he will take. He takes advantage of the health services provided, wherein, there is no expense to be born by the indigent patient. With this philosophy, there is no doubt that it causes increases in medical care costs and forces county medical facilities to increase their costs to meet the ever-increasing population of indigent patients making use of this care.

County medical facilities, the major source of public health care for low income people, are in deep trouble. Local taxes cannot keep up with the county medical facilities ever-mounting costs. Counties are unable to improve county medical facilities, and therefore are figuring out ways to sell or transfer the operation of the facilities to the private sector, or to corporations who will operate the medical facilities on a lease basis with a need to financially

operate the leased facilities at a profit. This will create more competition to the already existing private hospitals. The private sector or corporations will take care of program patients, private insurance and private patients, and charge the counties for indigent patients only.31

The private sector throughout California is pressuring county governments to close, or reduce in size, their medical facilities, and to pay private hospitals for the care of low-income patients. Private hospitals are not interested in the program patients, such as Medicare and Medi-Cal, because of the heavy burden placed by regulations for justifying the care and services provided to patients. Thus, everything is stacked against county hospitals which is known and strengthened by many authorities, such as, Elinor Blake of the San Francisco staff for the Health Policy Advisory Center in New York.32

From the very beginning, America's health care system has been based on economic class. Wealthy and middle-class people were attended by private physicians in their homes. Care for the destitute, on the other hand, was left to public poor houses which were used like jails to separate the undesirable and contagious from society. The country's first hospitals—typically dirty, overcrowded, and poorly ventilated—were never used for the treatment of well-to-do patients. In fact, since medicine had little to offer the sick, they were not a place for treatment at all, but a place to die.33

31Ibid., p. 1.  
32Ibid., p. 2.  
Even in this century, the county medical facilities are still seen by many of their users as places to die, whereas in the private hospitals, they are considered places to get well. With the emergence of scientifically-based medicine, university affiliated medical schools began to use urban public hospitals for teaching and research. Poor patients receiving free medical care were in no position to object to being used as teaching and research subjects. The medical schools would supply cheap medical manpower to the charity hospitals, and they in return would foot the bill for a great deal of the schools' operation.

The California County Hospitals, since 1855, have been responsible for the health care of the poor people. The California State Welfare and Institution Code, Section 17000, states that:

Every county and city shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends by their own means or by State Hospitals or either state or private institutions.

Until recently, county medical facilities in California were generally open only to the medically indigent. People, able to pay, had to be referred to private doctors and private hospitals. This was first established in 1933 when a group of Bakersfield doctors sued to stop Kern General Hospital from admitting paying patients. The doctors won. The California Courts determined that county hospitals were not to compete with private facilities, but were to fill in the gaps unprovided by them. In this way, the private sector would not receive competition from tax supported institutions.\textsuperscript{34}

\textsuperscript{34}Ibid., p. 4.
The Medi-Cal and "County Option" programs provided by federal and state funds were originally designed to relieve the burden placed on the counties. However, the counties first had to contribute a significant portion of the Medi-Cal budget through yearly lump-sum payments to the state. Second, the Medi-Cal patients would gravitate to private care, leaving county hospital facilities with the medically indigent who were ineligible for Medi-Cal. The California Legislature passed an all important clause in the Medi-Cal Law. The "County Option" which is no longer in existence provided that the state would pay all expenses for county hospitals above the base year 1964-1965, which was the date prior to adoption of the Medicare and Medi-Cal Program. 35

In addition, the Medi-Cal Law overturned previous court decisions and allowed county medical facilities to open their doors to private patients. However, the dream of Medi-Cal's creators failed to materialize. Governor Ronald Reagan soon limited funds for the county option so that county hospitals by and large failed to upgrade their facilities to attract private patients and become community hospitals for rich and poor alike. Private patients and doctors continue to view county medical facilities as institutions only for the poor.

Yearly Medi-Cal cut-backs reversed the 1966 shift toward federal/state financing of medical facilities, but the final blow came with the 1971 Medi-Cal "Reform" Act. Though the act placed more people on Medi-Cal, at the same time it abolished the county option, raised

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35 Ibid., p. 5.
each county's contribution to Medi-Cal budget and lowered rates at which Medi-Cal reimbursed county hospitals. Under this reform act, it was impossible for the county medical centers to upgrade their facilities, or even to maintain them at their present status because of the increase of funds required to be paid to the state for their program. 36

The private hospitals have always exploited their public counterparts. In the past, they have taken away paying patients and sent non-paying and undesirable patients to public facilities. This "patient dumping" has reached enormous proportions. This creates problems in the emergency departments of the county medical facilities and causes deaths due to transfers from the private sector to county medical facilities. With the pressures being placed upon the county medical facilities by the private sector; a multitude of people who can't go to the private sector will not receive urgently required medical care. 37

When the California Counties close their hospital systems, the patients and the taxpayers will lose as the patients will have to receive services through the contracting-out method for county government, which is that the county government pays the private sector their charges for taking care of the indigent patient. This, in reality, provides that counties contract, or form agreements, with private hospitals to provide health services to indigent patients.

At the present time, many of the physicians being trained are

36 Ibid., p. 5.
37 Ibid., p. 5
receiving their training through the county medical facilities. Contracting out, though ideal for private hospitals, is a problem for money starved county governments. If counties paid for everyone without Medicare, Medi-Cal, and private insurance, their hospital costs could soar to unreasonable and catastrophic totals. Unless the private sector makes more physicians available to care for patients under county contracts, these contracts will be empty promises by the private sector hospitals.

The medical schools have traditionally formed affiliations with county hospitals. The schools provide doctors to give service, and the county supplies the staff and an equipped facility for teaching purposes. The medical schools obtain virtual control over the health care delivered, yet they have no responsibility for the hospital financing. 38

Under-financing and fragmented administration have plagued the county medical facilities throughout California and the nation. Closure of public hospitals solve problems for local politicians, but create new problems for patients who are left to their own devices. Private hospitals and doctors show little, or no willingness or capability to take care of everyone. Legally, the public has control over the resources of governmental hospitals. However, people must fight to maintain this control since it can slip away into the hands of the complex bureaucracy in private contracts such as medical school affiliations, or via bought-off public officials. The widespread

38 Ibid., p. 7
belief that health care is a service rather than a business implies that health institutions should become increasingly public, not increasingly private. The closure or private takeover of public hospitals is an assault on that belief.  

When Medi-Cal went into effect, everyone expected that the "freedom of choice" it supposedly offered would lead beneficiaries away from "charity care" into the "mainstream" of medicine. Private hospital spokesmen predicted that county and municipal hospitals would become obsolete. Public Health Administrators, on the other hand, looked to Medi-Cal as a source of funds to upgrade their hospitals to the level of the best private hospitals.  

Both were wrong. In the first year of the program, county facilities did see fewer patients, but the decline was small and of short duration. Many patients who sought care in the private sector returned to county facilities soon after. The public hospital administrators' dream of converting their facilities into institutions competitive with the private sector faded as Medi-Cal quickly threatened to bankrupt state and federal treasuries.  

To slow down the outpouring of funds, cutbacks ensued in state capitols and in Washington. With each cutback, fewer people were eligible for fewer services. As fees went down, paperwork went up, and the

\[39\] Ibid., p. 12.  
\[41\] Ibid., p. 13.
private providers became less willing to give care. Altogether, financial responsibility reverted increasingly to county governments.  

California was one of the first states to take advantage of the government program called Medicaid. California called its program Medi-Cal, and it offered the most generous services and standards of eligibility in the nation when it went into effect in early 1966.

In the early days of the Medi-Cal Program, it was easy to see that two complementary but separate forces were at work in California. One was the political ambition and ideology of the Governor and his staff, and the other was the massive cost of Medi-Cal. The Medi-Cal Program has been expensive, but state administration exaggerated its problems and manipulated figures to justify extreme corrective measures, which in turn has created more problems for lower income Californians, who needed the medical health care services.

Medi-Cal is a good example of the failure of financial insurance which alone cannot guarantee adequate health care. Possession of a Medi-Cal Health Card does not mean that the patient can find a doctor even if every physician agreed to treat Medi-Cal patients. A mal-distribution of doctors, geographically and among specialties, would continue to leave large numbers of people with no primary physician, as is already the case. Moreover, paying for health services does not assure that services will be available in an emergency or on weekends. Medi-Cal highlights, but it is not able to correct the inadequacies of the health care system. A national health insurance

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42 Ibid., p. 13.  
43 Ibid., pp. 14-16.
program must not only provide physician coverage, but facility coverage and prevent catastrophic illnesses through the use of preventive medicine for all Americans. 44

It is almost impossible in today's hospital journals and news items to avoid articles or references to the problems and difficulties facing public hospitals. Although the advent of Medicare and Medi-Cal had suggested the rapid demise of the public medical facilities, no real evidence has been provided to support this contention. In point of fact, the legislation of these two programs has served to magnify and spotlight the "plight of the public hospital." 45

One of the major problems of the public medical facilities has been the lack of adequate funding. This is primarily due to the fact that the present types of funding are unable to provide sufficient financial support. County medical facilities primarily exist to serve the local entity and its constituents; therefore, their main source of income has been the property tax. But property tax resources have not been able to meet increasing health care needs because the property tax rate has risen at a less rapid pace than the rate of health care costs. Federal programs, such as Medicare and Medi-Cal, have not improved the situation because they change so often and are so limited in what cost they will reimburse the hospitals, and what health care services are to be provided to program patients. The public medical

44 Ibid., p. 19.
facilities usually have to assume anywhere from 30% to 60% of their costs through local government appropriations. Another set of problems for the county medical facilities has been the result of local government control, interference and insensitivity. The bureaucratic inefficiencies that result from government civil service restrictions; budgetary problems that are primarily caused by the costly process of line-item budgeting, misplacement of authority which leads to those individuals with responsibility not being given proper authority to operate, innovate, and develop programs, and the time lag caused by the systems and the centralized functions of government. Each of these hinders the effective administration of programs and policies. These inefficiencies are compounded by the fact that health care is competing with police and fire protection, housing development, and maintenance of streets and roads for local government support. The result of these bureaucratic entanglements is a system that greatly hinders effective management in county medical facilities.

One of the basic needs to improve the status of the county medical facility is the development of a new means of financing. The most logical solution for new financing must be developed and supported by a federal program of national health insurance. Almost any form of national health insurance would still result in a group of individuals with incomplete coverage, and they would have to be taken care of in county medical facilities (no proposed health insurance plan covers every contingency); nevertheless, an influx of federal funds could certainly put the county medical facilities on a more equal footing.

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46 Ibid., p. 2. 47 Ibid., p. 3.
with the community and private sector hospitals. If national health insurance does not arrive in the near future, both state and local governments must be prepared to accept a larger share of the financial burdens of the county medical facilities. Finally, if neither one of these events occur, (new financing or national health insurance) the county medical facilities must be prepared to venture forth alone and develop some form of financing that meets its needs and the needs of the patients. One system could be enterprise fund financing that could provide working capital to make public hospitals successful. However, the County's Board of Supervisors would have to provide payment for services provided to the county's truly indigent patients.

The county medical facilities must develop new organizational structures and management techniques if they are to survive. Systems will have to be developed that will enable county medical facilities to collect what is owed them more rapidly, to bill properly, and to assess their costs effectively. The county medical facilities must initiate a change in their health care delivery systems which is in need of revision and change. A national health insurance program will require changes to existing programs and regulations.

The restructuring of America's health service system must take an entirely different approach. This does not imply that consideration of a national health care delivery system means the nationalization of the health provider industry. Any national health care services delivery system program will look toward a continuation of the private

48 Ibid., p. 9. 49 Ibid., p. 10
provider and practitioner sector, and will focus on two major issues: first, the degree to which the health insurance industry is federally versus privately financed and operated, and the degree and type of change to be effected in a health delivery system; second, and how this change can best be brought about.  

The county medical facilities today no longer serve a limited constituency made up of only the poor. Today, everyone, regardless of his economic or social class, looks upon the county medical facility as a place to be treated for a major illness or injury. Hospitals today are the major source in this country for medical research. They are also the major means for applying research to curing and preventing diseases. With the increased public expectations of county medical facilities, there has evolved the attitude that health care is a right, and not merely a privilege. Patients no longer come to the county medical facilities asking for help. They now demand high quality care, rendered in a personalized, dignified and economical manner. If the patients don't get this type of service, they complain to their elected officials.

Changes in today's county medical facilities can be measured in the population trend. The numbers of the very young and the very old have grown, and their special health care needs, which have grown at a faster rate than the population as a whole, demand the greatest

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51 Ibid., p. 35.
financial and scientific resources. Pre-payment plans, such as Blue Cross, Blue Shield, Medicare, and Medi-Cal, have greatly increased the number of patients seeking hospital care, and the demand to improve the quality and range of services.\textsuperscript{52}

Today's county medical facilities are delivering more care to more people, more intensively than ever before. There are many changes which they are expected to absorb. County medical facilities are no longer in the position to cure just illnesses or to treat injuries once they have occurred. County medical facilities are now called upon to do the job once done by clergymen and social workers. They are called upon to care for the alcoholic and the drug addict, and these responsibilities only suggest that a much greater job is expected of county medical facilities by the public. There will continue to be many new programs and requirements that the public will expect county medical facilities to accomplish and control without additional financing or facilities. This impact must be planned for and needs must be met if the Americans are to receive full medical services which they feel is their inalienable right.

\textsuperscript{52}Ibid., p. 35.
Chapter 4

BASIC PLAN FOR A NATIONAL HEALTH INSURANCE PROGRAM

The basic goals of a national health insurance program would be to establish a broad system for health care services and delivery in the United States, not just set up a method of paying bills for doctors, hospitals, and other health services. National health insurance would be equally concerned with making health care services available to all Americans. Improving the quality of care and holding the costs of the care within reasonable limits will be mandatory for the program to succeed. The program would be a working partnership between the public and private elements of the medical society concerned with health care. Health care would be provided by physicians, hospitals and other private sectors in much the same way as it is done today; but it would be financed and administered through the United States Government.\textsuperscript{53}

The national health insurance program would not establish requirements wherein the United States Government would own the facilities and employ the personnel and manage all of the finances of the health care delivery system. The funds made available through the national insurance program would finance and control the essential cost of good health care delivery for all Americans. These funds would also

build a foundation to provide adequate, efficient and reliable health care services to all Americans. 54

The national health insurance program must be designed so that it not only meets today's needs, but also is flexible enough to adjust to the demands of changing medical technology. Determinations will be required to establish the many possible features for a sound national health care program which will provide all Americans with preventive medical services, immediate medical services, and protection and funds to meet the medical care expenses for catastrophic illnesses.

The basic issues in establishing a national health insurance program requires evaluating the possible alternative approaches to determine which of the multiple issues the program should address itself to if the overall proposal is to provide adequate health care to all Americans:

I. WHO SHOULD BE COVERED BY NATIONAL HEALTH INSURANCE?

A. The national health insurance program must be designed to provide medical services to the total American population. Today, governmental programs are primarily aimed at assisting people with low incomes or high medical bills. The national health insurance program must attempt to meet not only their needs, but the needs of all Americans. If the national health insurance program only provides medical services to low income people, the program may totally fail. If the wealthy patients are not covered

54 Ibid., p. 104.
by the total program, their demands may require, or dilute, the availability of physicians to treat the poor.

B. Physicians and private facilities may find the treatment of higher income patients financially more attractive; and therefore, refuse to treat the poor, while at the same time they would have fewer restraints on their methods of practice. 55

C. Everyone living in America would be entitled to have all health care with few exceptions paid for by the national health insurance program. The program would have no exclusions for pre-existing conditions. There would be no limits on preventive medical services, no co-insurance, no deductible, and most importantly, no waiting periods. 56

D. While universal coverage does have disadvantages, the major goals of national health insurance cannot be achieved so long as there are segments of the American population that do not have adequate protection against the high cost of medical care. Universal coverage for all Americans, regardless of their family composition, employability, or Social Security contribution would provide the most equitable solution for all Americans. 57

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57 Davis, op. cit., p. 57.
II. WHAT SERVICES SHOULD BE COVERED BY THE NATIONAL HEALTH INSURANCE PROGRAM:

A. The range of medical services provided under national health insurance would be wide and emergent. Services included should be any type of medical services that will eliminate sickness to Americans. Services should be provided, not only in physicians offices and hospitals, but also in outpatient clinics. The types of services that should be available are:

1. Physicians' Services, which would include professional services by physicians furnished in their office or elsewhere, and this coverage should be in full.

2. General medical major surgery, and other specialized services, if performed by qualified specialists.

3. Psychiatric Services, would be provided to outpatients if given for active treatment of emotional or mental disorders, and if provided by comprehensive mental health organizations.

4. Dental services would be limited to children, and it should also include all preventive diagnostic and therapeutic services.

5. Emergencies and Rehabilitative Services for adults, such as oral surgery to correct accident damage.

6. Institutional Services would be provided for full payment of hospital services.

7. Skilled Nursing Home Care, would be covered, and other approved non-custodial health care services and home health care services.

8. Pathology and Radiology Services and all other necessary services whether it is furnished by a hospital or other institutional facility.

9. Physical, Occupational, and Speech Therapy drugs would be covered for hospital inpatients and outpatients and for persons enrolled in comprehensive plans and professional foundations as long as the drugs were on approved lists.

10. Drugs that are necessary for specific chronic diseases and conditions requiring long and costly drug therapy would be covered.

11. Devices, Appliances, and Equipment, required for therapeutic services, such as physical therapy and occupational therapy; and appliances, including eye glasses, hearing aids, and prosthetic devices and equipment. All such equipment would be provided if it was on approved lists of covered items.

12. Other Professional and Supporting Services, would be covered, such as optometrists and podiatrists.

13. Diagnostic services of independent pathology laboratories.

14. Diagnostic and therapeutic services of independent radiologists, mental health day-care services, ambulance services, and other professional services, such as psychological counseling, physiotherapy, nutrition,
social work, and home care or health education.

15. Diagnostic and therapeutic services of free standing alcohol, drug abuse, family planning, and rehabilitation centers.

III. HOW SHOULD THE NATIONAL HEALTH INSURANCE PROGRAM BE FINANCED?

A. It is clear that money alone will not solve health care delivery services problems. If only money is added through national health insurance, without specific increases in health manpower, or the change in medical care organization, the program will generate more inflation and create general chaos. However, it is clear that the financing of medical care services is essential as it is closely intertwined with professional and patient motivation and other aspects of the medical care delivery service organizations. 59

B. One of the most controversial issues related to the national health insurance program is what role there should be for direct payment by patients. By establishing a program cost sharing of services to be provided creates several problems of which the most important is, should some patients or services be exempt from cost sharing for certain patients. There are some services that many patients would never use. Should they be expected to pay for such services? The financing

of the national health insurance program will require review and decision of the appropriate method or methods to insure that a regressive tax structure is avoided, to prevent adverse affects of employment, and minimize any windfall gains to those providers currently financing medical care.

C. The equity in financing is considered to be regressive if its costs represents a higher fraction of income for lower income than higher income families. In the case of national health insurance, the cost is the sum of the premiums and taxes, whether payroll or other Federal and State Taxes paid by the family, either directly or indirectly.

D. The control of finances for the national health insurance program should be through the Health Security Trust Fund similar to the Social Security Trust Fund.  

E. The financing of the program would be based upon premiums, payroll tax revenues, and Federal and State general revenues. The financing by premiums paid directly by employers or private individuals to private insurance companies would limit the Federal Budgetary Costs of the plan. However, if the premium is mandatory, this lower budgetary cost is actually no different from a tax assessed on the employer for purposes of providing the benefits.

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F. Prior to implementing the national health insurance program and the financing thereof, the government should match the funds that have been accumulated towards the program. After setting aside contingency reserves and money for the development of additional health resources, the remaining money would be divided throughout the various programs in the national health insurance program. This would be done with regard for recent and current use and expenditure patterns provided by the program. 61

G. Following the establishment of, and distribution for allocated funds, the various program elements would be determined by actual expenditures and estimates established of what was needed to meet the program obligations and objectives.

H. The national health insurance program and its cost should not only be fairly born of varying incomes, but families with the same income should be treated equally. Making all sources of incomes subject to taxes is one means of achieving this end. The inequity of using family incomes becomes detrimental when a family living in an area with limited medical resources and low medical prices may receive lower payments from the plan than a family with the same income and premiums that lives in an area with ample medical resources of high quality. 62

61 Ibid., p. 111
IV. HOW SHOULD HOSPITALS, PHYSICIANS, AND OTHER PROVIDERS BE PAID?

A. The financing of the national health insurance program is very important; however, cost control features must be established and defined within a budget established in advance. The national health insurance program would establish an advance budgeting procedure for the cost of personal health services. Advance determinations would be made of the total amount to be spent in the various areas throughout the United States, regarding physician services, institutional services, and other categories of services provided in local communities. The cost of each of these services and the overall cost of the national health insurance program would be allowed to increase on a controlled and predictable bases.

B. The program would use the budgetary process to control costs and to strengthen local, state, and regional planning. This would stimulate more efficient institutional administration and gradually reverse the current undesirable emphasis on inpatient hospitals and other institutional services. This can only be accomplished by stressing preventive and early curative health care services and by making alternative levels and forms of care available outside of institutions.63

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C. The national health insurance program would provide coverage for all kinds of medical expenses; however, one of the difficulties will be to establish what would be a medical expense, such as physicians services, medicines, and psychiatric services, etc.; and a non-medical expense, such as, eyeglasses, hearing aids, and orthodontics, etc.. These become very controversial points when trying to resolve what the program would cover and what the patient would be expected to provide at his own expense. 64

D. One of the most difficult issues to resolve for a national health insurance program is how to pay providers of services. The cooperation of hospitals, physicians and other providers is not only essential, but mandatory if the program is to be a success; and any substantial reduction in their relative incomes or changes in their modes of practice may delay meeting the objectives of the program. One very important objective of the national health insurance program is to limit rises in medical costs and encourage more efficient and effective use of resources. 65 A major issue for national health insurance is, should reimbursement or payment constitute total payment for services, or should physicians, hospitals, and other providers be permitted to charge some patients, or all patients, more than the plan allows?


E. Experience with the Medicare Program suggests that given an option, many physicians may choose to charge more than the allowed reimbursement, thus, undermining the objectives of the national health insurance program. The program is to insure that medical care is not unduly expensive for those with limited means so as to eliminate the financial burden of medical care for all and to restrain cost increases.

F. Hospitals and other types of institutional providers would operate on an approved budget basis rather than being able to charge whatever they decided was required. Hospitals would receive reimbursement based on previous fiscal experience, taking into account standards of participation, range of desirable services, and quality controls required by health security.

1. The hospitals and other providers would develop proposed budgets for the next fiscal year, and they could be assisted by the regional and local offices of the health services agencies while they prepared their budget requests. The budgets would be reviewed and given final approval at the health services agencies level.

2. Physicians would be provided reimbursement on the level established by the program as allowable. Several choices among reimbursement methods would be made. Physicians could be reimbursed on the basis of customary or usual fees, according to a pre-established fee schedule, or on a salary basis.
Each of these methods of reimbursement has its own set of incentives, and abuses could occur under any one method. 66

G. A uniform national payment plan would provide positive incentives for physicians, and they would be provided additional payment if physicians were to locate in a lower cost area, or move to an area where there is a shortage of medical services. Other providers, such as pathology, laboratory, radiological services, pharmacies, and providers of appliances would be paid through methods adapted to their characteristics.

H. Under the national health insurance program, hospitals, physicians, and institutional providers would be required to agree not to charge individuals for all, or part of any service provided. Payment in full would be made directly by the national health insurance program to the provider or the agency representing him. There would be no billing to the patient for services provided. If the provider operates in a Health Maintenance Organization (HMO), or a professional foundation which has accepted responsibility for providing, or securing all covered services for a defined population, it would receive the total amount budgeted and negotiated for providing patients health care services. They would

66Ibid., p. 78.
also share in the savings they helped to achieve by preventing unnecessary hospitalization of their enrollees in their HMO's, or professional organizations, or foundations.

I. Reimbursement to other providers would be made possible through the determination in advance of the provision of services and the cost experience encountered by the institutional provider. This type of reimbursement could easily lead to an ineffective and inefficient operation because there would be no incentives, or no reasons for a provider to improve his efficiency or effectiveness in providing the improved care.

J. The national health insurance program would be compulsory because it would be financed through taxation. Persons with higher incomes would not be willing to pay more for their health care insurance than it is worth as their excess would be used to subsidize patients with lower incomes. Some persons might not be willing to purchase such comprehensive coverage even at subsidized premiums. The national health insurance program would be an all-or-nothing program.

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To insure that health care is delivered at reasonable costs, it would be necessary, and advisable, to maintain governmental controls

over some or all health care fees, charges, and wages to avoid runaway costs. With controls and budgets established, the providers of health care services must be held responsible for bad judgments in projected costs. They must have established quality and quantity controls which, when installed, can be monitored to assure that the provider also takes a risk to provide the health service at a sound, reasonable cost. The risk then is not only born by the purchaser and patient, but also the providers.

\footnote{Committee for Economic Development, Building a National-Care System, Committee for Economic Development, New York, N.Y., April 1973, p. 75.}
Chapter 5

ANALYSIS OF MAJOR LEGISLATION COVERING
NATIONAL HEALTH INSURANCE PLANS

Congress has considered a succession of legislative proposals intended to alter the role of the federal government in providing personal health care services to the American people. The various measures are loosely classified as, "National Health Insurance" and include specific proposals having the endorsement of widely divergent groups and representing a variety of philosophies. Each plan would give the federal government more responsibility in varying degrees for financing of care, the regulation of health providers, and in some instances the organization of the health delivery system. 69

The analysis of national health insurance entails examination and consideration of several interrelated issues and problems. There is a great deal of concern about the spiraling cost of medical care and about the economic burden resulting from such costs. There is also an awareness of the difficulties that many Americans have in obtaining health services even when finances are no problem. There is much discussion of the strengths and weaknesses of the various ways of organizing the delivery of medical care, and developing additional health resources to meet the demands of the public for more and higher quality health care which they have come to believe is their inalienable right.

The public's interest in the subject of national health insurance has developed in a growing climate of wide-spread public discontent with the present status of the country's health delivery system. Major sources of this apparent dissatisfaction are:

1. Sharply escalating medical care prices.
2. Incomplete and partial protection against medical care expenses paid for by private health insurance.
3. Inadequate protection against the cost of distribution of health resources and services.
4. The absence within the health industry of incentives to improve the efficiency and effectiveness of health resources.

Traditionally, expenditures for health in the United States have been financed from private sources; however, beginning in the Fiscal Year 1966-67, with the advent of the Medicare and Medi-Cal Programs, the trend has been toward increased public financing of health. 70

Although private health insurance has grown over the years, many Americans still have relatively little, if any, protection. Approximately three out of every four Americans have some form of private coverage against the cost of in-patient hospital care; but far less than half the population has coverage against the cost of physician services rendered in the home or office.

Health care costs of a catastrophic nature are among the most difficult to protect against. Although slightly more than half the population under 65 is covered under a major medical or comprehensive health

70 Ibid., p. 2.
plan, many of these plans contain limits on maximum benefits per lifetime that prove inadequate in the face of long-term illness, or the need for exotic medical treatments. Persons without major medical or comprehensive coverage are even more vulnerable to economic ruin in the face of catastrophic expenses.

The allocation and distribution of health resources in the United States are most uneven. In some communities, virtually no hospital facilities are available to serve the public. Elsewhere, there may be a surplus of beds and other needed manpower and equipment resources. Many institutions are old and badly in need of modernization or repair.

The health industry is one of the largest in the nation, and it is also believed by its critics to be one of the most inefficient. Increasing specialization and other factors have established requirements for greater and greater numbers and kinds of manpower. There is concern over the possibly excessive use of costly hospital resources to treat persons who could be equally and more economically served in other ways. There has been criticism that the methods used to pay for health care contain little in the way of incentives for the economical and efficient use of facilities, manpower and special services. The array of national health insurance proposals, which will be analyzed, reflect divergent viewpoints as to what should be considered the priority problem areas to be resolved under a national health insurance program. The proposals analyzed concentrate on meeting the cost problem through improved and expanded public and/or private health insurance. Some proposals

\[^{71}\text{Ibid., p. 2.}\]
incorporate provisions that would reform and restructure the health
delivery system. Several major policy questions have been raised:

1. What is the proper role of the federal government in
financing and administering health insurance?

2. What portion of the population should be covered
under such a program?

3. How should the program be financed—through multiple
public and private sources, or through a single chan-
eling of funds to the public sector?

4. What should be the nature and scope of benefits to
be insured?

5. To what extent should the private health insurance
industry be involved in the program?

6. What is the potential effect of the program on the
organization and delivery of health services throughout
the United States?

In addition to these major policy questions, there are several
pertinent issues which should be included, such as the reimbursement
methods and cost controls to be devised for providers of health services,
provision for consumer participation and control, and the need for
quality control procedures. 72

Proponents of a federalized health insurance approach maintain
that the United States government is not only the appropriate, but per-
haps the only institution through which universal national health

72 Ibid., p. 3.
insurance coverage and equitable financing can be achieved and leverage can be exerted upon the health system to control costs and improve quality and efficiency in services. However, there are some supporters who profess that the decentralized approach should be taken which would require pluralistic financing and administration of health insurance and would seek to minimize government intervention in the health delivery system.73

The detailed analyses of the proposed legislation summarize the salient features of major national health insurance bills introduced into the 94th Congress, drawing particular attention to those aspects of each bill which address the six issues enumerated above. The bills include measures that would:

1. Entitle all Americans to comprehensive health benefits, federally financed and administered.

2. Make the government responsible for financing health care only for the high risk in society, the aged, poor, disabled, and persons experiencing catastrophic illness cost.

3. Provide federally financed economic incentives toward the purchase of private health insurance plans.

4. Mandate employers to purchase adequate private health insurance plans for employee groups and their families.

There were many proposals reviewed and analyzed; however, this report covers seven bills before the 94th Congress. To insure

73 Ibid., p. 3.
continuity and ease of comparison, the bills are presented as follows: bill title, bill number, sponsor, and description of bill. The description of the bill is detailed by: A. General approach, B. People covered, C. Scope of Benefits, D. Administration, E. Financing, F. Payments to providers, G. Effect on other government programs, H. Other major provisions. The seven bills analyzed and presented are:


The analysis of the major national health insurance bills clearly substantiates that the evolution of national health insurance in the United States has been curtailed. Political prediction is a hazardous game, and the cost of medical care, accessibility to it, and the control of its quality, have all become political issues. With so many interrelated issues and problems at the national, state and local levels,
it appears that one can expect that the United States will soon lose its dubious distinction of being the only industrialized nation on earth whose people lack the protection of a social insurance program for general health services. Almost all of the bills sent to Congress encourage changes of varying degree. The continued demands by the American people could force Congress to expedite the establishment of a national health insurance program which will provide national health care services to all Americans who have the desire and the need to go to necessary areas providing medical care services.

The seven major bills have been analyzed and are presented in condensed form to eliminate the extraneous legal verbage from the proposals submitted before the 94th Congress.

1. **Title:** The National Health Care Services Reorganization and Financing Act of 1975, H.R.I., by Representative Al Ullman.

   **Description of Bill**

   A. **General Approach:** The bill would establish a program of comprehensive health care benefits for all U.S. residents, phased in over a five year period, and would provide for creation of Health Care Corporations (HCC's) to cover every geographic area of the country. A federally financed plan would provide health insurance for the aged, low income, and medically indigent, administered through federal contracts with insurance carriers. The self-employed and others could enroll voluntarily under plans made available by the states at reasonable group rates.

   B. **People Covered:** Effective six months after enactment
of the bill, the aged and low-income would be covered under the combined Medicare Program. Concurrently all employers subject to the Social Security Tax, (including non-profit organizations and other employees who have elected Social Security on a voluntary basis) would be required to provide their employees and dependents with the same level of coverage through private insurance plans. The coverage requirement would not apply to the federal government as an employer, but it would apply to state and local governments.

C. **Scope of Benefits:** Initially, the program would cover the level of benefits currently provided under Medicare, plus additional catastrophic coverage which would take effect after health expenditures by, or on behalf of, an individual or family reached a specified limit graduated according to income. Medicare deductibles and co-insurance would not be applicable to low-income groups.

D. **Administration:** All federal health programs would be consolidated within the new Department of Health. The federal government would administer the insurance program for the aged and low-income, and would contract directly with carriers to provide covered benefits. Employer-employee plans would be administered through approved carriers or Health Care Corporations. New independent State Health Commissions (SHC's) would be established in each state to designating geographic service areas for Health Care Corporations, authorizing incorporation of Health Care
Corporations, enforcing regulations pertaining to providers, controlling premium rates charged by carriers and non-affiliated providers, approving charges for institutional and non-institutional providers of services, approving expansion of health facilities and services.

E. Financing: The federal insurance program for the aged would be financed through payroll taxes and general revenues with some cost-sharing for services. Government insurance for the poor and medically indigent would be financed through general revenues with some cost-sharing and premium contributions required of the medically indigent. Employers would be required to pay at least 75% of the premium cost for employee plans, with employees responsible for the remaining 25%. Individual taxpayers would be allowed to deduct 100% of the amounts paid by them as premiums.

F. Payments to Providers of Services: State health commissions would be responsible for determining premium rates to be used by private insurers and Health Care Corporations for mandated comprehensive health care benefit packages. State health commissions would review the activities and performance of Health Care Corporations and non-affiliated providers to assure that providers were meeting their obligations under the bill.

G. Effect on Other Government Programs: Medicare for the aged would be replaced by the new program. Federal financing of Medicaid would eventually be limited to services not covered under the new program. Federal financial assistance under
the Maternal and Child Health Program would be limited to non-covered services for persons covered by federally contracted insurance.

H. Other Major Provisions: The bill provides that every geographic area within a particular state would be covered by at least one non-profit Health Care Corporation, charged with the responsibility for making available and furnishing to all residents within the assigned area all the comprehensive health care benefits mandated under the bill.\textsuperscript{74}


Description of Bill

A. General Approach: The bill would provide for establishment of a national health insurance program covering the entire population and affording a broad and comprehensive range of services. For covered services, there would be no cut-off dates, no co-insurance, no deductibles, and no waiting periods.

The proposal includes provisions which are intended, through study and evaluation, as well as economic incentives and grants and loans, to reorganize and improve the delivery of health care services, to alleviate shortages and maldistribution of health personnel and facilities and for the development of community home care programs, designed to assist and

maintain chronically ill or disabled persons in their homes in lieu of institutional care.

B. **People Covered:** All residents of the United States would be eligible for benefits, including aliens admitted as permanent residents or for employment. No history of contributions to the program would be required. The bill would allow for reciprocal and buy-in agreements to cover certain non-resident aliens, and in some cases U.S. residents traveling abroad.

C. **Scope of Benefits:** A comprehensive range of health services would be covered under the program with no payment required of the patient for those services covered in full and without limitation. Limitations would be applied primarily in the area of psychiatric care, nursing home care, dental services, and certain prescription drugs.

D. **Administration:** The program would be administered within the Federal Department of Health, Education, and Welfare. A five-member Health Security Board, appointed by the President, with the consent of the Senate, would be responsible for general administration of the program, including policy and regulation, control of expenditures, standards and reimbursement for providers of services, initiation of studies as to the adequacy of the financing of the program, quality and cost of services, etc. A National Health Security Advisory Council would assist the Board by advising on policy and evaluating operation of the program. A commission on the quality of health care would be established in the Department to recommend to the Secretary and to the Board, standards pertaining
to the quality of health care provided under the program.

E. **Financing:** The program would be financed through a Health Security Trust Fund. Income to the fund would be derived from the following sources:

1) a 3.5% tax on the employers' payrolls,
2) a 1% tax on the employees' wages up to $20,000 a year,
3) a 2.5% on self-employed income and on unearned income up to $20,000 a year,
4) contributions from federal general revenues equal to the total amount collected through health security taxes.

F. **Payments to Providers of Services:** Each year a national health budget for the coming year would be established. The budget could not exceed the estimated total receipts for that year from health security taxes and general revenues, but could be modified if later estimates of program experience indicated that tax receipts or expenditures differed significantly from the estimates, or if an epidemic or similar event required higher expenditures. Funds would be allocated by the Board to each region on a per capita basis for institutions, physician services, dental services, drugs, appliances, and other professional and miscellaneous services. Providers of health services would be compensated directly by the Health Security Board.

G. **Effect on Other Government Programs:** Medicare would be terminated, and the assets and liability of both Medicare Trust
Funds would be transferred to the Health Security Fund. Federal aid to the states, for Medicaid and other programs, Vocational Rehabilitation and Maternal and Child Health would cease.

H. **Other Major Provisions:** Financial, professional, and other incentives are provided in order to stimulate the establishment of group practice organizations to encourage the training, continuing education, and effective utilization of health personnel, particularly those in short supply, to encourage linkages between physicians and specialists and other patient care resources.\(^75\)

3. **Title:** National Health Insurance Act, H.R.94., by Representative John Dingell.

**Description of Bill:**

A. **General Approach:** The proposal would establish a national health insurance program, covering almost all residents of the United States. Standard benefits are broad, and would be financed through payroll taxes and federal/state general revenues. The bill contains provision designed to improve the supply, quality, and distribution of health, manpower, and facilities.

B. **People Covered:** Virtually all U.S. residents would be covered. Almost all employees and self-employed persons would be covered, and all persons eligible for Social Security benefits

would be protected. Funds appropriated for various federal/state health care programs could be used to obtain coverage for recipients of public assistance and the unemployed.

C. **Scope of Benefits**: The proposal permits broad medical benefits, but in implementing the program benefits would be made available in accordance with the state plan. The standard benefits available, without limit, except as indicated, are as follows: institutional services; general hospital in-patient care, 60 days; psychiatric and tuberculosis health care, 30 days; hospital out-patient care; personal services, physician services, dental services; physical check-ups; periodic medical and dental examinations; home health services; podiatry services; optometry services and eye glasses; laboratory and x-rays; physical therapy and related services; other services and supplies—medical appliances; prescription drugs, types of drugs which are unusually expensive.

D. **Administration**: The program would be administered at three levels of government: federal, state and local with the major operating responsibility falling to the state and local jurisdictions. Each state would evaluate its health resources and capabilities, and in accordance with national guidelines would develop a health care plan. Federal level—a National Health Insurance Board, with five members, would be established in the Department of Health, Education and Welfare. State and local levels—the administration agency in each state would, if possible, be the same agency that administers its public health material and child health programs. Local
area agencies, with the assistance of a similar advisory council representing consumers and providers, would administer the program at the local level, make payment to providers, and carry out related administrative duties.

E. **Financing:** A personnel health service account would be established to hold the funds of the national program. The account would receive an amount equal to 3% of total earnings.

F. **Payments to Providers of Services:** The National Board would allocate funds among the states for each of the five facets of health services—medical, dental, hospital, home health, and auxiliary, on the basis of population, availability of health resources, and the cost of services as indicated in the state plan. The state agencies would contract with the providers of care for services under the program and determine rates of payments. Hospitals, and other institutions, would be reimbursed on the basis of reasonable costs. Physicians and dentists could select reimbursement under various methods. Rates of payments would be geared to local conditions. Standards of participation for providers of services, under the program, would include: 1) hospitals and institutions, 2) professional practitioners, 3) nurses, and 4) specialists.

G. **Effect on Other Government Programs:** Initially aged persons could receive those benefits of the program not provided under Medicare. The Department of Health, Education, and Welfare would be required to study the relationship between the National Health Insurance Plan and the Medicare Program.
and devise methods for incorporating Medicare into the national plan.

H. Other Major Provisions: The National Health Insurance Board, after consultation with the National Advisory Council and other federal agencies, is authorized to make grants in aid for training and education to students and educational institutions. To finance this program, ten million dollars would be available for the first year of the program, fifteen million for the second, and for each following year an amount equal to one-half of 1% of benefit expenditures in the previous year. 76


Description of Bill

A. General Approach: The bill proposes three voluntary health insurance plans which would include:

1. An employee-employer plan.

2. An individual plan.

3. A state plan for the poor and near-poor.

After a phasing-in period, all plans would be required as a minimum to provide a broad range of health care services with benefit generally subject to cost sharing by the patient.

B. **People Covered:** Private health insurance covering minimum standard health care benefits would be made available to all U.S. citizens through three separate plans as follows: 1) qualified employee health care plans, 2) qualified individual health care plans, and 3) qualified state health care plans. Coverage under the plan would continue as follows: 1) two months after lay-off or termination of employment, 2) two months coverage for the surviving family in case of an employee's death, and 3) thirty months, if absent because of illness or disability. Under the individual plans, all persons would be eligible to purchase voluntarily a qualified individual health insurance policy for themselves and their families. The State Health Care Plan would provide benefits for the poor and near-poor by establishing state pools of private health insurers.

C. **Scope of benefits:** Minimum standard benefits would be identical for all three plans and would be phased in two stages as follows:

**Phase I - 1977**

1. For physical and psychiatric care, unlimited service.

2. All professional services for the diagnoses for the treatment of injuries, illness, or conditions other than dental and mental.

3. The first 20 out-patient mental health visits to a physician or community mental health center.

4. Prescription drugs and contraceptive devices.
5. One hundred-eighty days of skilled nursing care.

6. Two hundred-seventy days of home health care services.

7. Use of radium or other radioactive materials; oxygen, anesthetics, prosthesis other than dental and rental of medical equipment.

8. Oral surgery on impacted teeth and for a tooth root.

9. Diagnostic x-rays and laboratory tests performed other than while an in-patient in a hospital or skilled nursing facility.

10. Well-child care, including immunizations for children under the age of 5.

11. One oral exam per year.

12. One eye refraction per year for children under age 13.

13. Counseling on family planning and fitting of contraceptive devices.

14. One pap smear every two years for women, age 19 and over.

Phase II - 1985

All of the above listed services and items plus the following:

15. Dental care for fillings and extractions.

16. Other dental services and prostheses except orthodontia.

17. Services of a physical therapist.
18. Services of a speech therapist.

19. One eye refraction every three years for persons age 13 and older.

20. One pair of eye glasses per prescription, with a limit of one prescription per year for persons under age 19; one every three years over 19.

21. One hearing exam every three years.

22. Hearing aids, one per three years under 19; one per lifetime over age 19.

23. One physical exam every five years for persons 5 years and older.

The bill would allow private insurance plans for employees and individuals to apply a deductible of not more than $100 to covered benefits prior to January 1978.

D. **Administration:** Private insurance carriers would administer their own policies for qualified group and individual plans. The policies would have to be approved by the state insurance department as satisfying the requirements for a qualified policy. For the qualified state health plans, each state would establish a health insurance pool, a portion of the risk of which private carriers participating with qualified plans would be required to underwrite. The underwriting risks for persons previously uninsurable for health reasons would be born entirely by the health insurance industry.

E. **Financing:** Private group and individual plans would be financed by premium contributions from the policy holders. A portion of the cost of this protection would be met by reductions in
federal income tax collections.

Employees could be required to contribute to the premiums and the percentage of participation of each party could be dependent on collectibly bargained agreements.

The state plan would be financed by premium payments of enrolled families, graduated according to income and by contributions from state and federal general revenues. Each state would have the primary obligation to provide the administering carrier that portion of the total premium cost, not paid by enrolled individuals and families.

F. Payments to Providers of Services: Present methods under private insurance for reimbursement for services rendered would prevail, except that payments would be limited to the 75th percentile of reasonable charges for professional services and to rates approved by state health care institutions, cost commissions, and the HEW for health care institutions.

G. The Effect on Other Government Programs: The Health Care Act would supplement Medicaid and Medicare. Persons 65 and over could be covered under the state plan, if they met the conditions for enrollment in the plan, and if in addition they were enrolled in the voluntary supplementary medical insurance plan, (Part B) of Medicare. Most other government programs would not be effected.

H. Other Major Provisions: The bill includes provisions which would provide grants and loans to increase and distribute the supply of health manpower, promote ambulatory care, and
strengthen health planning. The bill would establish in the executive office of the President, a Health Policy Board which would recommend procedures for coordinating, consolidating, or eliminating health programs of the various federal agencies and departments, conduct health research, provide guidelines for health care funding allocations, develop recommendations for national policy to improve the organization, financing and delivery and quality of health care, and help prepare the President's Annual Health Report.  


Description of Bill

A. General Approach: The bill would provide catastrophic health insurance protection for all legal U.S. residents through one of the following plans:

1. A federally administered public plan for the unemployed, welfare recipients, the aged, and persons who do not opt for private insurance coverage.

2. A private catastrophic insurance plan allowed as an option for employers and the self-employed who would be required under the terms of the bill to provide and pay the full cost of such catastrophic protection.

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for their employees.

3. The bill would replace Medicaid with a uniform national program of medical benefits for low income persons, administered by the Department of Health, Education, and Welfare.

B. People Covered: Under the Catastrophic Health Insurance Plan, every individual who is a resident citizen or a lawfully resident alien would be entitled to Catastrophic Health Insurance benefits under either the public plan or the private plan for employers and self-employed. All employers, including federal, state, and local governments would be required to provide health insurance protection for full-time employees and their family members.

C. Scope of Benefits: The Catastrophic Plan would cover the same kinds of services as currently provided under Parts A and B of Medicare, except that there would be no upper limitation on hospital days or home health visits. Benefits excluded from Medicare would also be excluded under this program. Medicare's limitation on skilled nursing care would also be retained. The Catastrophic Plan would apply different limits on in-patient and out-patient mental health services than those currently applicable under Medicare.

The Medical Assistance Plan for the low income would cover only specific benefits, generally without any limit on the amount of services or any cost-sharing required.

A special co-payment requirement would also apply to individuals
who are not a member of a family due to reaching a majority, after
the 60th continuous day spent in a long-term facility.

D. **Administration:** The Public Catastrophic Health Insurance Plan
would be administered by the Social Security Administration in a
manner parallel to the administration of Medicare. The private
catastrophic plan would be administered by a qualified private
insurance carrier of the employer's choice. The Secretary of
Health, Education, and Welfare would be responsible for approving
the employer plans and the self-employed plans administered
through private carriers.

The medical assistance plan for the low-income person would be
administered by the Secretary of Health, Education, and Welfare.

E. **Financing:** The Catastrophic Health Insurance Plan would be
financed through a 1% tax on the payroll of employers and on the
income of the self-employed now subject to the Social Security
Tax. No employee contribution would be allowed. Amounts
collected as taxes would be deposited in a Federal Catastrophic
Health Insurance Trust Fund.

Employers and self-employed persons opting for private coverage
would pay premiums directly to the carriers. The bill requires
that the employer plans, administered through private carriers,
must make available to the employer certain arrangements for the
pooling of risks among various employee groups of different
employers, so that premiums can be covered on a class rather than
an individual basis.

F. **Payments to Providers of Services:** Providers of Services under
the Catastrophic Insurance Plan and the Medical Assistance Plan would be reimbursed on the same basis as under Medicare. Reimbursement controls would include the payment of audited "reasonable cost" to participating institutions and agencies and "reasonable charges" to practitioners and other suppliers. Payments to skilled nursing facilities and intermediate care facilities would be reimbursed on a "cost related" basis.

G. Effect on Other Government Programs: The Catastrophic Insurance Plan would supplement benefits provided under Medicare for persons covered by that program. The Medical Assistance Plan would replace the existing Medi-Cal Program. The Catastrophic Insurance Plan would always be the primary payer in cases where an individual was also entitled to have payment made under either Medicare or the Medical Assistance Plan.

H. Other Major Provisions: The bill would also establish:

1. Voluntary certification program for private basic health insurance.
2. Government sponsored standard health insurance policies on a cost basis.
3. Amendments to Medicare Program.
4. Philanthropic support for health care includes provisions designed to encourage philanthropic support for health care, especially in support of experimental and innovative efforts to improve the delivery system.

Description of Bill

A. General Approach: The bill would require employers to provide employees with comprehensive health care insurance coverage, purchased from qualified private health insurance carriers. Employers would have to pay at least 65% of the premium cost. Acceptance by the employee would be optional. Federal subsidies in the form of cash payments, or tax credits, would be available to employers who experienced substantial cost increases as the result of complying with the requirement for health insurance coverage.

Benefits would be comprehensive in scope and would not be subject to payment of a deductible; however, 20% co-insurance would be applied to covered services with the total amount of co-insurance in any one year limited according to income.

B. People Covered: All employers, including federal, state, and local governments would be required to make health insurance coverage available to all their full-time employees and their families. Acceptance of coverage would be optional on the part of the employee, although the employees decision would have to be rendered within 30 days of beginning employment, or during an open enrollment period.

Non-employed, or self-employed U.S. residents and their families, who are not eligible for an employer sponsored plan would be eligible for the tax credit provisions of the bill.
Individuals eligible for Medicare would also be entitled to the tax credit provisions, or for health insurance certificates for coverage supplemental to Medicare.

C. Scope of Benefits: A qualified health insurance plan for purposes of either the employer sponsored coverage or federal tax credits for the non-employed, self-employed, and elderly would have to provide: in-patient hospital care, skilled nursing facility care, home health services, emergency and outpatient services, diagnostic, therapeutic and preventive medical care, dental care, and ambulance service.

D. Administration: Private insurers offering qualified health insurance plans would directly administer claims for benefits and payments to providers. The federal government would continue to administer the Medicare Program as it now does through carriers and intermediaries. State governments would continue to regulate insurance within the state and appropriate state agency, (generally the State Insurance Department) would be responsible for approving private carriers for participation in the program.

E. Financing: Mandated employer plans will be financed through premium contributions from the employer and employee with the employer required to pay at least 65% of the premium.

Health insurance for the non-employed and self-employed would be financed through premium payments to private insurers.

Non-employed persons, aged 65 and over, who are eligible for Medicare would also be eligible for a federal subsidy under this program.
F. Payments to Providers of Services: Physicians services would be reimbursed on the basis of "usual and customary or reasonable charges" for covered services. Payment for hospital services would be determined by an appropriate state agency after consultation with providers on a reasonable cost basis under "acceptable methods of reimbursement, including appropriate perspective rate determination systems." (That is budget review, negotiated rates, target rates, formulated negotiations, etc.) Other costs would be paid either on a reasonable cost or reasonable charge basis as appropriate.

G. Effect on Other Government Programs: Medicare would continue to cover the aged and disabled as at present. The program would allow Medicare eligibles to obtain private coverage supplemental to Medicare and receive tax credits or certificates of entitlement toward the cost of such private coverage.

H. Other Major Provisions: The bill provides that in an action for damages against a medical provider, no liability would be recognized with respect to the cost of health care that are payable under this program or any other health care program under the Social Security Act. 79


Description of Bill

A. General Approach: The bill would create a system of national care benefits provided through an independent contributory social insurance program. All U.S. residents would be covered for a comprehensive range of health care benefits, without deductibles, co-insurance, or other forms of patient cost sharing. The program would be financed through payroll taxes on employers and employees, taxes on self-employed individuals and on unearned income. The program would be administered through a newly dependent Social Security Administration with a role for private insurance carriers in the first ten years of the program's existence.

B. People Covered: All U.S. residents would be eligible for health care benefits under the program. Residents of foreign nations with which the U.S. had in effect reciprocal agreements for payment of health care benefits would also be eligible while they were physically located in the United States.

C. Scope of Benefits: Benefits covered with the National Health Care Program would be as follows: in-patient hospital services, physician services, home health services, hospital extended care services, out-patient drugs and biologicals, dental services, vision services, hearing services, physical exams, and mental health services. No deductibles, co-insurance, co-payments, or durational limits, other than those indicated above would be applicable to covered benefits. Services listed above would be covered for all individuals under the program, regardless of age or income category.
D. Administration: The present Social Security Administration would become a new independent agency, headed by a Social Security Board composed of three members (no more than two members from the same political party). The independent Social Security Administration (SSA) would continue to administer the present cash Social Security Program with Supplemental Security Income Program and the National Health Care Benefits Program, established under the bill.

The bill would also create area health care services boards in each geographic area designated as a professional standards review organization (PSRO) area.

E. Financing: The program would be financed from the following sources:

1. A 5% tax on unearned income and self-employment earnings.
2. A 2% payroll tax on employee's wages.
3. A 6% tax on employer's payroll.

The contribution base, for purposes of the Health Care Benefits Program would be unlimited.

F. Payments to Providers of Services: The standards for the various payments of services under the program would resemble those now used in the Medicare Program. State health agencies and/or area health care services boards would be used to determine compliance with the conditions of participation for hospitals, skilled nursing facilities, intermediate care facilities, home health agencies, health maintenance organizations, neighborhood health centers and community mental health centers.
Payment for services of physicians and certain other professional practitioners would be on the basis of fee schedules established by the area Health Care Services Board.

G. **Effect on Other Government Programs:** Medicare would be replaced by the new program. The Veterans Administration would continue to operate a separate health care system for those eligible for Veteran Administration benefits.

H. **Other Major Provisions:** The bill authorizes transfer of funds. The trust fund established for the Health Care Program through the Secretary of Health, Education and Welfare for purposes of Title XVI of the Health Service Act.

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Chapter 6

INEFFECTIVENESS OF CURRENT PROGRAMS
AND PROPOSED SOLUTIONS

Over the past decade, there have been enormous increases in health care services expenditures. These increases are due to many factors, some, such as inflation, out of the control of the industry. There are also many demands now made upon the health care services industry by the people requiring the services. Unprecedented scientific and technological advances have also contributed to the tremendous increases in health care expenditures.

Primarily, the continued demand for services by millions of people in the United States are enormous. Many millions of patients are admitted each year as hospital in-patients, and many more millions receive out-patient care. There are hundreds of thousands of people residing in nursing care homes. There have been tremendous increases in the pharmaceutical services through physicians and prescriptions to provide the proper medications to patients who have received various types of medical services.

The expenditures for health care services are rapidly reaching catastrophic totals. The burden for financing today's expensive health care services system is growing at such a rapid pace that it is inevitable that the responsibility to control and administer the financial element of health care services will be shifted to the federal government.
The American people continue to spend billions to purchase health care services and supplies which will protect their own personal health care, and their family's health care.

The majority of the American health services industry is operated through the private sector. State and local governments share in providing health care services; however, state and local governments' share of national health expenditures does not compete with the private sector, nor with the federal government expenditures. There are basically two income sources for the present health care delivery system: 1) individuals provide funds by purchasing services directly by paying taxes to federal, state, and local governments, 2) individuals pay health insurance premiums. To a lesser extent, individuals help by contributing to charities which sponsor health care.

The system for financing the health care delivery system in the United States has not functioned well because it has been unable to provide for the various services according to the need, or for distribution of the burden for expenditures. While many of the American people are covered by some form of health care insurance, there are notable gaps in the insurance system which leave large numbers of people with either inadequate coverage or no protection at all. These factors, plus the inability of providers to effectively plan and control rising costs, and the lengthy and complex debate as to whether the burden of health care delivery system expenditures are to be shifted to the federal government or state and local governments continue to plague responsible providers. It does seem inevitable, at this time, that the shift must be made to the federal government because of the catastrophic expenses of providing
health care services to all Americans.

The ineffectiveness of the current programs for the county medical centers is created because of the patient volume and of inadequate facilities. County medical facilities are the primary source of care for both the poor and the medically indigent. As a result, these institutions see an extremely large number of patients. This fact is borne out by the following statistics:

1. Public hospitals average 14 out-patient visits for every 1 admission; while non-public hospitals average 4.5 visits for 1 admission.

2. Public hospitals average 250,000 out-patient visits per year, while community hospitals average only 70,000.

3. Public hospitals, on an average, record slightly under 20,000 admissions per year, while their private sector counterparts average slightly over 15,000. 81

This patient load is complicated by the fact that public hospitals are the dumping ground for "undesirable patients": alcoholics, drug users, serious trauma cases, transients, aliens, suicide attempts, psychiatric disorder cases, minority groups, and those who are poor and ineligible for other aid. 82

On top of these problems, the public hospital usually suffers from a poor image in the community. Much of this is due to inadequate funding, political control and interference, increasing patient volume,

81 Cooney, James P. Jr., Ph.D., "Public Hospitals: We must love them or leave them, study says." Modern Hospital, May 1972, p. 63.

82 Ibid., p. 63.
and outmoded facilities. The public hospital's community image also suffers due to the lack of support by the community constituency. The patients prefer not to come to public hospitals because they dislike, what they feel, are long waiting times, impersonal service, and inadequate care—all of which are created because of current programs and types of services.

The final problem is that local political governing boards prefer to use the county's tax money for other purposes. At the same time, administrators and physicians see county medical centers as unable to deliver adequate levels of care to the county populace. This poor image is further intensified by inadequate public relations programs that fail to counteract media coverage that accentuates the negative, "political entanglements, examples of inadequate care" and de-emphasizes or overlooks the positive. The result created is an image throughout the community that can only be described as "needing improvement" if the county medical facilities are going to meet the challenge of the private sector with either the current programs and/or the potential proposed solutions. 83

The current involvement of the federal government in both the Medicare and Medicaid Programs, and their overwhelming costs to provide the limited coverage for so few Americans, should clearly substantiate that some form of national health insurance will be required if all Americans are to receive the type of health care they feel is their right.

There have been many bills introduced into Congress which represent a wide difference of political and economic philosophy. There are three

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basic approaches involved. Their philosophies and claims differ as do their financial effects on the economy, federal budget and taxpayers. First, there are proposals calling for a unitary, all-embracing, federal program, administered exclusively by the federal government without any use of private carriers. This approach is modeled by the Edward M. Kennedy/James C. Corman bill, Health Security Act of 1975 (see page 60). Secondly, there are proposals for mandatory purchase of private health insurance by the employer for their employees and their families, with a separate federal insurance scheme for low-income families with children. In addition, there will be state plans, whereby persons not protected by other programs, such as Medicare and Medicaid, are provided coverage. This approach is modeled by the Thomas McIntyre/Omar Burleson bill, National Health Care Act of 1975 (see page 66). Thirdly, there are proposals for tax rebates or incentives to stimulate voluntary purchases of private health insurance. This approach is exemplified by the American Medical Association's Medi-Credit Plan, offering a tax credit against the individual's federal income tax. Potentially, this approach would be made available to all U.S. residents except those who qualified under Medicare (see page 57). Medi-Credit provides fairly comprehensive benefits regardless of the patient's income.  

All of the above approaches have considerable value as a solution to the cost of health care services; however, philosophies differ as to the service and how these services will be provided and at what cost. It is still evident that health care will continue to cost the nation more. The review of the many proposals and bills reveals the net cost to the nation of all proposals would be remarkably similar. However, the distribution

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84 Ibid., p. 31.
of cost, and the burden of paying have important differences.

The case for national health insurance must rest on at least one of the following conclusions about the private sector: they produce too little medical care; the care they provide is either inadequate in quality or excessively costly; and the burden of providing the care is unfairly distributed. There are arguments as to why the private sector is not providing enough medical care—some are persuasive; others are not. But, the government already subsidizes about 43% of all physician costs; therefore, it must be concluded that, if anything, this nation may already be over-producing medical care. If so, national health insurance, especially a totally subsidized program, will aggravate the health care problem. 85

Despite the numerous problems facing the public hospitals, many good and positive actions are being carried out in these institutions. The public hospital system is the primary, and often the only, source of care for the poor and medically indigent. The public hospital is very often a significant participant in the medical education function. In addition to assuming a large portion of the training of paramedical personnel and allied health professionals, it has been estimated that more than half of all practicing physicians have received some part of their training in a tax-supported public hospital. Approximately the same ratio of the clinical developments in use today have come out of the public hospitals. 86

One of the major drawbacks of teaching programs in the public hospitals is the fact that patients who come to the hospitals are assumed to be "willing recipients" of these teaching programs, since the people who come to public hospitals generally do not have sufficient funds to cover the costs of their medical treatment. These impoverished individuals must pay for their health care by submitting to teaching programs that they have little opportunity to avoid. Public hospitals often must maintain and develop programs that community hospitals cannot, or will not, offer because of the expense involved or the type of patients serviced.  

California has undergone a major experiment in the provision of medical care services which have been placed under the Medi-Cal Program. In 1973, responding to a nationwide interest in prepaid health plans, Congress enacted the Health Maintenance Act of 1973 (PL93-222). The law was designed to stimulate interest of both providers and consumers in such plans and also to facilitate the growth of health maintenance organizations (HMOs).  

A Health Maintenance Organization (HMO) is one that agrees to provide a specific health benefit package at a predetermined periodic rate to individuals and groups who choose to enroll. Such an agreement differs from traditional private health insurance, that is, an HMO assumes the financial risk of potential loss; whereas, in private insurance plans, this risk is born by an insurance company.

The law specifies basic services that an HMO must provide for prepaid fee as well as supplemental services that may be supplied for

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87 Ibid., p. 7.

an additional prepaid fee. Fees must be fixed under a community rating system, without regard for the medical history of any individual or family. HMOs are required to be organized and operated as described in the HMO Act of 1973. HMOs must be fiscally sound and assume full financial risk, enrolling people who are broadly representative of various groups within the area they serve and assure that consumers comprise at least one-third of their policy-making board. HMOs must also establish grievance procedures, assure quality of care, and provide medical/social services, and health education.

HMOs are faced with practical problems which have caused delays in expediting the implementation of not only the concept, but also increasing the number of HMOs throughout the country. The most frustrating problem is recruiting physicians, which is created by negative public image and shortage of physicians. Also, physicians are not distributed according to need, either geographically or by speciality. There is a shortage of trained HMO management personnel, along with the shortage of experienced and competent middle management personnel. There is also the problem of financing; preliminary financing is necessary to acquire facilities, hire staff and operate the HMO during its development. The final big problem is bringing all the elements into balance. The enrollment of patients must be integrated with facilities development, available medical staff and monitory planning to cover the cost during the development years. The smooth integration of these elements is mandatory if

89 Ibid., p. 2.

the objectives of an HMO are to be met—that is the development of a fiscally sound, competent HMO. 91

HMOs are medical service organizations that represent the diverse providers and consumers, and through coordination will focus on the total health needs of the area it serves, and will be able to generate the corresponding political strength to meet its needs. HMOs must assume that modern medical management techniques, such as team delivery of care, problem and family oriented treatment, and reliance on non-medical ancillary services and personnel will improve the quality and efficiency of delivered health care to its consumers. 92

The Medicare Program for the aged is a comprehensive health insurance program available to an entire group of the general population of the nation (those 65 and older) regardless of income or ability to pay for care. The Medicare Program has since been extended to encompass the permanently disabled and those with chronic kidney disease. This population group is not only the most sickly, but also the least able to pay for care out of current income or asset depletion. The Medicare Program provides the elderly with a "no charge" hospital insurance, Part A, and a general medical/surgical insurance, Part B, at a charge considerably less than its actuarial value. The program's effect on medical care use have been dramatic. Hospital admission rates for the elderly rose nearly 25% after the introduction of Medicare, and the rate of

91 Ibid., p. 25.

surgical procedures rose 40%. The average length of hospital stays rose considerably. However, physician office visits did not follow the same patterns. 93

An important distinction must be made between demand and utilization of medical care. Demand is the number of persons trying to obtain medical care (at a given price, income distribution, etc.) whereas, utilization is the amount of care actually received. If more persons attempt to obtain care at a given price than there are services to be provided, then utilization would be less than demand.

Despite the considerable income transfer under Medicare, the elderly still face substantial medical expenses not met by the federal program. A major reason is the structure of the program itself. For hospital stays in excess of 60 days, the patient must pay a fixed amount per day through the 90th day. A lifetime reserve of 60 days coverage (beyond the 90-day coverage limit) requires an established daily payment. Beyond that, no coverage exists for hospitalization. For physician, and other services, a deductible and a 20% co-payment are structured into Part B with no limit on co-payments. Thus, Medicare has poor coverage for high loss (but presumably lower probability) events. The resultant, out-of-pocket expenditures arising for the elderly constitute what are commonly described as "catastrophic" expenses for a large fraction of the enrolled population. As an offset to Medicare coverage gaps, many persons over age 65 purchase private insurance to supplement their Medicare plans.

The Medicaid Program for the poor is the other major public program providing insurance against medical expenses for low-income persons. Unlike Medicare, which is uniform for all states throughout the nation, Medicaid is a state administered program financed by federal/state matching funds. Eligibility criteria, services covered, and administration of the plans are established by state governments and vary substantially from state to state. The unevenness of eligibility for Medicaid Programs across the states and the uncertainty of eligibility even within a given jurisdiction have grown to public uneasiness about Medicaid as an appropriate vehicle for providing medical expense protection for the low-income population. Virtually, every national health insurance proposal before Congress includes plans to federalize coverage for this population group. Nevertheless, several features of this program deserve mention. First, Medicaid has provided a significant leveling of coverage for medical services across income groups, particularly for physician ambulatory services. Second, the leveling of financial coverage has lead to a similar even distribution of physician services per capita across the income groups for adults. Children of low income families still receive significantly fewer physician visits than is true for other income groups.\footnote{Ibid., p. 138.}

It is clear that public insurance programs for the elderly, disabled and poor have significantly shifted the demand for care to these population groups, and this increased access has been correctly viewed as at least partially successful in meeting the program objectives.
The inevitable result is that the cost of medical care must rise because of the demand. The acceleration of medical care costs have resulted from an increase in total demand for medical care that previously was modest because of the limited population coverage by the new insurance programs. However, universal insurance coverage for the entire United States population is projected to lead to much larger increases in demand than those generated by Medicare and Medicaid.\(^{95}\)

Public intervention in medical care services has risen steadily over time, and now approaches 50% of the total health care expenditures in this country. The major portion of this intervention has been directed towards increasing the demand for medical services by specific population groups, notably the poor and the elderly. Simultaneously, a long history of public supply of medical care has primarily focused on these same groups. Most national health insurance proposals would extend the public role in the health sector even further and would further specialize the public involvement into stimulation of demand for care. The economic efficiency of the actual production of medical care may be significantly affected by how much production is undertaken in public hospitals. The current existing public production of hospital care with its decentralized control appears to allow more flexibility to respond to new environments than would be possible under the proposed centralized bureaus.\(^{96}\)

\(^{95}\) Ibid., p. 142.
\(^{96}\) Ibid., p. 164.
The proposed national health insurance plans that have been studied promise to be costly; therefore, it is important to review the benefits that can be expected and the consequences of national health insurance. There could be several approaches taken to examine national health insurance. One approach would be to examine the impact of a new system of financing health care for the general health of the American people and to assess the effects of this improved health on greater productivity and well-being. Another approach would be to estimate the value of reduced concern over the possibility of incurring severe financial hardship (catastrophe) in meeting medical bills. The final approach would be to examine the distribution of medical payments, in effect equating receipt of medical services with the benefits of the plan. While there is merit in all of these approaches, the evaluation of the benefits that can be expected from any health insurance plan is perhaps best undertaken in terms of the original goals. These goals are to insure that every American has access to medical care, that no one faces financial hardship as a result of large medical bills, and that incentives are created for limiting the rise in health care cost by, or through, the providers of health care services.

The first major goal of national health insurance is to insure
that everyone has access to high quality medical care. Experience with the Medicare and the Medicaid Programs has demonstrated that adequate financing can increase the utilization of medical services by the poor, to levels commensurate with those of higher income groups. However, if providers of medical services are penalized with lower financial compensation for treating the poor, instead of other patients, the supply of high quality medical care, easily and conveniently accessible to the poor, will be restricted.

National health insurance for the nation is approaching at a rapid and dangerous rate because many Americans are requiring an adequate program which will furnish personal health services, and be provided and supported by the federal government. This nation has been striving at an accelerated pace for improved health for the whole population. At the same time, there is a great desire to strengthen health security for the whole population. Finally, there is a need to enhance the general public welfare through all that both improved health and health security can contribute or achieve for a broader foundation of well-being in our society.

In reviewing the benefits to be obtained through a national health insurance program, it must be realized that to prevent the existing inadequacies and inequalities in the nation's health services systems,


there must be a reallocation of resources which will provide improvement in today's poor or substandard care of large segments of the nation's population. The people must be assured that they will have the ability to cope financially with the cost of health care, made realizable by a substantial base of coverage to be provided by both private and public insurance plans. There must be step-by-step alterations made to insure that the means of delivering services and paying providers is made and that the gaps are closed on financing the system, or it will over-burden an already inadequate system and offer little prospect of materially improving the quality and quantity of medical services or health of the American people.

The Medicare Program has been in effect since 1966. As the program was enacted, it was necessary to contact the aged and inform them of their rights to coverage and benefits under the program. In addition to enrolling potential patients, the Social Security Administration was given the task of evaluating health facilities—hospitals, nursing homes, and home health agencies. The Medicare Law required that the health facilities apply to participate and meet certain conditions specified in the law before they can be reimbursed for services provided to Medicare patients. These requirements were designed to insure a higher quality of care. The facilities also had to prove that the services provided were on


100 Ibid., p. 18.
The dispute over national health insurance is shaped by the origins of Medicare. The processes by which national health insurance has become a strong political issue in the United States recall the Medicare episode. The contestants remain markedly similar, and the national health insurance program raises similar issues of private versus public control, cost and price increases, federalism and the like. Moreover, within the federal government, the same departments and committees already involved in Medicare will deal with national health insurance.

The experience with Medicare and Medicaid in the late 1960's created the discussions on national health insurance and shaped its character in ways without precedent in the Medicare or Medicaid cases. Following the experiences with these programs, there is widespread anxiety about the adequacy and financing of a health care system. The inflation of physicians fees and hospital daily service charges have become symbols of a health-care crisis. The increases in the cost of medical care will be the central problem when the debates start over national health insurance. Nonetheless, those interested in public insurance coverage over United States national health insurance might well find the account of the Medicare and Medicaid programs relevant to their concerns in finalizing the policies for a national health insurance program.

The Medicaid program has made significant progress in providing


\[102\] Ibid., p. 90.

\[103\] Ibid., p. 93.
protection for the poor against the cost of health care services. The coverage under the Medicaid program has been expanded dramatically during the history of the program; however, many poor persons are still not covered. Coverage of the poor varies widely by state, so that less than 10% of the poor are covered in some states while most of the poor, and many of the non-poor are covered in others. Benefits provided those eligible under the program also vary widely by state. 104

There are insufficient incentives in the Medicaid program for consumers as well as hospitals, physicians, and other providers to use scarce resources efficiently. Because of the poverty status of the eligible population, no cost sharing is imposed on use of any service. The methods of reimbursing physicians and hospitals place few incentives on these providers to control utilization and cost. Medicaid program costs have risen, and the most important reason for increases in these costs over time has been the increases in the numbers of people eligible to receive Medicaid program services. 105

It is important to explore not only which medical services a plan puts financially within the means of the poor, but also the ability and willingness of medical care providers to supply the poor with high quality services.

With the exception of the Health Security Act, which provides comprehensive health services free of charge to all, the major health

105 Ibid., p. 111.
insurance proposals all contain special provisions subsidizing the care of the poor more heavily than of others. All the plans represent a major improvement over the Medicaid program by covering nearly all those in low incomes. None of the proposals would exclude families or individuals from coverage on the basis of geographical location, family size, employment status or welfare status. In certain plans, a small number of low income people may fail to be covered because they are poor health risks, because they have yet to obtain a full-time job, but are too old for coverage under their parent's policy, or because they fear they will be refused a job if they elect coverage. Closing these specific gaps and requiring universal coverage would insure that the goal of adequate access to medical health care services for all Americans could be obtained.106

Since care under a national health insurance program would be free to everyone, not just the poor, the poor would have to compete with others for a limited supply of medical services. They are at a disadvantage, in that high-income families tend to live in areas with a greater concentration of medical resources and many medical care providers have a preference for patients from a similar socio-economic class. Without a financial advantage, the poor may be unable to overcome their existing disadvantage of more limited physical access to medical care. Methods of reimbursing providers can also affect the services received by the poor. Thus, patients requiring more time and effort will be less attractive to a physician or medical organization

than those with fewer medical problems. None of the bills prohibits physicians from discriminating among patients in the amount, type, or quality of care rendered on the basis of income (or any other basis). 107

Nearly all of the national health insurance bills reviewed provide a broad package of benefits to most low income people at a minimal or no direct cost. Some plans restrict services essential to the poor, such as well baby care, family planning and eye and ear care for children. Several plans provide only limited skilled nursing home care. With the exception of these limits on benefits or coverage, however, the success of the plans in meeting the goal of insuring high quality medical care to those unable to pay, depends on a large part on the availability of medical resources in low-income communities and on the willingness of providers to provide high quality services to the poor. Experience with the Medicare and Medicaid programs indicate that members of minority groups and rural residents often encounter special difficulties in obtaining adequate medical care, even with an extensive financing program.

Benefits from the Medicare and Medicaid programs have been disproportionately low for minorities. Fewer blacks eligible for benefits visit physicians, and those receiving a physician's care are much more likely to receive it from public hospital out-patient departments rather than from the family physicians or private specialists. Blacks, even when covered by Medicare or Medicaid, receive more of their hospital care from crowded city or county hospitals than do whites. Discriminatory practices by physicians also restrict access of minorities to high quality hospital and nursing home care, while direct discrimination by

107 Ibid., p. 155
hospitals is prohibited under Medicare and Medicaid, considerable disparities among races in the care received continue to exist.

None of the national health insurance plans would eliminate the shortcomings that have existed in the Medicare and Medicaid programs. None of the plans contain provisions prohibiting physicians from discriminating on the basis of race, creed or national origin. None establishes administrative procedures for enforcing nondiscriminatory provisions; informing beneficiaries of their rights to high quality services or eliciting patient complaints of discriminatory treatment. In the absence of such safeguards, it can be anticipated that the benefits of national health insurance will not be equitably distributed. Therefore, the goal of insuring quality medical care for all Americans will not be fully achieved. \(^{108}\)

While the introduction of the Medicare and Medicaid programs cause the poor as a whole to make rapid gains in the use of medical service, rural residents have not experienced any gains in use relative to urban residents. The failure of Medicare and Medicaid to reach many rural residents suggests that national health insurance, too, may be less than fully successful in rural areas. Several factors contributing to the failure of medical care financing programs to reach rural communities are: 1) rural communities have only limited medical resources; 2) state and federal restrictions on who can provide medical care prevent the optimal use of paramedical personnel; 3) transportation is frequently an important barrier to medical care in isolated rural communities;

\(^{108}\) Ibid., p. 157.
4) the poor in the rural areas are inadequately represented by organizations supporting their interest. They are more likely to have a variety of problems that contribute to poor health, such as insufficient income maintenance, poor housing, inadequate diets, impure water, and inadequate sanitation. Coordination of medical care services with other supporting services therefore is particularly crucial; 5) Few forces exist to induce a greater concentration of medical resources in rural communities. Medical schools rarely or adequately prepare students for rural practice and, in fact, frequently undermine their confidence to provide quality care in an area without specialized supporting services. National health insurance alone cannot encounter all these forces militating against adequate medical care in rural areas. However, through careful design it can avoid some of the problems inherent in Medicare and Medicaid. Special programs designed to meet the particular needs of rural areas should also be pursued to insure that the goals of national health insurance are achieved.109

The second major goal of national health insurance is to protect all families from the financial hardship of large medical expenses. Private health insurance plans have failed to protect everyone from the financial consequences of poor health by excluding some benefits from coverage, by refusing coverage to poor health risks and by setting limits on the maximum amounts that will be paid. Furthermore, only half the population now has any major medical coverage at all.

All the major national health insurance proposals would reverse

109 Ibid., p. 159.
the pattern of private health insurance coverage to incorporate the principle of a ceiling on patient liability for medical costs. In spite of the desirability of setting ceilings on family contributions, it is still possible under most plans for a family to incur severe financial burdens. First, most plans exclude substantial numbers of people from coverage. Second, some plans do not provide ceilings for all allowed persons. Third, all plans exclude some medical services from coverage. Fourth, a number of plans permit physicians to charge patients more than the amounts that will be paid by the insurance plan. Establishing the requirement of physicians to accept the allowed charge as total payment would help protect everyone from the possibility of excessive financial burden.  

The third major goal of national health insurance is to limit the rise in national health care costs that have not been controlled in the past. The prospects of achieving the third goal are not as bright under any of the major proposals. All the proposals are expected to result in a net reduction in direct payments by patients for medical care and hence, are likely to contribute to upward pressures on costs. Nonetheless, some characteristics of the major plans would help to constrain costs. All the plans cover lower cost substitutes for in-patient hospital care, including payment for physician services whether provided in a hospital or on an ambulatory basis. Some plans, however, have such extensive insurance coverage even for families reasonably able to meet their medical expenses directly as to invalidate any automatic market incentives for efficiency or cost constraint.

110 Ibid., p. 162
Even under plans retaining substantial payments by patients however the increased pressures of demand, particularly for ambulatory services, are likely to lead to substantial price increases unless special measures are taken to restrain prices. Thus, the methods of paying physicians and other medical care providers is of the utmost importance. Radically changing the methods of compensating physicians however can lead to rejection of the plan by the providers, whose cooperation is essential to its success.\footnote{Ibid., p. 163.}

The method of compensating physicians should not be different for different geographical areas, or it will likely penalize those areas where medical charges have been lower and reward those areas where charges are higher. Those areas that have been attractive to physicians in the past because of higher compensation, will continue to be most attractive in the future. Similarly, compensating services rendered by specialists at a much higher level than services rendered by family physicians would entrench existing incentives for physicians to specialize. Such distortions would contribute to the inefficient allocation of resources and raise the true costs of national health insurance. Even more importantly, however, these methods of physician reimbursement would not effectively constrain cost increases. Physicians, electing to accept the established fee, receive some billing and collection advantages; but, given the increased demand likely to be generated, most physicians are likely to choose the more generous incomes they can derive from setting their own fees.

If these pitfalls are to be avoided, several steps are required
under a national health insurance program. First, physicians should be required to accept the allowable charge as full compensation for services. Second, fees should be established on a basis that will encourage a socially appropriate distribution of physicians by location and specialty, rather than on the basis of past patterns of physician charges. Third, adjustments in the fee schedule over time should be established in such a way as to constrain increases in total expenditures to an economic index, such as earnings in the economy. 112

The development of a sound health services delivery program requires knowledge in the areas of program development, quality of care, delivery mechanisms, community relations, manpower recruitment, and fiscal management, and all of these must be given a high level of attention. All of these areas need continuous attention, but high quality project management, especially fiscal management, has suffered from lack of attention in the past. 113

It is believed that there is room to improve the management of the health services delivery projects and that improvement will result in better use of federal dollars. To assist and help program management to improve management techniques, it is necessary to encourage and then assist management in increasing revenues by taking full advantage of existing third party reimbursements. By improving the sophistication of management, the programs will not only be able to improve the financial situations, but be in a more favorable position to deal with a

112 Ibid., p. 165.
broader national financial program when a national health insurance program is approved and implemented.\textsuperscript{114}

While an adequate financing program is essential to assuring access to medical services and preventing financial burdens arising from large medical bills, such a financing program cannot be relied upon to solve all the problems of the Health Care System. Experience with existing financial governmental programs clearly suggests that even with comprehensive national health insurance, some groups, especially minority groups and residents of central cities and farms would still receive substantially less care than others, unless special efforts are made to increase the access of these groups to available health care services. Under Medicare, for example, uniform benefits are available to all participants, but average expenditures are substantially less for blacks than whites. Most of this discrepancy is explained by the fact that elderly whites use more medical services, even though elderly whites enjoy better health than elderly persons of other races. Elderly whites have fewer restricted activity days, fewer bed disability days, and fewer suffer from chronic health conditions. In spite of the better health status of elderly whites, whites are admitted to the hospital more frequently, use more days of hospital care, and visit physicians more frequently.\textsuperscript{115}

In addition to barriers to medical care for blacks and other non-white groups, residence is also an important determinate of use of medical care services.

\textsuperscript{114}Ibid., p. 103.

care services. Rural residents lie well behind residents of urban areas in use of medical services, even though rural residents are more likely to have some limitation of activity. Special efforts to improve medical transportation systems will be required to improve access of rural residents to high quality care. In addition, there will be a requirement to promote policies designed to overcome the nonfinancial barriers of access to medical care. Federal intervention is required to improve the operation of the market for medical services. The most crucial of these are supplementary measures to control costs of medical services, incentives to foster the development of innovative forms of organizing and delivering medical care services, and measures to assure a desirable mix and supply of medical manpower.

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116 Ibid., p. 75.
Chapter 8

FINDINGS AND RECOMMENDED SOLUTIONS

This chapter will summarize the most important findings and recommended solutions for a national health insurance program. There can be no doubt that the American public now favors the enactment of some form of national health insurance. The public consensus is that the federal government must take the lead in establishing a national health insurance plan that will guarantee medical care to all who need it.

Most of the national health insurance proposals reviewed contain several good features; however, none is without flaws. Since evaluation of any given approach to national health insurance must carefully weigh the possible advantages and disadvantages, selection of a best plan is most difficult. Members of Congress are now struggling to decide what needs to be done to improve American health care delivery services and American health care. They are considering a variety of complex national health insurance proposals and other federal health initiatives. The need for expanded federal involvement has clearly been accepted by the people and the key professionals, primarily the doctors. The public, in particular, has confidence that through a partnership approach, the government and various institutions, professions, and organizations concerned can resolve the present problems in the American health care services and delivery systems.
The most important findings established during the research of the national health insurance proposals and the supporting data are the following:

1. Many people look to the federal government to provide adequate remedies, but they feel that the government should rely on the expertise of experienced professionals, doctors, health insurance officials and hospital administrators foremost among them, in formulating fair and workable policies for a national health insurance program.

2. Most Americans have considerable confidence, at present, that they can obtain good medical care when they or their families need it, but they recognize the serious problems in the health care system that require basic changes.

3. The public realizes that some form of national health insurance is essential, and the federal government must assume principal responsibility for creating the program. Further, choosing between the options of having national health insurance administered by the federal government, state, or local governments, local corporations with citizens and physicians involved or private insurance companies, the federal government is favored to run the plan.

4. There has been no singling out of any specific people to blame for present problems. Indeed, approval and support has been expressed in various ways for all of the established health institutions, professions, and organizations.

5. A national health insurance program should include a deductible provision to insure equality of benefits, and regardless of how
much those covered by a national health insurance plan contribute to it, either through premiums or deductibles, the American public strongly believes that all people should receive the same benefits.

6. Each American should have access to quality health care regardless of income.

7. Many people believe comprehensive health insurance coverage should be made available to all Americans at the earliest date consistent with the availability of health care services.

8. Many people feel there is a shortage of physicians.

9. Many people still assert a preference for personal care, for knowing their own doctor and having him know and be willing to come to them, as a cornerstone to a good health care system.

10. Many people, on the whole, continue to approve and support existing federal health programs, such as support for medical research and medical education including the training of physician assistants and paramedical personnel.

11. Many people are concerned about "unnecessary treatment" of patients which raises the cost of health care services, and also overloads the health care delivery system.

12. Many physicians favor assigning responsibility for national health insurance to the health insurance industry rather than to the federal government. Salaried physicians, including those in teaching and research facilities, often in disagreement with their medical colleagues on other issues, prefer that any national health insurance plan be administered by private insurance companies.
13. Many physicians do not accept the assessment that there is a health crisis in the United States, but most recognize serious problems; however, they have a high degree of confidence that the present U.S. health care system can handle emergencies and the nation's routine medical needs well.

14. Many physicians prefer to keep the health care system under their complete control if possible, sharing direction only with private insurance companies and excluding with even-handed firmness both lay citizens and other health professions, such as hospital administrators.

15. Many physicians believe the best general medical care can be provided for people through a family doctor with modern equipment, backed up by specialists when needed and with access to a good hospital.

16. Many physicians acknowledge the federal role requirement in helping to overcome existing health services problems. Many physicians also feel that the role should be primarily a continuation and possible expansion of present programs, such as aid to medical schools and support for medical research.

17. Many physicians who practice in hospitals and other medically oriented institutions favor changes in the pattern of traditional health care and are willing to see the federal government take the lead in encouraging such change.

18. Many physicians believe an important step to be taken in improving the health care system is to increase the supply of health manpower.

19. The nation needs a new health care system which combines the
strengths of our present system with new programs, reforms, and additions where the present system, for one reason or another, does not meet the nation's needs.

20. The nation should take action simultaneously to improve the organization and delivery of health care and to improve the financing of health care.

21. Many people place a high degree of confidence in institutions, government and private, involved in health care. On the other hand, a strong majority of the people are not satisfied with no progress, and they expect all relevant institutions to join in bringing about basic improvements.

22. Many people believe that citizens should be equal participants with physicians in governing health maintenance organizations and that other professionals also should be involved.

23. There is a national requirement for federal standards for comprehensive health care benefits to be established for all Americans.

24. The federal government should clarify and develop a health insurance policy that is not complicated or excessively costly.

25. The present system of financing health care provides inadequate protection, encourages inefficient use of resources and accelerates the inflation of medical costs.

The national health insurance proposals that have been presented to Congress will not remedy the American health care services or delivery system as it is today. The principle features of a national health insurance plan that would meet the major goals of insuring access to care, avoiding financial hardships, and limiting the rise in medical costs
while at the same time distributing the cost equitably among various income classes will require adoption of the following recommended solutions:117

1. **Universal coverage**: The plan should cover all U.S. residents and should not exclude anyone because of family composition, employment status or working ability (past, present, or future). The plan should prevent deprivation of care as no individual should be deprived of medical care because of inability to pay, just as no individual should go hungry or lack adequate housing because of low income. Moreover, no one should be encouraged to delay care because his insurance will not pay for preventive or ambulatory care, but only for hospitalized treatment for more serious illness that may ensue.

2. **Comprehensive benefits**: The plan should cover both in-hospital and ambulatory services including services of health centers or clinics, prescription drugs, preventive services for children, maternity and family planning services, dental services for children, and at least limited skilled nursing home and mental health benefits. Services provided by paramedical personnel should be covered if provided under the supervision of a physician, whether the physician is physically present or not. This would assist in providing care in the rural communities and to the non-white populace. The same broad comprehensive benefits should be available to all families.

3. **Direct patient payments**: Direct payments should not be required for low-income families; while moderate direct patient payments should be required for middle and upper income families which would reduce the cost of the plan and encourage efficiency. Some reduction in these amounts should be made for lower income families. Ceilings should be placed on maximum contributions to health care required by any family.

4. **Tax subsidies for supplementary insurance**: Purchase of supplementary insurance to pick up required direct patient payments should not be subsidized by tax provisions. Any contributions by employers to such plans should be counted as taxable income to the employee and not a legitimate business expense of employers. No personal income tax deductions for premiums of supplementary insurance should be permitted. The plan should avoid a large tax. A national health insurance program should not raise substantial funds from taxpayers and return it in the form of health insurance, because it has a large hidden cost and lowers national income.

5. **Financing**: The plan should be financed in such a way that burden does not fall disproportionately on low-income families. A combination of general revenues and a tax on payroll and on earned income would be preferable. The plan should keep costs down as a financing system should both encourage efficient use of resources and discourage medical care price inflation. Whenever possible,
patients should use relatively low-cost ambulatory facilities rather than high cost in-hospital care. Hospitals should be induced to moderate the forces that raise the cost of care, increased personnel, unnecessary pay raises and a proliferation of technical facilities and services. Physicians should not be encouraged to increase their fees by the knowledge that because of insurance the cost to their own patients will rise little, if at all. In fact, the financing method should encourage cost consciousness in the decisions of patients, doctors, and hospital administrators.

6. **Administration**: The plan should be administered by the federal government. Reimbursement of claims for segments of the population could be undertaken by private organizations or state governments on the basis of competitive bidding under federal supervision provided safeguards on privacy of income information are installed. The administration of the health care system should not require complex procedures, which are costly and inconvenient or create arbitrary decisions which imply that resources are not used appropriately.

7. **Consumers**: Consumers should be represented on all advisory boards. Grievance processes should be established for patients to file complaints about improper handling of claims or inadequacy of care provided.

8. **Minorities and access to care**: Hospitals, physicians, and other providers should be prohibited from discriminating against patients on the basis of race, nationality, or creed. Procedures for
enforcement of nondiscriminatory provisions should be incorporated in the plan, including sight visits for compliance, administrative procedures for informing patients of rights, and processes of filing complaints of discriminatory treatment.

9. **Rural residents and access to care:** Methods of reimbursement should encourage the creation and optimal utilization of medical resources in rural areas, including the establishment of fee schedules for physicians that reward rather than penalize physicians for practicing in under-served areas. Health care services provided by paramedical personnel and rural health centers must be reimbursed when the services have been provided whether a physician is physically present or not.

10. **Reimbursement of hospitals, physician, and other providers:** Prospective methods of reimbursement for hospitals and other institutional providers should be developed and tried experimentally. Controls that place limits on per patient costs should be considered. Limits should be placed on the incomes of such hospital-based specialists as anesthesiologists, radiologists, and pathologists. Physicians and other non-institutional providers should be required to accept the allowable charge as full compensation for services. Fees should be established on a basis that encourages a socially appropriate distribution of physicians by location and specialty, rather than on the basis of past pattern of physician's charges.

11. **Acceptance by patients, physicians, providers, taxpayers, and federal, state, and local governments:** The plan must be generally
acceptable to all parties involved whether they be patient, physician, provider or payor. Any new method of financing a national health insurance program should be acceptable to physicians and to hospitals as well as to the general public. A national health insurance system that is disliked by either would encounter substantial political opposition, and if instituted would be hampered by lack of cooperation and an inadequate supply of new personnel in the long run. Therefore, it would not meet the major goals of insuring access to care, avoiding financial hardships, limiting rise of medical care costs or distributing cost equitably among different income classes.

Summary of National Health Insurance:

A national health insurance plan should be made available to all Americans for all of the benefits that could be provided within the resources available on the implementation date. From the implementation date, benefits should be expanded through a progression of phases geared to the availability of services, to the reorganization of the health system, to the minimization of price inflation and to the achievement of greater uniformity and effectiveness of coverage. The method of health care delivery must be restructured. Health services must be reorganized and a new health delivery system developed so that resources can be used to the level of their capabilities in bringing care to the American people. Basic to the establishment of a national health care system is a determined and adequately supportive program to make health care services more accessible to people, all of whom will be entitled to receive basic benefits. Specifically, this will require a greatly accelerated development of ambulatory and primary care centers, particularly in areas of special
need, mental health centers, and especially organizations that assume responsibility for providing comprehensive and continuous care.

There should be a strong and sound organization established to implement an effective planning and administrative structure required to bring together both the financing and delivery functions of health care. The comprehensive health planning organizations should bring to bear the new financial resources developed through a national health insurance program to plan and foster improvements in the delivery system. These comprehensive health planning organizations should be converted as soon after the adoption and implementation of a national health insurance program into regional health services agencies.

The powers of the established agencies should be augmented to include the planning of facilities and resources—the review of those presently existing and development of priorities for improvement. These agencies should have authority to delegate tasks to other planning agencies handling these functions and to assume planning functions of other agencies that are performing inadequately. They should be empowered to encourage, support, and authorize organizations to develop comprehensive health maintenance programs according to approved guidelines and standards for better services and lower costs. Essential to the development of effective new health delivery systems is the proper training and use of manpower, particularly of physicians' assistants and other allied manpower. Planning of manpower development should be coordinated on a national level. There should be increased support and development of health manpower training programs, following systematic central planning by a national health manpower program located in the
office designated by the President as responsible for the program.

The financial aspects for a national health insurance plan should be provided through: 1) employers who are required by statute to provide a minimum level of employment-based insurance protection for all employed persons and their dependents for specified basic benefits under qualified plans, 2) Medicare, which would be continued to cover aged persons under the Social Security System and those eligible for disability benefits under both the Social Security and the Railroad Retirement Acts with certain modifications in benefit provisions. The Medicaid program would be abolished and, 3) federally sponsored community trusteedships should be established to assure basic benefits for all persons ineligible under the above categories. These would include the poor and near-poor people between jobs as well as the long-term unemployed, part-time employees not qualified for employment-based plans, and the self-employed. Also, covered in this category would be aliens, the temporarily disabled and people regarded as uninsurable by customary insurance standards, to the extent practically and legally feasible. Because market forces work imperfectly to supply health care at reasonable cost, it is recommended that it would be advisable, during the inauguration of a national health insurance program to keep governmental controls over all health care fees, charges and wages to avoid runaway costs during the transitional period.

The role of the public hospitals as the most highly organized component in the delivery of health care are becoming even more critical as they have remained at the core of many proposals for new delivery systems, even while little progress has been made in converting them to
this role. Hospitals have encouraged and sponsored the development of prepayment and insurance funds, and they have received a large share of these funds. Steps should be taken to improve the efficiency of hospitals, to moderate rising costs which have been passed on through carriers to consumers, and to bring hospitals into full participation with new delivery systems. Many of these steps have been identified and are now well known. They are more honored than practiced, and they include the following:

1. Rounding out planning networks so that all hospitals are involved in effective planning and every locality has a strong planning agency concerned with health needs and facilities.

2. Converting under-utilized beds to other needed uses before expansion of a hospital is permitted.

3. Encouraging full operation of hospitals on weekends.

4. Consolidating some hospitals and converting others to different kinds of uses.

5. Making Professional Standards Review Organizations (PSROs) and utilization review procedures function as a requirement of all insurance plans and providing external as well as internal review.

6. Strengthening hospital management by exchange of data and by providing technical assistance to aid hospitals in solving management problems.

7. Improving statistical reporting by establishing uniform categories and definitions.

8. Expanding existing programs of grants and loans to replenish facilities and build new facilities.

9. Establishing cost incentives that put the hospitals at risk.
The hospital has a central role in any health care system. The degree to which it may involve itself in the organization of that system is dependent on its success in internal restructuring and its success of, and participation in community programs. Although it is believed that each hospital has an individual responsibility for bringing about many of the needed reforms, it is clear that some of them cannot be accomplished without concerted or group action by hospitals generally. The public hospitals should have a major role in meeting the major objectives of a national health insurance plan which will meet the goals of insuring access to medical care, avoiding financial hardships, limiting the rise in medical care costs and distributing the cost among the different income classes of all Americans.

A Recommended Plan for National Health Insurance Security and Services:

National Health Insurance for Americans has become a national and political issue which must be resolved by the federal government, because the total health care delivery system is not meeting the needs of the nation. The American public is spending too much for health care and services. The quality of care is not as it should be, and it is not available to all who need it. America has not kept up with other industrial countries in the field of health care delivery and services, such as infant mortality, maternal mortality, and life expectancy. In addition, many studies show that a high percentage of today's surgery is unnecessary and should not have been performed.

The primary issues of a national health insurance program will require establishment of a broad system for health care services and delivery for all American citizens. Not only must the program provide
health services and delivery of services, it must also establish the
methods and means of implementing and controlling preventive medical
services which will be made available to all Americans regardless of
their race, color, creed, background, or geographical location. The
program must eliminate all possibilities of discrimination being prac-
ticed by any provider or institution in the health care services or
delivery system.

The American government and its people cannot wait for solutions
to be developed by the private sector, (insurance companies, hospitals,
or physicians) who have already substantiated that, because of their own
desires and interests, it is impossible for the private sector to estab-
lish a private insurance program which is capable of providing health
care services to all Americans at a reasonable cost which can be equitably
distributed among different income classes.

The following plan is recommended to meet the American's overall
health requirements and the established major goals of ensuring access to
health care, avoiding financial hardships, limiting the rise in medical
care costs and distributing the costs equitably among all Americans.

Plan Title: National Health Insurance Security and Services Plan of 1977.,
California State College, San Bernardino (C.S.C.S.C.) I., by
Citizen Wallace D. Kinney.

Description of Bill

A. General Approach: The plan would provide for the establishment of a
national health insurance program that would cover all United States
residents and would not exclude anyone because of family composition,
employment status, or working ability (past, present, or future).
The plan would eliminate, or prevent deprivation of care because of inability to pay for medical care. The program includes requirements that would reorganize and improve the method of delivery for health care services, alleviate shortages and mal-distribution of health personnel and facilities, and provide incentives, through grants and loans, to encourage providers of health care services to utilize their staff and facilities more efficiently and effectively.

B. People Covered: All United States residents would be eligible for benefits as covered by the plan. There would be no requirement for contributions to any other governmental programs or prior employment status.

C. Scope of Benefits: The plan would cover in-hospital and outpatient hospital services, including services of specialty and emergency clinics, family planning services, prescription drugs, preventive medical services, dental services, skilled nursing home services, and mental health services. Services provided by paramedical personnel would be covered if provided under the direction of a physician. The broad benefits would be available to all members of American families.

D. Administration: The plan would be administered by the federal government through the use of Health Services Agencies. The agencies would be responsible for the general administration of the plan, including policy and regulation, control of expenditures, standards and reimbursement for providers of services, quality of health care services provided, and monitoring of costs.
for the program. The agencies would be provided assistance through state and local governments who in turn could utilize private organizations to perform, control, and monitor activities over the various health care providers, with supervision being provided by the federal governmental agencies.

E. **Financing:** The program would be financed through a combination of general revenues and a tax on payrolls and on earned income. The plan would be financed to insure that a burden does not fall disproportionately on low-income families. The program is planned to keep costs down, as a financing system must both encourage efficient use of resources and discourage medical care price inflation. Hospitals would be required to control the forces that raise the cost of care, increase requirements for personnel, unnecessary pay raises, and expansion of technical facilities and services. Physicians would be required to accept the allowable charge as full compensation for services. The financing method of the plan would encourage cost consciousness in the decisions of patients, doctors and hospital administrators.

F. **Payments to Providers of Services:** The federal office assigned to administer the nation's health care delivery system would budget annually for the nation's health care services to provide total health care services to all Americans. During the implementation phase of the adopted plan, the prospective methods of reimbursement for hospitals and other institutional providers would be finalized and maintained in a constant state of flexibility. The reimbursement plan must be flexible to insure that
rapid payment is possible due to constant changes that may have been unforeseen during the planning and implementation phase. The plan would have controls established that place limits on per patient costs. There would be limits placed on incomes of physicians and hospital-based specialists, such as anesthesiologists, radiologists, and pathologists. Fees would be established on a basis to encourage a socially appropriate distribution of physicians by location and specialty.

G. **Effect on Other Government Programs:** Medicare and Medicaid programs would be terminated. Many of the good elements of the Medicare program would be incorporated into the detailed aspects of this plan. The Veterans Administration hospitalization and out-patient treatment program would be continued without change.

H. **Other Major Provisions:** Incentives are established to stimulate group practice organizations to encourage the training of medical personnel, continuing education and effective utilization of health personnel and facilities. The plan encourages strong ties and relationships between physicians, specialists, and other patient-care resources. The plan would establish ceilings on maximum contributions to health care required by any family. It eliminates tax subsidies for supplementary insurance payments. Places health care consumers on advisory boards of the federal agencies, and establishes grievance procedures for patients to file complaints for inadequacy of care or resolving problems in handling claims. The plan would prohibit hospitals, physicians, and other providers from discriminating against patients on the
basis of race, nationality, or creed. The plan creates reimbursement programs to encourage optimal utilization of medical resources in rural areas.

The plan establishes methods and means for restructuring and reorganizing the health care delivery system. It insures that all Americans who desire and need health care services to improve or maintain their health status have access to, and opportunity to receive health care without being fearful of financial hardships. The plan would limit allocation of financial resources for capital expansions to approved projects that are needed in communities to provide the needed health care services.

There is control over utilization of health services to assure that American people receive and pay for only the health care actually needed. The plan would create a program of health education that would teach patients and the public to make better use of health care services, and to exercise greater responsibility for their own health. The plan's major objectives are to make health care more accessible, more effective, and more efficient, so that the American public can realize a greater return from the tremendous national health expenditures necessary to control and operate a national health insurance security and services program.
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