Problems and Issues in National Health Insurance

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Foreword

For many years the Federal government has conducted a wide variety of programs dealing with specific medical problems and providing health care for certain groups. This role was greatly enlarged in 1965 with the adoption of Medicare and Medicaid, two broadly based programs to assist the aged and the poor. Among other effects, these new programs were largely responsible for a sharp rise in medical care prices. Some observers hold that these high costs have placed adequate health care beyond the range of many persons. This problem, and other considerations, have led critics of the present health care system to call for a further extension of the national government's role in medical and health care.

Since the early 1970's many different plans for a national health insurance system have been proposed, and scores of bills are now before Congress, representing a broad range of approaches. Both executive and legislative leaders have recently underscored their interest in early adoption of national health insurance. However, no consensus has been reached on certain important issues.

Developing a plan for national health insurance requires decisions and compromises on a host of confusingly complex questions. This study attempts to provide a comprehensive, though abbreviated overview of the major issues under discussion. It compares the salient features of the major proposals which have emerged to date, provides perspectives in differing points of view, and points up some of the broader implications.

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I. Summary and Conclusion

Although dating back more than half a century, proposals for comprehensive national health insurance in the United States received only scant public attention until recently. Since the early 1970's both Congress and the executive branch have demonstrated new interest in the issue. Numerous bills calling for national health insurance were introduced in both the 92nd and 93rd sessions of Congress. These different measures reflect a broad spectrum of political opinion. Suggested changes range broadly, from those which would mitigate only the most serious problems in the present health care system to those which would bring sweeping innovations, virtually replacing the existing system.

Both the Administration and congressional leaders have indicated a strong desire to institute a comprehensive national health insurance program at an early date. At the same time, many issues remain in dispute as to the kind of program which would best serve the nation's health needs, if changes are to be made.

The Federal government has for many years maintained a variety of health programs, including research, construction, prevention and control of health problems, and provision of services for defense personnel and veterans. In 1965 the scope of the national government in medical and health-related activities was greatly expanded by the adoption of Medicare and Medicaid. The impact of these new programs is reflected in the rise in Federal health and medical expenditures from $5 billion in 1965 (4 percent of Federal outlays) to an estimated $36 billion (12 percent of the total) in 1975. During a similar period Federal health outlays rose from 12 percent of all national health expenditures in 1965 to 26 percent in 1973.

Somewhat ironically, much of the recent interest in comprehensive national health insurance stems from the adoption of Medicare and Medicaid. It is widely acknowledged that these two programs were influential in generating sharp price increases, by over-stimulating demand for medical and health services relative to available supplies, combined with the use of financing methods which proved ineffective for controlling price increases. Advocates of national health insurance hold that the high costs of health services have placed adequate care beyond the reach of large numbers of the population.

The major proposals recognize the inflationary potential of still broader programs of health care. All contain some cost control provisions, even those measures which are based on the concept that access to medical care in whatever amounts and at whatever quality level is a "basic right." Deductibles and co-insurance payments are required under the great majority of proposals. In addi-
tion, some measures foster prepaid group insurance plans, under the assumption that this new approach to health care delivery could play an important role in cost control.

While discussants are at odds on many facets of the health care issue, there is widespread agreement that there are at least two problem areas deserving attention: (1) protecting the entire population against the costs of catastrophic illness and (2) closing the remaining gaps in basic coverage. Even the aged, otherwise generously treated under Medicare, and middle and upper-middle income families can suffer financial disaster as a result of prolonged, serious illness. While private and public insurance provides some coverage for most Americans, it has been estimated that millions of persons - 11 percent of the population - have no protection. Many with coverage do not even have adequate basic benefits.

All major proposals would entail at least small to moderate increases in health care expenditures by American society as a whole. In the first year of a new program, total health outlays would be higher (by an estimated 4 to 13 percent) than costs under present financing arrangements. All measures would expand - in some instances substantially - the share of costs borne by Federal taxpayers. The most costly of the major proposals calls for an increase to 86 percent (from the present 26 percent) in the share of all personal health care expenditures financed through the national government.

Various experts have called for a cautious approach in developing a national health insurance policy, and for a careful weighing of the alternatives and full public discussion of the complex issues involved. Concern has been expressed as to a number of possible effects, including the following:

(1) The variety of financing methods under consideration presents basic issues regarding the distribution of program costs among segments of the population and the effects on the over-all operation of the economy. Under most proposals examined in the study, much of the cost increase would fall - in the first instance - on employers, either through higher insurance premiums or payroll taxes. To the extent that financing does impose heavier burdens on private industry, the costs of doing business will be raised. Depending on the type of firm and its product, such increases may be borne by the consumer, the employee, the employer, or varying combinations of all three. To the extent that added costs are borne by employers, there is the attendant risk that these costs would dampen business incentives to generate new productive capacity and employment opportunities.

(2) While there is general agreement that there are areas of legitimate concern, justifying policy changes in the present health care system, there are many areas of uncertainty as to how a new system would work out in practice. The entire subject involves a host of detailed, intricate issues difficult even for experts in the field to comprehend. No one knows for certain how well or how poorly the various cost control devices in the different proposals would work; what the actual, as compared with the estimated, cost increases under any of the proposals would be; or what economic effects the financing proposals would have. Moreover, there is no guarantee that higher outlays - even if accompanied by increases in both quantity
and quality of medical services — would improve the basic health status of the American people.

(3) There are serious difficulties in designing a program which will ensure adequate health services for the general population while guarding against "over-utilization." While some assert that unlimited access to health care is a "basic right," others contend it would give an open-ended commitment to one social objective at the expense of others, equally desirable.

(4) There is uncertainty as to the broader economic effects of adopting a comprehensive national health insurance program. Its operations would clearly have ramifications extending throughout American society. Thus it is important that careful consideration be given to all aspects of proposed changes, both to ensure that maximum benefits are obtained per dollar of outlays, and to avoid creating serious new problems while attempting to eliminate others.

Finally, recent surveys indicate that national health insurance commands a fairly low priority among problems of broad popular concern, with the “number one” problem being the economy and inflation. While the estimated incremental costs of any of the proposed health care measures appear small in relation to a gross national product of some $1.4 trillion, this added spending would undoubtedly have some effect on inflationary pressures. In view of current emphasis on the containment of over-all demand, restraining growth in Federal outlays, new budgetary control procedures, and tight monetary controls, questions may also be raised as to the possible adverse psychological effects on the nation at large of embarking on a major new spending program. Moreover, should the subsequent development of national health insurance parallel experience with many other new Federal programs, actual future outlays could well be far in excess of initial cost estimates.
II.

Background

Private health insurance in the United States first developed in response to public demand for protection against the frequent rail and steamboat accidents of the mid-19th century. The nation's first accident insurance came into being in 1850. Since that time, the American people have also been interested in obtaining insurance coverage against the unpredictable costs of sickness. The earliest forms of private health insurance in this country protected the policyholder against loss of earned income resulting from illness due to a limited number of diseases. The insurance did not pay the costs of hospitalization or physicians' services.

By the late 1930's, private group insurance became the most common approach for protection against the costs of medical treatment. Group benefit plans of employers, contracted with private carriers, became the prevailing means by which the great majority of Americans have obtained insurance coverage.

There is a long tradition of government support for medical care. During most of the nation's history, however, such assistance was provided primarily at the state and local level, with states supporting mental health facilities and localities providing help for the indigent. Serious discussion of compulsory

national health insurance did not occur until the second decade of the twentieth century. By the end of World War I, suggestions had been made for comprehensive, tax-financed health insurance coverage. The issue was revived during the early 1930's when it was argued that if there were to be national health insurance, it should be a Federally-administered compulsory plan. The concept was subsequently periodically revived during the administrations of Presidents Franklin D. Roosevelt and Harry S. Truman. However, Congress was not receptive to the idea.

While the Federal government was reluctant to consider any over-all national health plans, it did engage in a number of limited activities to mitigate certain national health problems. Health services for reservation Indians, merchant seamen, veterans, and research in health programs were of long standing. The Hill-Burton program, which was enacted in 1946 and became effective in 1948, provided assistance in the construction, improvement, and equipping of public and non-profit voluntary hospitals. In 1950, a program of Federal participation in state vendor payments for the medical care of public assistance recipients was initiated. In 1960, the Kerr-Mills act provided for Federal sharing in state programs of medical

References in this study to the Federal government's role in the health area exclude its programs for increasing the number of medical practitioners as well as operations of the Food and Drug Administration of the Department of Health, Education, and Welfare.
assistance to cover the "medically indigent" aged.2

In 1965, two broadly-based programs — Medicare and Medicaid — were set up to assist the two groups considered most in need of help in meeting their health care costs — the aged and the poor. Proponents felt that these two segments of the population had inadequate private health insurance, and that out-of-pocket costs deterred them from seeking medical care.

Since then various developments have engendered considerable discussion of the nation's health care system. Even prior to adoption of Medicare and Medicaid, medical costs were rising more rapidly than the general price index. Following enactment of these two programs the increase was spectacular. This resulted from imposing a sharply expanded effective demand for medical services on a supply which responded slowly, combined with financing methods which were ineffective in controlling cost increases.

Apart from their inflationary impact, Medicare and Medicaid led to a substantial increase in the role of the Federal government in financing the nation's health care. For many years prior to 1966 about 12 percent of all health and medical care was financed through Federal programs. (See Table 1.) By 1973 this share had risen to 26 percent. In this interim — 1965 to 1973 — Federal spending for health purposes rose by 432 percent, as compared to a rise of 92 percent in private spending and 163 percent in state-local outlays for health and medical care.

Advocates of drastic change in the health care system make much of the fact that American medical and health spending costs increased nearly 8-fold between 1950 and 1973 and that these expenditures, measured both in absolute terms and as a percentage of Gross National Product (GNP), exceed those of any other industrialized country. At the same time critics of the present system point out that the United States trails certain foreign countries, such as the Netherlands, Norway, and Sweden in such basic health criteria as infant and maternal mortality, and over-all longevity of the population.

Widespread attention has also been given to accounts of the damaging effects on individuals and families of gaps in existing health insurance coverage. Spectacular, even if isolated, instances are cited where families were driven to financial ruin as a result of the costs of prolonged, severe illness. Critics charge that the existing system, taken as a whole, places the costs of "adequate" health care beyond the reach of large numbers of American citizens and is in general incapable of responding to current medical requirements.

Proponents of substantial revisions assert that "opposition to national health insurance has melted on the left as on the right"; that "if national health insurance fails to pass this Congress, it will not be because the idea is too radical ..." and "that some form of national health insurance will be enacted in the next couple of years now seems virtually certain."3 Some of the concept's more enthusiastic proponents have referred to "National Health Insurance: An Idea Whose Time Has Come?"4

2. "Medically indigent" persons may be defined as the near poor who would experience considerable difficulty in meeting normal health care expenses, but who do not receive cash welfare allowances.


Other students of health care, however, dispute the over-all validity of these criticisms. While admitting that the American health care system has its shortcomings, they contend that it operates in a reasonably effective manner, even when compared with certain foreign systems which are often held up as models to be emulated. These commentators charge critics with resorting to overstatements and sweeping simplifications which, they assert, are not borne

Table 1
Health and Medical Care Expenditures by Source of Funds and Type
Selected Fiscal Years 1950-1973

<table>
<thead>
<tr>
<th>Item</th>
<th>1950</th>
<th>1960</th>
<th>1985</th>
<th>1970</th>
<th>1973a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount (millions of dollars)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total expenditures</td>
<td>12,027</td>
<td>25,856</td>
<td>38,892</td>
<td>68,083</td>
<td>94,070</td>
</tr>
<tr>
<td>Private expenditures, total</td>
<td>8,962</td>
<td>19,460</td>
<td>29,357</td>
<td>42,851</td>
<td>56,516</td>
</tr>
<tr>
<td>Health and medical services</td>
<td>8,710</td>
<td>18,815</td>
<td>28,023</td>
<td>40,492</td>
<td>53,583</td>
</tr>
<tr>
<td>Direct payments</td>
<td>7,107</td>
<td>12,575</td>
<td>17,577</td>
<td>23,281</td>
<td>28,127</td>
</tr>
<tr>
<td>Insurance benefits</td>
<td>874</td>
<td>4,698</td>
<td>8,260</td>
<td>14,406</td>
<td>20,463</td>
</tr>
<tr>
<td>Otherb</td>
<td>724</td>
<td>1,542</td>
<td>2,166</td>
<td>2,805</td>
<td>4,963</td>
</tr>
<tr>
<td>Construction of facilities</td>
<td>215</td>
<td>524</td>
<td>1,172</td>
<td>2,166</td>
<td>2,743</td>
</tr>
<tr>
<td>Medical research</td>
<td>37</td>
<td>121</td>
<td>162</td>
<td>193</td>
<td>220</td>
</tr>
<tr>
<td>Federal expenditures, total</td>
<td>1,362</td>
<td>2,918</td>
<td>4,625</td>
<td>16,600</td>
<td>24,620</td>
</tr>
<tr>
<td>Health and medical services</td>
<td>1,060</td>
<td>2,175</td>
<td>3,075</td>
<td>14,494</td>
<td>22,005</td>
</tr>
<tr>
<td>OASDHI</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Public assistance</td>
<td>84</td>
<td>200</td>
<td>555</td>
<td>2,507</td>
<td>4,846</td>
</tr>
<tr>
<td>Public health activitiesc</td>
<td>583</td>
<td>879</td>
<td>1,115</td>
<td>1,651</td>
<td>2,587</td>
</tr>
<tr>
<td>Veterans' care</td>
<td>336</td>
<td>820</td>
<td>858</td>
<td>1,496</td>
<td>2,108</td>
</tr>
<tr>
<td>Defense Department care</td>
<td>57</td>
<td>184</td>
<td>254</td>
<td>805</td>
<td>1,550</td>
</tr>
<tr>
<td>Other</td>
<td>229</td>
<td>295</td>
<td>376</td>
<td>529</td>
<td>638</td>
</tr>
<tr>
<td>Construction of facilities</td>
<td>73</td>
<td>448</td>
<td>1,174</td>
<td>1,577</td>
<td>1,977</td>
</tr>
<tr>
<td>Medical research</td>
<td>1,704</td>
<td>3,478</td>
<td>4,910</td>
<td>8,632</td>
<td>12,934</td>
</tr>
<tr>
<td>State-local expenditures, total</td>
<td>1,411</td>
<td>3,172</td>
<td>4,566</td>
<td>8,082</td>
<td>12,004</td>
</tr>
<tr>
<td>Health and medical services</td>
<td>51</td>
<td>293</td>
<td>812</td>
<td>2,606</td>
<td>4,077</td>
</tr>
<tr>
<td>Public assistance</td>
<td>240</td>
<td>1,870</td>
<td>2,378</td>
<td>3,099</td>
<td>4,329</td>
</tr>
<tr>
<td>General hospital and medical care</td>
<td>327</td>
<td>551</td>
<td>544</td>
<td>1,329</td>
<td>2,150</td>
</tr>
<tr>
<td>Public health activitiesd</td>
<td>188</td>
<td>411</td>
<td>569</td>
<td>959</td>
<td>1,340</td>
</tr>
<tr>
<td>Worker's compensation</td>
<td>4</td>
<td>47</td>
<td>64</td>
<td>89</td>
<td>108</td>
</tr>
<tr>
<td>Other</td>
<td>293</td>
<td>283</td>
<td>289</td>
<td>474</td>
<td>850</td>
</tr>
<tr>
<td>Construction of facilities</td>
<td>-</td>
<td>23</td>
<td>55</td>
<td>76</td>
<td>80</td>
</tr>
<tr>
<td>Medical research</td>
<td></td>
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</tbody>
</table>

Percentage distribution

| Total expenditures                  | 100.0  | 100.0  | 100.0  | 100.0  | 100.0  |
| Private                             | 74.5   | 75.3   | 75.5   | 62.9   | 60.1   |
| Public                              | 25.5   | 24.7   | 24.5   | 37.1   | 39.9   |
| Federal                             | 11.3   | 11.3   | 11.9   | 24.4   | 26.2   |
| State-local                         | 14.2   | 13.4   | 12.6   | 12.7   | 13.7   |

Exhibit: Total as a percent of GNP  
Consumer price index (1950 = 100)  
Medical care price index (1950 = 100)

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>4.6</td>
<td>5.2</td>
<td>5.9</td>
<td>7.1</td>
<td>7.7</td>
<td></td>
</tr>
<tr>
<td>100.0</td>
<td>123.0</td>
<td>131.1</td>
<td>161.3</td>
<td>184.6</td>
<td></td>
</tr>
</tbody>
</table>

1. Preliminary.
2. Includes expenses for prepayment, industrial in-plant services, and philanthropy.
3. Includes maternal and child health programs and school health services.
4. Includes temporary disability insurance, military dependents' medical care, medical vocational rehabilitation, OEO health and medical care.
5. Includes governmental services.
6. Includes government services.
7. Includes government services.
8. Includes government services.
9. Includes government services.
10. Includes government services.


10
Opponents of drastic revision of the health care system cite evidence indicating that while there is broad interest among the American people in this issue, it does not appear to be very intense. A recent survey by a well-known national polling organization found that a 54 to 28 percent majority of the sampled population (with 18 percent, unsure) favored passage of a comprehensive Federal health insurance program. However, another recent sampling of the population by the same group indicated that health care ranked 14th among a list of 15 items currently of concern—3 percent of respondents mentioned this issue, compared to 72 percent referring to “economy/inflation.” A survey by a similar organization found that national health insurance was not included at all among the seven major items of greatest concern.

The following section describes salient features in several of the more significant proposals introduced in the 93rd Congress for comprehensive revision or at least important modification of the existing health care system. Succeeding sections discuss various issues related to the over-all problem.

7. Louis Harris & Associates; mid-April, 1974 survey.
8. Ibid., September, 1973 survey.
III. Proposals to Revise the Health Care System

Since the early 1970's, proposals for changes in national health care policy have been topics of intensive study and discussion. Among those participating have been: private organizations dealing with public policy issues,1 academicians specializing in medical economics, members of both parties in Congress, and the national Administration. Over 40 national health insurance bills were introduced in the 92nd Congress (1971-1972). In the 93rd Congress (1973-1974), no fewer than 98 such proposals were submitted in the House of Representatives, as of July 16, 1974.

In general, discussions, recommendations, and legislative proposals concerning health care revision have focused on the following principal subject areas:

(1) Closing the gaps in coverage for those segments of the population now lacking any form of public or private health insurance protection;

(2) Protecting all socio-economic groups from the unusually high costs of catastrophic illness, which only the very affluent may be able to face without incurring financial ruin;

(3) Controlling the upward trends in the costs of all medical services and hospital facilities;

(4) Insuring availability of health services for those in genuine need of them, while discouraging over-utilization by hypochondriacs and the "worried well";

(5) Agreeing on the appropriate amounts of national resources to be allocated for health needs versus other socially desirable purposes;

(6) Determining the proper role which the public sector, particularly the Federal government, should assume in the administration and financing of health care;

(7) Deciding the suitable share of medical expenses to be borne by patients as contrasted to "third parties";2

(8) Determining whether alternative methods of delivery of health services would promote efficiency and reduce costs.

There is a wide variation in both the private recommendations and legisla-


2. "Third parties" in this context are public and private health insurance plans.
tive proposals. Some would scrap virtually the entire existing health care system, replacing it with a drastically innovative alternative. One such approach would provide comprehensive government-operated and financed health insurance for all, granting almost unlimited benefits for services and use of facilities—with no stipulations for deductibles or requirements for coinsurance payments. Other suggestions would retain varying elements of the present arrangements while extending coverage, enriching benefits, tightening supervision, or modifying financing methods.

This wide diversity of views concerning the most effective manner to deal with the national health care system was pinpointed by a 1972 statement by the Brookings Institution:

Deciding what is the appropriate role in providing health insurance and designing a system to carry it out pose some of the most difficult problems of social policy facing the government and the electorate today. The availability of medical services is critical to those who need it; the system that delivers these services is exceedingly complex and to those who use it often mysterious; the objectives that a federally subsidized insurance system seeks to accomplish often conflict with one another and must inevitably be compromised; and the clash of interests is sharp. Difficult substantive questions and acute political controversy combine to make health insurance an exceptionally thorny problem.

As far back as July, 1969, President Richard M. Nixon expressed the view that America's medical system faced a "massive crisis." In February, 1971, he followed up this remark by the even stronger comment that the crisis had subsequently deepened. These statements were followed by introduction of bills in the 92nd Congress, on behalf of the Administration, embodying what was described as the "mixed public-private approach," and establishing a two-part national health insurance plan covering nearly the entire population below age 65.

No action was taken on these proposals, nor on any other national health insurance measures presented at that time, and the bills were not reintroduced in the 93rd Congress. Instead, as part of his 1975 budget message, the President referred to a new Administration health plan which "would bring comprehensive insurance protection against medical expenses within reach of all Americans." Immediately thereafter substantially modified Administration measures were submitted, eliminating the gaps in coverage as well as the "two-level" medical treatment approach embodied in the earlier recommendations.

While not withdrawing his earlier proposal, which recommended the most drastic revisions in the American health care system ever submitted to Congress, Senator Edward M. Kennedy, in conjunction with Representative Wilbur D. Mills introduced a subsequent bill, considerably less far-reaching in its objectives. Variations between the main features of this measure and the bill submitted for the Administration were

3. This approach was embodied in the Health Security Act, introduced in the 92nd Congress (1971) by Representatives Martha W. Griffiths of Michigan and James C. Corman of California, and Senator Edward M. Kennedy of Massachusetts. The measure was reintroduced in the 93rd Congress. It has been endorsed by the AFL-CIO, the United Automobile Workers (UAW) and the Committee for National Health Insurance.
thought by many commentators to be sufficiently narrow to permit compromising the differences through the normal political process.

Program administration is one important area in which there is less of a gap between the most recent Administration and Kennedy health insurance plans than was the case concerning their earlier proposals. The designation accorded the Administration plan introduced in the 92nd Congress — a “mixed public-private approach” — remains a valid description for its current recommended legislation. While the new Kennedy bill still involves a “mainly public approach,” it does provide a greater role for private institutions than the earlier version.

The Administration’s earlier bill provided for administration by both the Department of HEW and private insurance carriers operating under Federal supervision. Senator Kennedy’s previous proposal would have eliminated the role of the private health insurance industry on the grounds that “there is no place for profit-making and competition for profits” in health care. The proposed health insurance plan was to be administered by a special board within the Department of HEW, with actual program operation entrusted to regional and local offices.

The Administration’s present proposal would provide insurance through private carriers (or self-insured arrangements) supervised by the states under Federal regulation; as well as through coverage administered directly by the national government. The Kennedy-Mills plan would be administered by a new independent Social Security Administration, but would employ “intermediaries” for institutional services as is presently done under Medicare. “Carriers selected by large employers” would administer physicians’ and other non-institutional services for their employees. For persons not covered by large employers, the Social Security Administration would award two-year contracts, on a competitive basis, to carriers in each geographic area of the country.

Other significant health insurance proposals currently before Congress include: the measure introduced by Senators Russell B. Long of Louisiana and Abraham A. Ribicoff of Connecticut,8 aimed at remedying two specific shortcomings in the present system by providing catastrophic illness protection for the general population, and basic health insurance for those poor and near poor who still lack such elementary coverage; the “Medicredit” bill, endorsed by the American Medical Association, which relies heavily on promoting adequate health coverage through purchase of private insurance policies by granting personal income tax credits to cover all or part of premium costs;9 and bills supported by the American Hospital Association10 and the Health Insurance Association of America.11 The last two plans, though differing somewhat in content, would provide a three-part national health insurance system covering: (1) employees, (2) individuals, and (3) low-income or otherwise disadvantaged groups.

8. The Catastrophic Health Insurance and Medical Assistance Reform Act, S. 2513.
10. The National Health Care Services Reorganization and Financing Act, H.R. 1, introduced by Representative Al Ullman of Oregon.
This section deals with specific issues that have arisen in connection with current discussion of national health insurance or which relate to the entire existing health care system. These items include: (A) catastrophic illness, (B) health insurance coverage and (non-catastrophic) benefits, (C) “over-utilization” of health care services, (D) alternative methods of delivering health care, (E) financing methods of current proposals, and (F) estimated costs of current proposals.

**A. Catastrophic Illness**

Of all the problems related to operations of the health care system, perhaps the greatest amount of public concern has been caused by those spectacular instances where families, including some in the middle and upper-middle income brackets, have been forced into acute financial straits, at times even bankruptcy, by the huge financial burdens resulting from severe, prolonged, “catastrophic” illness on the part of one of their members. There is, in fact, a noticeable tendency to equate alleged shortcomings of the present health insurance system and its lack of safeguards against these severe economic duress resulting from unusually high medical bills.

Moreover, many persons, within and without Congress, who are cool to proposals for major revamping of the present health care system appear to regard the lack of protection against “catastrophic” sickness as a legitimate shortcoming which should be remedied. For this reason, some observers have stated that if the problem of “catastrophic” illness were resolved, much of the pressure to revise the overall health care and health insurance systems would be substantially reduced. For exactly the same reason, proponents of large-scale revamping oppose adoption of such legislation, fearing — possibly correctly — that this would postpone indefinitely achievement of their basic goal.

Large numbers of the poor and near poor are not covered by health insurance of any sort. Thus, they do not have even partial protection against the effects of catastrophic illness. In addition, many other persons who have health insurance of one sort or another are only partially protected against such a contingency. The aged are in many respects “generously” covered by Medicare. They are, nevertheless, exposed to the possibility of high out-of-pocket costs in the event of prolonged hospitalization or extremely serious out-of-hospital illness. Medicare sets definite ceiling on the expenses which it will assume.  

Many middle and upper-middle income individuals and families also have inadequate protection. Private insurance


2. The elderly, four-fifths of whom had annual incomes below $10,000 in 1970, paid twice as much out-of-pocket medical expenses as did younger segments of the population. Since the aged are much more likely to incur prolonged illness than other groups, a sizable proportion of their out-of-pocket payments must be for catastrophic illness.