policies under which such persons are covered do not as a rule offer safeguards against catastrophic medical expenses. For example, in 1970 only half the population was covered by major medical plans which reimbursed the policyholder for very large medical bills. Moreover, even major medical plans typically contain limits on the expenditures which they will assume and require patients to pay sizable portions of expenses incurred. Finally, the Federal personal income tax deductions for medical and drug expenses may be of relatively little help in the event of catastrophic illness.

For these reasons, catastrophic illness protection has been given considerable attention in the new health care legislation introduced in the 93rd Congress, as it had been in earlier proposals submitted in the 92nd. This provision is an important feature in a number of the more significant bills, introduced by both the Administration and the opposition party, aimed at affecting significant revisions in the entire health insurance—health care system. The Administration’s proposal would provide unlimited quantities of virtually all important medical services, save for such items as treatment of mental illness, skilled nursing facilities, or home health services. The Kennedy-Mills bill would also ensure whatever amounts were required of almost all significant health care benefits, with almost identical limitations.

In addition, there are a number of bills which because of their special focus on this issue have been specifically labelled catastrophic protection legislation. Probably the most publicized of these plans is the previously mentioned proposal by Senators Long and Ribicoff. Title I of the bill would set up a catastrophic health insurance plan for all persons covered by the social security system, their spouses and dependents. In addition, state and local governments could exercise an option to buy into the program to cover, as a group, all their employees and annuitants not covered by social security, under an agreement with the Federal government.

Catastrophic coverage would provide additional hospital and extended care services after individuals have been hospitalized for a total of 60 days in one year, and medical services after a family had incurred a total of $2,000 for such covered items as physicians’ treatment, home health visits, physical therapy, and laboratory and X-ray services. Thereafter, patients would only be liable for coinsurance payments, not to exceed $1,000 per year, to defray:

1. One-quarter of the inpatient deductible stipulated by Medicare for each additional hospital day;
2. One-eighth of Medicare’s inpatient deductible for every day of post-hospital institutionalization in an extended care facility;
3. One-fifth of medical expenses in excess of $2,000.5

3. There has been a tendency, however, to increase substantially the limits of expenses covered by major medical components of health insurance plans provided by private corporate employers. According to data developed by the Conference Board the typical maximum coverage increased from $10,000 “toward $50,000 per individual” over the past decade. David A. Weeks, “If National Health Legislation Is Enacted . . . What about Corporate Benefits Plans?” The Conference Board Record, Vol. XI, No. 7, July, 1974, p. 46.

4. At least four other bills, focusing on catastrophic protection were introduced in the 93rd Congress.

5. Patients would be treated more generously in regard to deductibles by both the Administration and Kennedy-Mills proposals. The employee health insurance portion of the Administration’s measure would require beneficiaries to pay the first $150 of medical bills per person per year and 25% of expenses exceeding that amount up to a maximum of $1,500 per family, annually ($1,050 for individuals). The “assisted plan” portion provides for identical cost-sharing provisions, but at the same time stipulates that they are to be reduced “according to individual or family income.” The “plan for the aged” portion prescribes $100 deductible and 20% coinsurance per person, but reduces cost sharing “according to individual or family income for low-income aged.” The Kennedy-Mills bill provides for deductibles of $150 per person on all services except “those listed as preventive care.” Coinsurance (except for drugs) would be limited to 25% up to $1,000 per family per year. There would, however, be reduced cost-sharing for lower-income families, with none for those at the lowest level.
B. Health Insurance Coverage and Benefits

As noted previously, the general population’s lack of protection against the financial ruin which can result from “catastrophic” illness is recognized as a reasonable cause for concern by many persons opposed to extensive revision in the health care system. There is another area which seems to be recognized as a genuine problem by a broad spectrum of political opinion. This involves the gaps in coverage for even basic medical services remaining under all existing public and private health insurance plans.

There has been a tremendous increase in private health insurance in this country in recent decades so that by 1972 the commercial insurance firms, Blue Cross and Blue Shield, independent plans, and other forms of protection covered at least three-fourths of the American population. The Social Security Administration has estimated that as of December 31, 1972, private health insurance covered 159.5 million persons (77 percent of the civilian population) for hospital care, and 153.3 million (74 percent) for physicians’ surgical services. Group contracts, varying widely in benefits provided, are by far the most important type of private coverage. In 1970, slightly more than 150 million persons were covered under these employer plans.

In addition, the Federal and state governments have enacted programs to cover certain population groups against the costs of various health care services. The two most important of these are Medicare to assist the aged (65 and over) and Medicaid to assist the poor, and in some states the near poor and medically-indigent as well.

Private health insurance and the various governmental programs now provide health insurance coverage of one sort or another for the great majority of Americans. However, a substantial minority remains without health insurance of any kind. These consist largely of the unemployed as well as large numbers of the poor and near poor who are working. Many low-income workers are unlikely to have health insurance provided as a fringe benefit by their employers and at the same time cannot afford to purchase this protection on their own. Even in those instances where these lower-income groups have private health insurance, it is often inadequate for even non-catastrophic medical bills.

Government programs do not provide either complete or uniform coverage. The Federal Medicare program contains rather generous provisions for persons 65 and over covered under the social security or the railroad retirement systems, as well as certain persons not insured under these programs. In addition to

6. Benefits mentioned in this section refer to over-all benefit packages—not to benefits specifically designed to cover catastrophic illness.
8. In addition, there are government-financed health services for members of the armed forces and their dependents, treatment for veterans in the Veterans Administration’s large health centers, and the system of neighborhood health centers set up under the antipoverty program.
9. Twenty-nine states provide medical care for the medically indigent.
10. Because of the overlapping of private and public insurance coverage, and the intricate problems involved in determining the exact number of persons eligible for Medicaid, it is difficult to ascertain precisely the number of persons not covered by any form of health insurance. Estimates range between 10 million and 40 million. The Department of Health, Education, and Welfare places the number at 11% of the total population, or some 23 million persons.
11. In 1970 only 39.3% of the population under age 65 with annual incomes less than $3,000 had hospital insurance; an even smaller proportion—36.7%—of persons in this category had surgical insurance. In contrast 90.1% of persons under 65 with yearly incomes of $10,000 or more had hospital insurance; 88.3% of such persons were covered for surgical benefits.
providing a compulsory basic hospital insurance plan, the Federal government also defrays — from general revenue — part of the cost of a voluntary supplemental insurance plan covering physicians’ charges and certain other services. All those eligible for the program are entitled to the same benefits.

While Medicare can be described as providing fairly generous services for its intended clientele, the comment cannot be made concerning over-all operations of Medicaid. While this joint Federal-state program has assisted increasingly large numbers of the poor and near poor in meeting their medical bills,12 it has left millions in these categories unassisted. States are left free to participate or not to participate in the plan13 and have a certain amount of leeway in determining both eligibility criteria and benefits. Certain basic services must be granted to welfare populations by states which opt to participate; however, these can be limited in scope and duration.

Individual states have even greater discretion to deny or limit services to persons who are not cash recipients under one of the categorical welfare programs. Basing Medicaid eligibility on welfare status resulted, in some states, in excluding from program benefits many of the working poor, childless couples, and low-income families with an unemployed father present. These are precisely the persons unlikely to have private health insurance adequate for even non-catastrophic illnesses — or in many cases any insurance protection at all.14

In addition to such direct programs of medical assistance as Medicare and Medicaid, the Federal government provides indirect assistance to individuals and families to meet their health care expenses. Deductions are permitted under the Federal personal income tax law for health insurance premiums up to certain amounts, and for medical and drug expenses in excess of certain percentages of adjusted gross income not reimbursed by health insurance payments. In addition, employer medical insurance premiums and medical care paid for on behalf of employees are excluded from the tax base.

This provision has been criticized as of little help to the poor and near poor who are not liable for Federal tax payments of the size that would make the deductions a worthwhile saving. At the same time these deductions have been simultaneously attacked as both overly generous and insufficiently helpful for the non-poor. Although the validity of their charges have been challenged, critics have stated that the Federal government foregoes substantial revenues15 to assist the middle and upper-middle classes to defray moderate-sized medical bills which they could pay out of their own resources without incurring unduly onerous burdens. On the other hand, it is asserted, the tax advantages do not fully protect the middle class against the type of health care expenses which they cannot pay without experiencing severe economic burdens.

The most important current health care proposals, introduced by both the Administration and others, are aimed at closing the existing gaps in health insurance coverage, and providing basic, as well as catastrophic, medical benefits to those who experience difficulties in fi—
nancing such services out of their own resources.

The Administration’s plan would make comprehensive health insurance protection available to all Americans through three separate coverage programs: (1) an employee health insurance plan (SHIP), (2) an assisted health insurance plan (AHIP), and (3) an expanded Medicare plan.16

In general, under the employee plan, employers with one or more full-time employees who had met what is described as “the full-time hours of work test,” would be required to offer a health insurance plan providing at least stipulated basic benefits covering all such employees and their family members under the age of 65. Employers could include themselves through the device of “self-insurance.” While offering the plan by employers would be mandatory, acceptance by employees would be optional. In addition to employees and employers, the basic plan would be available to self-employed and nonworking families, nonemployer groups, and separate individuals.

The assisted health insurance plan would involve state governments contracting with intermediaries to offer the basic plan to all residents with annual incomes under $7,500. This portion of the plan is aimed at providing health insurance coverage for: (1) families with annual incomes below $5,000 (less than $3,500 for individuals) irrespective of their employment status, (2) nonworking families with incomes between $5,000 and $7,500 ($3,500 and $5,250 for individuals), (3) what are described as “very high risk” working families with annual earnings between $5,000 and $7,500 ($3,500 and $5,250 for individuals), (4) nonworking families with “unusually high medical risks” — e.g. disabled persons and early retirees — irrespective of their income, and (5) “unusually high risk” employer groups. The expanded Medicare plan would be available to all persons 65 or over, now eligible for Medicare. Dependents of such persons below that age as well as disabled persons eligible for Medicare would be eligible under the assisted health insurance plan.

The Kennedy-Mills plan would provide comprehensive national health insurance under the Social Security Act for all civilian residents of the United States, except those 65 and over eligible for Medicare. The latter, 65 and over, would continue to be covered by the existing Medicare program. In contrast to the Administration’s plan which would permit optional membership for the groups for which coverage would be made available, participation under the Kennedy-Mills proposal would be mandatory for all those eligible under the plan.

Each person, save for Medicare beneficiaries, who are fully or currently insured under the present social security law, together with their dependents, would be eligible.

The plan contains special provisions providing immediate coverage for those individuals, described as “relatively few,” who are not “fully or currently” insured under social security because they have only recently entered the labor force. Those beginning work as self-employed persons or commencing to receive unearned income would be eligible for the new program as of the first day of the year in which they obtained income from such sources.

16. SHIP would provide insurance through private carriers, or self-insured arrangements, supervised by the states under Federal regulations; AHIP would be administered by the states, employing private insurance carriers operating under Federal regulations, to handle the benefits; the expanded Medicare plan would be administered by the Federal government in a manner similar to the existing Medicare program.
All social security and railroad retirement cash beneficiaries, including widows and widowers under 65, who are not eligible for Medicare would be covered by the new program. There would be no alterations in the present eligibility requirements for Medicare.

Both the Administration and Kennedy-Mills proposals would close all remaining gaps in health insurance coverage and provide almost identical benefit packages. Hospital and physicians' services would be available without limitations under both proposals, as well as out-patient prescription drugs. The two bills would provide the same eye, ear, and dental care for children under 13, and “well child care” up to age 6. Limitations on services are also strikingly similar.

The two measures would continue Medicare for the aged. Under the Administration’s expanded plan, Medicare benefits would be identical with those provided for the remainder of the covered population (thereby extending the services). The Kennedy-Mills bill would also enrich Medicare benefits to cover prescription drugs (with $1 copayment) and the voluntary long-term care program; current limitations on the length of inpatient hospital care would be removed. Under the Kennedy-Mills proposal, Medicaid would be repealed entirely. While the Administration’s measure would not eliminate this program completely, it would no longer provide Federal matching funds for covered benefits as well as for premiums and cost sharing (such specified non-covered benefits as in-emerogate-care facilities would continue to be provided however).

C. Over-utilisation of Health Care Services

Proponents of far-reaching revisions in the present health care system often assert that medical treatment, since it sometimes involves life or death, is inherently different from programs designed to provide food, shelter, education, job-training, or employment. Advocates contend that high quality health care, in whatever necessary quantities, is not just a desirable goal or a form of charity, but a basic right of every American citizen.

Supporting arguments put forward are: (1) medical bills often come in large and unpredictable amounts; (2) the poor are unlikely to be provided with health insurance by employers and cannot afford to purchase adequate coverage on their own; (3) concern for health care is not an entirely altruistic attitude, in that communicable diseases can affect the general population as well as the poor and the medically-indigent; (4) a healthier work force, less susceptible to absenteeism due to illness, and more likely to work with greater efficiency on the job, promotes economic development.

One of the strongest assertions of this position was made by Senator Kennedy: "Adequate health care is too basic to a family’s opportunity to hinge on good luck… I believe we should take actions to guarantee comprehensive health insurance to all Americans and to assure that health care is available at a cost any American can afford."
Serious students of health care emphasize, however, that a desirable national health system should not only ensure adequate services for the general population, but at the same time should provide effective safeguards against "over-utilization" of what under any circumstances will remain a not unlimited economic commodity. An unlimited "right" to medical services could, they assert, flood available facilities with hypochondriacs and the "worried well." At the same time, these observers contend that providing high quality medical care in unrestricted quantities even for the genuinely sick makes sense only in a society with unlimited resources — a situation which exists nowhere. Therefore, granting an open-ended commitment of the nation's resources to one socially desirable objective will inevitably reduce funds available for alternative, equally worthwhile, purposes. 21

Critics of health care as a "basic right" point out that adopting this concept will merely create new problems of access and distribution. Experience with the British National Health Service is often cited as an example. Since this plan covers virtually all types of health care, with but few, nominal charges imposed on recipients, the supply is inevitably tight in terms of the demand. While allocation is not determined by patients' ability to pay, it is affected by their ability to experience what are sometimes considerable delays in obtaining treatment.

A particularly strong criticism of making medical care appear as a free commodity to its recipients was voiced by Dr. Sidney Garfield, founder of the largest prepaid medical group in the United States. 22

The cause of today's medical crisis has been the inexorable spread of free care. The effect is an expanded and altered demand that is incompatible with the existing sick-care delivery system — wasting its medical manpower and threatening the quality and economics of the service it renders. . . . The change from fee to free would disrupt any system, no matter how well organized, and this is particularly true of medicine with its highly personalized sick-care service. 23

According to this school of thought, an effective health plan should encourage cost-consciousness by patients, physicians, and hospital administrators. Patients would be encouraged to use, where feasible, relatively inexpensive outpatient treatment for illnesses rather than comparatively costly hospitalization. Both doctors and health care institutions should be discouraged from exhibiting the casual attitude toward price increases which can result when a health insurance system, and not the patient directly involved, assumes the bulk of these rises in service charges. 24

Much existing health insurance, public and private, however, promotes an "uneconomic" utilization of health care services. Many private insurance policies have neither a substantial deductible (to be paid by the patient before insurance

21. Opponents of the medical care as a "basic right" concept often contend that factors such as unhealthy diet, inadequate shelter, lack of exercise, unsafe driving habits, air and water pollution, or over-indulgence in tobacco and alcohol, can affect the general population's health level more than provisions of any amounts of additional health care.
22. The Kaiser Foundation Health Plan, Inc. (Kaiser-Permanente), serving more than two million enrollees in California, Oregon, Hawaii, Denver, and Cleveland.
24. In fiscal 1973, patients paid only 35% of total personal health care expenditures, with governmental and private health insurance covering the remaining 65%. This represents an almost complete reversal of the situation which existed in 1950 when beneficiaries were responsible for 68% of such payments, with all other payment sources—Federal-state-local governments, private health insurance, and private charity—contributeing only 22%.
benefits commence) nor a sizable coinsurance rate (the percentage of the medical bill above the deductible which the patient must pay out of his own pocket).

In addition, many policies cover only the more expensive forms of medical care — inpatient but not outpatient services. This inevitably encourages physicians to hospitalize patients not only for treatment but also for tests, physical checkups, and similar services. This has been true of both private health insurance and government programs such as Medicare and Medicaid.25

Moreover, health care providers generally are reimbursed on a "cost-plus" basis, with hospitals paid "reasonable costs" and physicians the "usual" or "prevailing" rates. Providers thus have no incentive to select the most efficient and least costly ways of treating patients. Instead, they are in effect encouraged to charge what the traffic will bear. Since health insurance administrators tolerate a "pass-through" of higher costs, which eventually result in higher private insurance premiums and increased social security taxes, the system does little to reward efficient and penalize inefficient health care providers.

Physicians often prescribe the most costly treatment and utilize the most expensive medical equipment to deal with all forms of illness. Such conduct is often regarded as a measure of professional competence, enhancing the practitioner's prestige. The point has been aptly made:

It is a fundamental proposition in economics that decisions involving allocation of scarce resources to competing goals require a weighing of benefits against costs. However, there is little in the training or motivation of a physician to impel him to think in these terms. In this respect he is not different from any technologically oriented person, but almost nowhere else in the economy do technologists have as much control over demand. Almost the only exception ... is the influence exerted by the military in time of total war.26

To prevent "over-utilization" of any additional health care benefits, along with the attendant inflation in service costs, the great majority of the health insurance bills currently under consideration by Congress provide for varying amounts of deductibles and coinsurance. The only exception among proposals examined for this study is the bill introduced by Senator Kennedy and Representatives Griffiths and Corman in the 92nd Congress (and reintroduced in the 93rd).27

The plan's sponsors assert, however, that it has other types of effective control provisions. The system would be administered through 10 regional offices and approximately 100 local health areas. Each year, a national health budget would be determined for allocation through the major regions to the individual subareas. Funds would then be distributed among medical practitioners and hospitals within these localities. Since all providers of medical services would operate within this pre-established budget, and total health care charges could not exceed its over-all

25. In fiscal 1973, the $36.2 billion paid for hospital services constituted the largest single item in the nation's health care bill (38.5% of the total).
27. Senator Kennedy's more recent bill is less generous in this regard. See: footnote 5, p. 16.
limits, it is claimed this would curtail price increases and promote cost consciousness and quality control.

Proponents further state that the Federal government, as sole purchaser of medical services, would control the entire health care market, setting payment standards, enforcing quality criteria, and promoting efficient organization, distribution, and utilization.

Critics contend, however, that successful implementation of such a cost and quality control device would require monitoring the entire American health care industry; inevitably encounter enormous opposition; involve serious operational problems; and jeopardize many positive attributes of the existing system.

D. Alternative Methods of Delivering Health Care

Critics of the present health care system usually emphasize that unless there are fundamental changes in the methods of distributing and paying for services, new programs allocating additional funds for extended coverage and increased benefits could result in overutilization of facilities, increased strain on the existing system, and a renewed sharp rise in the costs of services. They point to the period following adoption of Medicare and Medicaid in 1965 when a number of these adverse developments did occur.

The most important as well as imaginative proposal for revising delivery and payment methods is the promotion of what are called health maintenance organizations (HMO’s). This concept, which remained on the periphery of thinking concerning health care operation for 35 years, is now accepted by a number of articulate social planners and medical practitioners as an effective institutional device.

An HMO, often defined as a prepaid group practice, is a combined medical facility where physicians with a wide range of skills are available in one place to provide services. These doctors are HMO employees and not independent practitioners. The organization contracts with defined population groups to provide comprehensive health services, in whatever quantity may be required, in return for fixed annual prepayments for each individual covered by the plan. There are no individual fee-for-service payments; participating physicians are reimbursed by annual salaries. At present, a particular HMO may or may not own the hospitals in which its patients are treated.

Some proposals encourage development of HMO’s to permit useful experimentation with alternative methods of health care delivery and payment and to provide “healthy competition” to the present system consisting largely of “solo” practice by individual doctors on a fee-for-service basis. Other suggestions are more ambitious and aim at making HMO’s the principal vehicle for delivering medical services. Such plans incorporate various devices for inducing or prodding independent doctors to

28. Many if not most of the physicians who would provide services under the plan would probably oppose it strenuously; this strongly negative reaction could create some very serious practical difficulties.
29. The statement has been made—rightly or wrongly—that technical capacity does not presently exist for determining whether physicians are prescribing unnecessary hospitalization, surgery, tests, repeat visits, or patient referrals.
30. Depending on how “prepaid group practices” are defined, the number of organizations providing medical services of this type ranges from 20-25 with less than four million contracted members to 125 with eight million participants. The more important are: the Kaiser Foundation Health Plan, Inc. (Kaiser-Permanente), founded in 1942, and operating largely in the west coast area; the Roos-Loos Medical Clinic in Los Angeles, set up in 1929; the Group Health Association, Inc., in Washington, D. C., established in 1937; the Group Health Cooperative of Puget Sound, Seattle, operating since 1947; and the Health Insurance Plan of Greater New York (HIP), in existence since 1947.
participate in the group practice approach.\textsuperscript{31}

The Administration has for some time supported widespread experimentation with HMO's. Its current proposal\textsuperscript{32} requires that eligible enrollees have the option to be covered by pre-paid group plans which meet specified standards. The Kennedy-Mills bill favors development of this type of health delivery system, authorizing funds to promote its establishment. However, as compared with the earlier Kennedy-Griffiths-Corman bills, the Kennedy-Mills proposal may be described as "more neutral" in regard to its intended effects on methods of delivery of health care services.

By adopting the Health Maintenance Act of 1973, the Federal government has already committed its support for a limited, trial-period development of HMO's. This legislation — the first in the major health care category to be adopted by the 93rd Congress — is intended to stimulate interest by both potential consumers and providers, and to ensure that this form of health care delivery is available and accessible to those desiring it.

Advocates claim that the HMO system has a variety of distinct advantages. Concentrating specialists with a wide variety of skills at one location permits patients, uncertain of the exact nature of their illnesses, to avoid being shunted among a lengthy array of physicians and facilities to obtain a correct diagnosis and treatment. In addition, it is claimed that the emphasis on diagnosis and prevention of sickness which the HMO's can provide will permit greater health maintainence rather than merely subsequent treatment of illness.

In addition, proponents contend that HMO's would promote important economies. HMO's providing health services for fixed annual prepayments would maximize their income (and minimize their expenses) by avoiding any overuse of health facilities. Since the patient's annual prepayment would be a fixed sum and fees for individual services would be disallowed, the HMO would have a strong incentive to prevent illness, treat it in its incipient stages, and in any event avoid unnecessarily expensive services.\textsuperscript{33}

Advocates also state that group practice increases the possibilities of effective peer review and limits instances of incompetent treatment. Since participating physicians would be bound together in common malpractice insurance coverage, each doctor would inevitably be concerned about the quality of services provided by his colleagues. In this connection, the point is made that while much is made of the "free choice of physician" system presently prevailing in the United States, in actuality, the patient often has little knowledge, or capacity to acquire knowledge, of the technical qualifications of a practitioner.

Other serious students of the American health care system, however, question the validity of the foregoing arguments. They do not view the wholesale proliferation of HMO's as a panacea for improving delivery of health care services and controlling their quality and cost. In their view there has been insufficient

\textsuperscript{31} One of the most far-reaching of these proposals was contained in the 1971 Kennedy-Griffiths-Corman bill. While the measure would not have prohibited individual "fee-for-service" medical practice, this approach would have been clearly discouraged, with strong impetus provided for development of the HMO method.

\textsuperscript{32} The Mills-Schneebeli-Packwood bill.

\textsuperscript{33} A 1971 report indicated that there were only 744 hospital days per 1,000 enrollees, annually, in HMO-type operations compared with 955 per 1,000 in other types of health care delivery systems. U.S. Department of Health, Education, and Welfare, 
empirical evidence to support the advantages claimed for HMO's.

Spokesmen for this point of view argue that while most existing prepaid groups have diversified their membership to some extent and provide services to all socio-economic strata, their clientele still consists largely of certain selected groups generally believed to be in better health and thus less likely to use medical services than the population at large. Therefore, it is held, economies claimed to have been achieved in the health care of such persons may not be very meaningful if the HMO system were expanded to embrace the total population including those who are in poor health, are high medical risks, and who would use health services to a considerably greater extent.

Skeptics of the claims made by HMO proponents point to a serious disadvantage that might result from utilizing the prepaid group approach. Conceding that the system would provide incentives to avoid overdoctoring and promote cost-consciousness in prescribing treatment, they allege that the fixed prepaid fee for services approach could also induce downgrading in the quality of care, or neglect of genuinely needed services. Even if adequate care were provided, recipients might have to wait considerably longer to obtain it than when they have recourse to independent, fee-for-service practitioners.

E. Financing Methods of Current Proposals

A variety of methods, and combinations of methods, have been devised for financing the multiplicity of national health insurance proposals under consideration. Examination of a selected sample of the most significant current health insurance bills indicates that their authors have for the most part favored three basic financing devices: (1) premium payments, (2) payroll taxes, and (3) governmental contributions from general revenues.

Premium payments would consist of several different types. For plans designed to cover members of the work force, and their dependents, premiums would be paid by both employers and employees, with significant variations in the proportions of total payments to be made by each. Some bills stipulate that the employers would be liable for as much as three-fourths of the combined contributions. Other measures leave the comparative share of the burdens indeterminate, stipulating that the amounts of premiums to be paid by employers and employees are to be based on arrangements worked out between the two parties.

Premiums required to finance health insurance protection for individuals would in some instances require assumption of full payment responsibility by the insured persons. In the case of those portions of comprehensive plans designed to protect the poor and the near poor, premium amounts would vary according to the income levels of families or individual program participants. Some plans would waive payment responsibilities entirely for the lowest income groups.

Certain plans would require payroll taxes to be paid by employers, em-

34. The Mills-Schneebeli-Packwood bill, introduced on behalf of the Administration, would require employers to pay 65% of the combined employer-employee premium obligations for the first three years of the plan; subsequently, the employer's share would increase to 75%. The National Comprehensive Benefits Act of 1973, H.R. 11345, introduced by Representative Harley O. Staggers of West Virginia, would require employers to pay at least three-fourths of the total premiums from the beginning.

35. At least one proposal, the Health Benefits and Health Services Distribution and Education Act of 1973, S. 2796, introduced by Senators Claiborne Pell of Rhode Island, and Walter S. Mondale of Minnesota, would require the employer to pay the entire premium "as a cost of doing business."
ployees, the self-employed, and on certain recipients (or up to certain amounts) of unearned income.36 Some proposals would impose equal rates on all categories of taxpayers and all forms of taxable income.37 Others would vary the levies, placing the heaviest burdens on employers.38 A number of the recommendations would continue existing Medicare taxes to support health services for the aged; at least one bill would divert this impost to finance a new coverage plan.

Most of the proposals examined would utilize Federal, and in some cases both Federal and state, general revenues to underwrite part of the benefit costs. Generally these governmental funds would be used to reduce the payment requirements for low-income or aged segments of the population39—in two instances to defray them entirely.40 One bill41 would utilize Federal general revenues and state contributions to eliminate or reduce deductibles and coinsurance payments for lower income groups. Two measures would require that Federal monies constitute precise proportions of receipts derived from all other financing provisions.42

An indirect use of Federal general fund financing is embodied in the “Medicare” concept, referred to earlier in this study, whereby Federal personal income tax credits would be granted to offset all or part of the premium costs of private health insurance policies providing specified benefits.43 Two general characteristics apply to the over-all pattern of financing methods proposed in the selected sample of national health insurance bills reviewed in connection with preparation of this study: (1) the great majority of the bills (14 out of 17) would employ more than one financing device, (2) there is a wide variation in the particular combinations of financing methods recommended—only two of the 15 listed combinations would be utilized by more than one proposed plan. While some of the remaining “packages” are quite similar, none are identical. Table 2 indicates the composition of each of these financing “packages.”

While there is a widespread opinion that payment of premiums is the most “regressive” method of financing national health insurance, this position must be modified when, as in the case of several of the proposed bills, employers will pay 75 percent of combined employer-employee premium obligations. At the same time general revenue financing is often considered as a “progressive” financing device. That would certainly hold true for financing derived from Federal general revenues, which in large part are derived from the highly progressive personal income tax. However, a number of recent bills also provide for partial financing from state general funds. While state tax systems have moved in the direction of greater “progressivity” in recent years, they still embody less of this characteristic than is the case at the national level.

36. Both the original Kennedy-Griffiths-Corman bill and the subsequent Kennedy-Mills proposal contain provisions along these lines.
37. The Long-Ribicoff “catastrophic” protection bill; and the National Health Insurance and Health Services Improvement Act of 1973, S. 915, introduced by Senator Jacob K. Javits of New York. However, for the Javits bill, the tax base for employers would be larger (total payroll), as compared to the first $15,000 of earnings for employees and the self-employed.
38. The initial Kennedy-Griffiths-Corman bill proposed the heaviest rates for employers; the later Kennedy-Mills bill would impose the heaviest levies, equal in amount, on employers, and on national or state governments for that component of unearned income derived from “certain welfare payments.”
39. The Mills-Schneebeli-Packwood bill contains such provisions.
40. The Long-Ribicoff and Saylor bills.
41. The Kennedy-Mills bill.
42. The Javits bill would require that Federal general revenues equal 50% of total payroll tax receipts; the Kennedy-Griffiths-Corman measure proposes a 100% matching.
43. The Fulton-Broyhill-Hartke bill.
The effects of payroll taxes on different types of taxpayers will vary according to whether uniform rates are applied to all those liable to pay the tax or - as is the case in several recent proposals - differing rates are to be imposed on different types of taxpayers or different categories of taxable income.

One obvious factor makes it extremely difficult to estimate with any degree of precision how many of the recent national health insurance proposals would distribute the burdens of their financing provisions among different categories of the population, affect entrepreneurial decisions on expanding or contracting em-

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<th>Financing method</th>
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<td>Payroll taxes on employers, employees, self-employed, and unearned income;</td>
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<td>Federal general revenues; state general revenues or contributions</td>
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</tr>
<tr>
<td>Tax credits financed from Federal general revenues; direct Federal revenue</td>
<td>2</td>
</tr>
<tr>
<td>payments for health insurance for poor</td>
<td></td>
</tr>
<tr>
<td>Payroll taxes on employers, employees, self-employed, and unearned income;</td>
<td>1</td>
</tr>
<tr>
<td>Federal general revenue</td>
<td></td>
</tr>
<tr>
<td>Payroll taxes on employers, employees, and self-employed;</td>
<td>1</td>
</tr>
<tr>
<td>Federal general revenues</td>
<td></td>
</tr>
<tr>
<td>Payroll taxes on employers, employees, and self-employed;</td>
<td>1</td>
</tr>
<tr>
<td>Federal and state general revenues</td>
<td></td>
</tr>
<tr>
<td>Payroll taxes on employers, employees, and self-employed</td>
<td>1</td>
</tr>
<tr>
<td>Premium payments by employers, employees, individuals, and medically-indigent;</td>
<td>1</td>
</tr>
<tr>
<td>Medicare payroll taxes; Federal general revenues</td>
<td></td>
</tr>
<tr>
<td>Premium payments by employers, employees, individuals, and families;</td>
<td>1</td>
</tr>
<tr>
<td>Medicare payroll taxes; Federal and state general funds</td>
<td></td>
</tr>
<tr>
<td>Premium payments by employers, employees, individual policyholders, and families;</td>
<td>1</td>
</tr>
<tr>
<td>Federal and state general funds</td>
<td></td>
</tr>
<tr>
<td>Premium payments by employers, employees, and low-income groups;</td>
<td>1</td>
</tr>
<tr>
<td>Federal general revenue</td>
<td></td>
</tr>
<tr>
<td>Premium payments by employers, employees, and individuals;</td>
<td>1</td>
</tr>
<tr>
<td>Federal general revenues</td>
<td></td>
</tr>
<tr>
<td>Premium payments by employers, employees, and individuals</td>
<td>1</td>
</tr>
<tr>
<td>Federal and state general funds</td>
<td></td>
</tr>
<tr>
<td>Premium payments by employers, employees, and individuals</td>
<td>1</td>
</tr>
<tr>
<td>Medicare payroll taxes; Federal general revenues</td>
<td></td>
</tr>
<tr>
<td>Premium payments by policyholders, with subsidy from Federal general funds;</td>
<td>1</td>
</tr>
<tr>
<td>carriers pay reinsurance premiums</td>
<td></td>
</tr>
<tr>
<td>Premium payments by covered families; Medicare payroll taxes; Federal general</td>
<td>1</td>
</tr>
<tr>
<td>revenues</td>
<td></td>
</tr>
<tr>
<td>Employer pays entire premium as &quot;cost of doing business.&quot;</td>
<td>1</td>
</tr>
</tbody>
</table>

ployment, or influence the over-all operation of the economy.\textsuperscript{44} These bills, as exemplified by the selected sample studied, usually provide for a combination of different financing devices, each of which will tend to have different effects in regard to tax impacts and economic consequences. Moreover, in most cases, it is impossible to determine in advance what proportion of the benefit costs will be defrayed by any one of the various prescribed financing sources.\textsuperscript{45}

In any event, whether directly through premium payments or payroll taxes, or indirectly through general taxes which may be required to provide the Federal general revenue subsidizations envis-

\textsuperscript{44} Precise estimates of the economic effects of financing methods proposed for public programs are generally difficult to come by. Referring specifically to the problem of measuring the results of additional tax costs, Dr. C. Lowell Harriss made the following observation in a 1973 address to the National Tax Association—Tax Institute of America: "A-\textsuperscript{e} not proposals for new government programs, and enlargements of those in existence, more often than not made without any responsible description of the taxes needed to pay? Can one think of any causes in which advocates of increased spending have tried to include in their discussions an explicit account of the effects of greater taxes?" "Government Finance, Political Processes and Economics," Tax Policy, Vol. XL, No. 2, 1973, p. 22.

\textsuperscript{45} For example, as previously mentioned, two bills stipulate the exact proportions of total financing to be obtained from Federal general revenues. Other plans, however, speak of Federal (or Federal and state) general funds being utilized "to the extent necessary" to compensate for financial gaps resulting from the varying contribution levels granted to lower-income groups.

\begin{table}
\centering
\caption{National Health Expenditures for Personal Services\textsuperscript{a} by Source of Funds}
\begin{tabular}{lccccc}
\hline
                      & \multicolumn{2}{c}{Amount (billions)} & \multicolumn{2}{c}{Percent Increase} \\
                      & \multicolumn{2}{c}{Actual 1973} & \multicolumn{2}{c}{Projected 1975} & \\
\hline
Total                & $84.0                & $103.0               & 22.6        & 22.6        \\
Private sector       &                      &                      &            &            \\
Out-of-pocket        & 54.5                 & 63.8                 & 17.1        & 17.1        \\
Health insurance     & 28.1                 & 30.1                 & 7.1         & 7.1         \\
Other                & 25.3                 & 32.5                 & 28.5        & 28.5        \\
Public sector        &                      &                      &            &            \\
Private premium payments & 29.5             & 39.2                 & 32.9        & 32.9        \\
under public programs &                      &                      &            &            \\
Federal              & 1.4                  & 1.7                  & 21.4        & 21.4        \\
State and local      & 19.4                 & 26.3                 & 35.6        & 35.6        \\
\hline
\end{tabular}
\textsuperscript{a} Excluded from "personal services" are medical research, construction, public health activities, and expenses of private voluntary agencies for fund-raising activities.
\textsuperscript{b} Based on the assumption that health costs will rise in line with projections initially used in designing Phase IV of the Economic Stabilization Program.
\end{table}
mand for their products, may be able to pass on part or even all cost increases to consumers. Others will seek to offset the heightened costs of providing health insurance for their employees by attempting to limit other components — wages and fringe benefits — to be included in future collective bargaining contracts.

Nevertheless, in many instances employers will be required to “swallow” varying proportions of the increased health insurance costs. This could result in diminished funds for investment in capital plant and equipment, or in decisions to reduce, or at least not expand, company employment. There is widespread consensus that either of these consequences would adversely affect operations of the national economy, and the over-all social well-being.

F. Estimated Costs of Current Proposals

Even without new legislation, national health care expenditures for personal services are projected to rise from $84 billion in fiscal 1973 to at least $103 billion in 1975, or 23 percent. (See Table 3.) By source of funds, the largest proportionate increase would occur in Federal spending (36 percent). Total private funds would increase less than half as much (17 percent) over the two-year period. The share of the private sector in supporting health services would decline by three percentage points (65 to 62 percent), with the public sector making up the difference.

The various proposals in Congress for changes in the system would have widely differing effect on costs. The U.S. Department of Health, Education, and Welfare has estimated the total costs and amounts of funding from various sources, for fiscal 1975, for eight of the major national health insurance proposals currently under congressional consideration. Projections and cost estimates were based on the assumptions: (1) that cost controls on health care services would be continued,46 and (2) that all the benefit provisions in each bill would be in effect for the entire fiscal year 1975. For those bills where participation is not mandatory, estimated costs are based on the disbursements required to finance the entire standard benefit package, assuming a participation rate calculated to result from the characteristics of the covered population and the incentives provided by each individual proposal.

All eight sample bills would increase the amounts to be spent by American society as a whole. (See Table 4.) The increments range from a high of $13 billion for the Kennedy-Griffiths-Corman proposal to a low of $4 billion for the measure introduced by Senator Paul J. Fannin. Even though five proposals would involve a rise in disbursements by private health insurance carriers, offsetting declines in out-of-pocket payments by patients and disbursements from other private sources would result in a net decline in private sector costs for all but two of the bills.47 In the case of the Kennedy-Griffiths-Corman bill, the decline in private expenditures would amount to $50.5 billion; even for the subsequent Kennedy-Mills proposal, spending from these sources would be diminished by $31.1 billion. For the Administration - supported Mills - Schneebell-Packwood recommendation, private sector savings would be limited to $3 billion.

46. According to the source of the data: “while the end of the economic controls (they were ended on April 30, 1974) and the probable inflation are likely to cause the actual expenditures to exceed the projected levels, the relative ranking of expenditures under the various bills should not be affected.”
47. The Ullman and Fulton-Broyhill-Hartke bills.
Table 4
Estimated Personal Health Care Expenditures under Eight Selected Bills by Source of Funds
Fiscal Year 1975

<table>
<thead>
<tr>
<th>Source of funds</th>
<th>No Bill</th>
<th>Mills-Schneebeli-Packwood</th>
<th>Mills-Kennedy</th>
<th>Ulman</th>
<th>Burleson-McIntyre</th>
<th>Fannin</th>
<th>Griffiths-Corman-Kennedy</th>
<th>Fulton-Broyhill-Hartke</th>
<th>Long-Ribicoff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aggregate (in billions)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$103.0</td>
<td>$109.5</td>
<td>$112.3</td>
<td>$114.0</td>
<td>$111.0</td>
<td>$107.0</td>
<td>$116.0</td>
<td>$112.8</td>
<td>$107.4</td>
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<tr>
<td>Private</td>
<td>63.8</td>
<td>60.8</td>
<td>32.7</td>
<td>64.2</td>
<td>62.6</td>
<td>63.6</td>
<td>13.3</td>
<td>70.2</td>
<td>59.9</td>
</tr>
<tr>
<td>Out-of-pocket</td>
<td>30.1</td>
<td>22.7</td>
<td>20.3</td>
<td>16.1</td>
<td>21.9</td>
<td>26.6</td>
<td>9.9</td>
<td>21.1</td>
<td>28.1</td>
</tr>
<tr>
<td>Health insurance</td>
<td>32.5</td>
<td>37.3</td>
<td>11.7</td>
<td>47.4</td>
<td>40.0</td>
<td>36.0</td>
<td>3.0</td>
<td>48.3</td>
<td>30.9</td>
</tr>
<tr>
<td>Other</td>
<td>1.2</td>
<td>.8</td>
<td>.7</td>
<td>.7</td>
<td>1.0</td>
<td>.4</td>
<td>.8</td>
<td>.9</td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>39.2</td>
<td>48.7</td>
<td>79.6</td>
<td>49.8</td>
<td>48.4</td>
<td>43.4</td>
<td>102.7</td>
<td>42.6</td>
<td>47.5</td>
</tr>
<tr>
<td>Private premium payments under public programs</td>
<td>1.7</td>
<td>6.3</td>
<td>3.3</td>
<td>1.2</td>
<td>4.4</td>
<td>1.7</td>
<td>1.7</td>
<td>1.7</td>
<td>1.7</td>
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<tr>
<td>Federal</td>
<td>26.3</td>
<td>32.2</td>
<td>68.8</td>
<td>44.5</td>
<td>35.8</td>
<td>31.7</td>
<td>99.4</td>
<td>34.4</td>
<td>34.6</td>
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<tr>
<td>State and local</td>
<td>11.2</td>
<td>10.2</td>
<td>7.5</td>
<td>4.1</td>
<td>8.2</td>
<td>10.0</td>
<td>3.3</td>
<td>6.5</td>
<td>11.2</td>
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<tr>
<td><strong>Percentage distribution</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
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<tr>
<td>Private</td>
<td>61.9</td>
<td>55.5</td>
<td>29.1</td>
<td>56.3</td>
<td>56.4</td>
<td>59.4</td>
<td>11.4</td>
<td>62.2</td>
<td>55.8</td>
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<tr>
<td>Out-of-pocket</td>
<td>29.2</td>
<td>20.7</td>
<td>18.1</td>
<td>14.1</td>
<td>19.7</td>
<td>24.9</td>
<td>8.5</td>
<td>18.7</td>
<td>26.2</td>
</tr>
<tr>
<td>Health insurance</td>
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<td>34.1</td>
<td>10.4</td>
<td>41.6</td>
<td>36.1</td>
<td>33.6</td>
<td>2.6</td>
<td>42.8</td>
<td>28.8</td>
</tr>
<tr>
<td>Other</td>
<td>1.2</td>
<td>.7</td>
<td>.6</td>
<td>.6</td>
<td>.9</td>
<td>.3</td>
<td>.7</td>
<td>.8</td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>38.1</td>
<td>44.5</td>
<td>70.9</td>
<td>43.7</td>
<td>43.6</td>
<td>40.6</td>
<td>88.6</td>
<td>37.8</td>
<td>44.2</td>
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<tr>
<td>Private premium payments under public programs</td>
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<td>2.9</td>
<td>1.1</td>
<td>4.0</td>
<td>1.6</td>
<td>1.5</td>
<td>1.5</td>
<td>1.6</td>
</tr>
<tr>
<td>Federal</td>
<td>25.5</td>
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<td>61.3</td>
<td>39.0</td>
<td>32.2</td>
<td>29.6</td>
<td>85.7</td>
<td>30.5</td>
<td>32.2</td>
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<tr>
<td>State and local</td>
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<td>9.3</td>
<td>6.7</td>
<td>3.6</td>
<td>7.4</td>
<td>9.4</td>
<td>2.8</td>
<td>5.8</td>
<td>10.4</td>
</tr>
</tbody>
</table>

Each of the bills would increase public sector spending, although the amounts would vary considerably. For the Administration's proposal the increment would be $9.5 billion; for three other recommendations, the hikes would be smaller—in one instance, much smaller. However, for the Kennedy-Mills bill the rise would amount to $40.4 billion; for the earlier Kennedy-Griffiths-Corman measure it would total $63.5 billion. Since both of the Kennedy-sponsored proposals envisage a decline in state and local spending, the rise in Federal spending would be even larger. In the case of the Kennedy-Griffiths-Corman bill, Federal spending would rise by $73.4 billion—almost quadrupling.

With no new health legislation and maintenance of medical cost controls, 61.9 percent of personal health care expenditures in fiscal 1975 would be paid from the private, and 38.1 percent from the public sector. The Administration's proposal would modify these proportions to some extent, reducing the private sector's share to 55.5 percent, while increasing public sector payments to 44.5 percent (Table 4).

In contrast, the two Kennedy bills would effect a drastic redistribution in the percentage of payments by the public, as contrasted with the private sector. The Kennedy-Mills bill would reduce the private sector's share to 29.1 percent, while the Kennedy-Griffiths-Corman measure would lower it even further—to 11.4 percent. At the same time, the former measure would increase the public sector's share to 70.9 percent, while the latter would expand it to 88.6 percent. Both proposals would result in an enormous expansion in the proportion of costs borne by Federal taxpayers—the Kennedy-Griffiths bill would set the percentage at 85.7 percent. Assuming no new legislation, the Federal share would be 25.5 percent; with adoption of the Administration's proposal it would be 29.4 percent.

While the Administration proposes only a relatively modest increase in Federal spending, it requires a proportionately sharp rise in private premium payments under public programs. Premium increases under the Kennedy-Mills proposal would be more modest; the Kennedy-Griffiths-Corman recommendation would eliminate this payment category entirely.

A word of caution should be inserted concerning cost data. Estimating even the first-year costs of new government programs can be hazardous, because many variables are involved—both economic and behavioral. This is especially so in an open-ended program such as medical and health care. Initial estimates of the last major Federal health programs enacted—Medicare and Medicaid—generally fell far short of actual outlays.

Moreover, experience shows that once new programs become operative they tend to expand. A 1967 Tax Foundation study of new Federal programs showed that by the sixth year nearly three-fifths of the programs were five or more times their first-year size. This tendency to expand is shown by data on Medicaid and Medicare. Under Medicaid, Federal-state outlays rose from $1.2 billion in the first year—when states were just beginning to implement the program—to $8.3 billion in its sixth year, almost seven-fold. Medicare spending rose nearly two-fold, from $3.4 billion in its first year (1967) to $9.5 billion in 1973.