

MAJOR ISSUES IN NATIONAL HEALTH INSURANCE

HERMAN M. SOMERS

AND

ANNE R. SOMERS

We have come a long way in a relatively short time on the question of health insurance. It now seems difficult to believe that only thirty years ago any form of health insurance, public or private, was highly controversial and, in fact, roundly condemned in many quarters as antithetical to sound medical practice.

It was not until the late 1940's that private health insurance was fully accepted and, even then, in large measure as a reaction to the fears engendered by President Truman's advocacy of a compulsory national program, which was tagged "alien" and "socialist." Private insurance was embraced as the lesser evil. A decade later came the bitter, protracted, struggle over Medicare. The accusations of totalitarianism, foreign influence, destruction of the doctor-patient relationship and corruption of medical standards are still fresh in our memories.

It is striking that within five years after Medicare went into effect the country seems to have arrived at a rather broad consensus among its major interests that some form of universal health insurance is needed and that substantial government financing will be required. This may mean that most people

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now recognize that government financing does not necessarily entail undesirable restrictions on good medical practice or professional freedom.

We are thus entering this new era of debate on national health insurance in a far healthier atmosphere than ever before. There is less suspicion, less rancor and fewer unfounded fears on all sides. For those with long memories this can be regarded as significant progress.

The reasons for the shift are many and apparent. There is widespread discontent in the United States with the health system and its financing. This is not because they have grown worse. On the contrary, any objective appraisal would show that substantial improvement has been made over the years. But medical practice and the social environment in which it operates have changed; and so have expectations.

The rapid development of private health insurance and Medicare have, ironically, contributed to the dissatisfaction through their relative success. By opening wider the door of access to care and by making the general public aware of what is potentially available through improved financial and organizational mechanisms, they have greatly increased impatience with and intolerance of remaining barriers and inadequacies.

The growing articulateness of the poor and underprivileged, and generally altered attitudes in respect to discrimination and poverty, have increased awareness that large sectors of the population have long been denied medical care or received it under frightfully humiliating conditions. The crisis in the nation's latest attempt to deliver care through a welfare system, Medicaid, has heightened the demand for a different approach.

Dramatic advances in medical technology, and their high visibility, have greatly increased the effectiveness of health services and enlarged public awareness of their value.

Undoubtedly, however, the primary influence has been the spectacular and persistent rise in health care prices, which is increasing the difficulty of access for large numbers of consumers, outraging others, threatening the viability of major

health institutions and challenging the capacity of private health insurance to maintain present levels of benefits let alone respond to demands for improvement. These discontents are shared by all classes of society. In fact, the current disenchantment with the delivery "system" stems primarily from distress over costs. It was cost concern that led the more sophisticated to take a closer look at the delivery system, which they then found wanting.

The nation and the Congress now have before them a wide variety of plans and endorsements for some form of "universal" health insurance, with legislative proposals from such diverse sources as the AFL-CIO, the American Medical Association, the Nixon Administration and the Health Insurance Association of America. The American Hospital Association is also preparing a plan and the Chamber of Commerce of the United States is reported to be developing one. The principle has been endorsed by the National Governors Conference. Numerous influential Congressmen have come up with plans of their own and more are promised.

But this apparent consensus can be misleading. The term, national health insurance, is being used to embrace a wide diversity of proposals whose only evident common factor is the proposed use of enlarged federal financing to increase public access to health services. Beyond this, the plans differ in almost all essentials. The areas of disagreement remain many and large.

CLASSIFICATION OF CURRENT PROPOSALS

The many legislative proposals now before the public can be most conveniently understood and appraised if grouped into four broad categories reflecting their most prominent characteristics.

Category 1: Proposals for tax or other incentives to stimulate voluntary purchase of private health insurance. The A.M.A.'s Medcredit plan (S.987) offers a tax credit against the individual's federal income tax; the Health Insurance Association

of America's (HIAA) plan (S.1490) provides incentive tax deductions. The American Hospital Association's Ameriplan (which has not been introduced in legislative form) uses a benefit incentive rather than a tax incentive. The only requirement of private insurance is generally that qualifying policies shall include specified minimum benefits.

Category 2: Proposals for mandatory purchase of private health insurance by employers for their employees. Originally unsuccessfully sponsored in New York State by Governor Rockefeller, this is now the core of the Nixon Administration's proposal embodied in Senator Bennett's bill (S.1623). A somewhat altered version has been introduced in the House by Congressman Byrnes (H.R.7741), the main change being the addition of a federal subsidy for small employers. The Nixon proposal also includes provision of a separate insurance scheme for low-income families with children and availability of insurance for voluntary purchase by persons not protected by the other programs.

Category 3: Proposals calling for a unitary, all-embracing, federal program, compulsory coverage of all the civilian population, broad and relatively comprehensive benefits, financed by a combination of payroll taxes and general revenues, and administered exclusively by the federal government without use of private carriers. The Kennedy-Griffiths bill (S.3) exemplifies this approach.

Category 4: Proposals that call for strengthening and extending Medicare to the entire population. Financing would be primarily through social security payroll taxes on employers and employees, as at present, with a special contribution from general revenues. Private carriers would continue to act as fiscal intermediaries. Senator Javits has introduced such legislation (S.836). This bill would establish options permitting employers or individuals to opt out of the program if they purchased insurance at least equal in benefits to those provided by the public program.

Such capsule categorizations are intended only to indicate

the general approaches taken by the main proposals. Additional provisions will be noted later. But, of necessity, the total will still present only greatly simplified versions of extremely complex bills, some of which run to more than 100 pages of print.

CRITERIA FOR EFFECTIVE NATIONAL HEALTH INSURANCE

Before undertaking an evaluation of proposed programs and different approaches to national health insurance it is necessary to establish some guidelines or criteria against which the programs may be measured.¹ So large and important a public undertaking should measure up to a demanding set of standards to be acceptable and effective. It should meet the following requirements.

1. *Universal coverage of the resident population without distinction as to income or premium contributions.* The undertaking of national health insurance is justified by the recognition that access to medical care is a necessity, not a luxury, and that universality of protection is required. Universality cannot be achieved by voluntarism, even when supported by incentives. Publicly imposed means tests are destructive to universality and, when accompanied by a separate program for means test eligibles, almost always lead to a double standard and a "two-class" quality of care. One of the objectives of a national system must be to end such discrimination.

2. *Equitable financing, with multiple sources of funds funneled through a single mechanism.* Only in this way can universal coverage of the population be assured. Sources of funds should include a balanced array of employer and employee payroll taxes (including taxes on self-employment income and other individual nonwage income) and general revenues, all centrally collected through one instrumentality and intended for all beneficiaries. This does not mean centralized administration of insurance or of program benefits; we refer only to tax collection and provision of an over-all fund.

3. *Comprehensive and balanced benefit structure.* Comprehensive protection is a relative term in medical care. Nobody

believes it is possible or desirable that the program furnish 100 per cent of all legitimate health services and goods. The goal is to eliminate, within practicable limits, financial barriers to health care without resort to means tests. At the present time, therefore, comprehensive benefits are considered to mean approximately 75–80 per cent of the average family's health care expenditures. If furnished in an appropriate mix, this will rarely result in an impossible burden upon families. The uncovered expenditures consist of a mixture of (1) small fixed fees (not copayment percentages) for specific services such as physician and dentist visits and some prescription drugs, and (2) noncovered items such as cosmetic surgery, some teen-age orthodontia and over-the-counter drugs. Even here provision can be made for exceptions based on overriding medical necessity. Long-term institutional care, with its special set of problems, should probably be dealt with in a separate program.

4. *Incentives to maximize efficiency and effective use of resources and to discourage health care price inflation.* All insurance is threatened by lack of restraint on the part of both providers and consumers because the necessary money appears forthcoming without immediate visible strain on individuals. Coping with this danger is one of the most important and difficult challenges for a successful national scheme. The primary difficulty is in dealing with providers, who are the major determinors of cost and utilization.

Similarly, hospitals must be induced to make more productive use of personnel and to avoid unnecessary facilities and services. The Medicare experience has made it abundantly clear that open-ended cost reimbursement to hospitals and other institutions establishes disincentives for efficiency and economy. Substitute devices, such as prospective negotiated rates, are being experimented with and others can be developed. However, any "one correct method" of paying either physicians or providers should be avoided. Frozen universal legislative prescriptions can be self-defeating.

Incentives should also be directed at consumers—one reason for the small charges previously mentioned and the desirability of identifiable consumer tax payments as in the social security system.

5. *Pluralistic and regulated competition in underwriting and administration.* Monolithic government operation of a field so sensitive, complex, and rapidly changing, for a diverse continent of 206 million persons, is likely to bog down in bureaucratic rigidities, or to become excessively vulnerable to political caprice and manipulation. Too little is yet known about “best ways” of delivering care to permit completely centralized decision-making with its inevitable demands for universal conformity.

All possible resources and experience will need to be harnessed to make the system operable. Competitive underwriting by a limited number, but wide variety, of private carriers, regulated by controlled centralized funding and standards—along the lines of the Federal Employees Health Benefits Program (FEP)—could provide decentralization, reduction of political vulnerability and incentives for competitive innovation in both quality and cost controls. (More will be said on this important point further on.) It would also be desirable to have a government agency as one of the carriers.

6. *Consumer options in respect to carriers, providers and delivery systems, as far as geographically feasible, on an informed, meaningful basis.* A sense of choice is necessary not only to promote satisfaction and acceptance but also to develop a responsible attitude toward the use and abuse of the services offered. The best of the prepaid group practice plans insist that enrollees have at least a dual choice, between joining them or some other type of insurance plan, both initially and at periodic intervals. But so-called “free choice” can be fictitious, unless fortified by information. The uninformed “free choice” available to the middle class in some communities is often less meaningful than the informed choice available, for example,

to members of FEP, which undertakes responsibility for informing them on details of each of the available options.

Moreover, government should not become a Big Brother deciding for individual consumers which option is "best." Prepaid group practice, for example, has admirable advantages, but it is not necessarily everybody's dish and should not be imposed. It is enough for government to confine the options to a limited number of approved and accountable carriers and delivery systems on the basis of quality and responsibility.

7. *Administrative simplicity.* This is, of course, a relative matter. No national scheme for the United States in a field so diffuse and intensely personal as health care can be easy to administer. But relative degree of complexity is important. A reading of the array of legislative proposals and published discussions demonstrates that administrative considerations generally get short shrift. They have little popular appeal. Everybody is concerned about "policy," but the problem of how to effectuate policy is assumed to be something to be left to the dull fellows, mechanics. It is little appreciated that administrative structure is itself a major policy question, and often determines the practical outcome of many other policy decisions. As John Gardner has warned, "any organization setting out to cure social ills had better be sure it isn't creating problems as rapidly as it cures them."

On the one hand, some programs boast of requiring almost no administration, to be virtually self-administering. This is a dangerous illusion. Years ago it was said that workmen's compensation was to be self-administering. The experience has demonstrated not only the need for rigorous surveillance and control but also that such administration has generally been a failure because adequate machinery was not furnished.² On the other hand, the attempt to establish a monolithic structure to control everything will result in cumbersomeness, rigidity and unresponsiveness.

Most important, perhaps, is the necessity for envisaging the relationship of program content to administrative capacities.

If, for example, a program's organization is fragmented into many separate pieces requiring delicate dovetailing, the administrative process may have to be so complex as to become a major impediment to effective implementation.

8. *Flexibility for adaptation to changing circumstances and public preferences.* Health care technologies are advancing at unprecedented exponential rates. Supply and demand structures are shifting rapidly and the only predictable is change. The financing system must not only be readily adaptive to differing regional conditions, it must be able to shift easily in time. This requires wide administrative discretion, plural approaches and a relatively loose system. Delivery system preferences, for example, should not be firmly rooted in basic law. Freedom of carriers to innovate and experiment should be assured.

The appropriate portion of national income to be devoted to health care cannot be firmly fixed. Worthwhile alternative uses of national income, including education and housing, will always be available and public preferences may change. Moreover, health services do not alone bring health and presumably it is better health that is the objective. Relative investment emphasis may need to be altered to meet that objective most effectively. A point of diminishing returns from health services may be reached as compared with similar investment in the quality of the living environment—pollution, housing, recreation, food and so forth. In the ever-present thorny problem of rational allocation of resources we must be prepared for the possible conclusion that marginal increments to health services, in preference to other social needs, are counterproductive. The way must be left open for the public to change its priorities.

9. *General acceptability to providers and consumers.* In a free society any large public system must have a reasonable degree of general acceptance by providers of care and consumers. A system that is widely resented will be seriously hampered and could become inoperable. It could result in long-term deterioration and inadequacy of resources—manpower, invest-

ment capital and philanthropy. It could produce serious stresses that are incompatible with effective delivery of personal services. Successful innovation requires a reasonably congenial climate.

Consumers must see the system as financially equitable, administratively responsive and consistent with the cultural norms of the community. For providers, it must assure continuation of accepted professional standards of practice and reasonable freedom within them, and also reasonable levels and stability of compensation. It would be rash and counterproductive to attempt to attain economy by "taking it out of the providers' hides." Of course, this is all a matter of degree, because what is "fair" and "reasonable" is not scientifically determinable. A controlled system of competition or regulation will not and should not elicit hosannas from the payees; this would indicate imbalance. On the other hand, so would rebellion. The point is that decisions cannot be arbitrary, punitive or unilaterally made. The process requires negotiation, bargaining, accommodation, and wide participation.

Other relevant criteria could be added, but these are central.

NATIONAL HEALTH INSURANCE AND THE DELIVERY SYSTEM

Some may feel that this list places insufficient emphasis on restructuring the delivery system. If our assignment dealt with the total problem of health services in this country, we would surely place heavy emphasis on this issue, as we have done in many previous publications. But here we are dealing only with the development of an insurance system, a technique for financing universal coverage. We believe not only that reordering the delivery system is a necessity, but also that the insurance scheme will be most effective if accompanied by substantial changes in organization. Elsewhere we have designed a proposal for large scale change that may be undertaken at the same time that a national health system is developed.³

Remedies for all health care problems cannot be expected

from changes in the financing system alone. The range of functions and issues is too numerous, varied, and complex. Other instrumentalities, private and public, other legislation must be looked to. If an insurance system alone gets too grandiose in its undertakings, too diffuse in its functions and objectives, it will be frustrated.

The financing scheme does have responsibilities that relate to and affect the delivery system and these are reflected in the list of criteria. The insurance system must encourage efficiency, exert cost controls and assure responsible fiscal behavior. Cost efficiency and service delivery efficiency are interdependent. The financing system can and should stimulate and encourage innovation, experimentation and diversity in delivery systems. But the actual decisions on how care will be organized and delivered must be left to others, including physicians, hospitals, the community and appropriate government agencies.

It is hazardous to employ a financial system to mandate or even to regulate delivery of care. For some 25 years we have witnessed distortions in the delivery system, at least partly as a result of health insurance. It downgraded primary care, drove people into the hospital and favored fee-for-service as the method for paying providers. The faultiness of that bias has become evident and pressures are generating to emphasize primary care, ambulatory service and capitation payment. Twenty-five years ago it seemed most efficient to concentrate most of the health care resources in the hospital. The shortcomings of that approach are now apparent. Now many feel it most efficient to ignore the hospital and concentrate resources in primary care units. Will the new biases prove less unbalancing in their effects than the old? Will the opposite mistakes be made? Will their harmful imbalances prove less difficult to correct?

Financial systems, including government programs, tend to be dominated by considerations of dollar savings, not an irrelevant consideration, of course. But the financial mechanism ought not be given exclusive or primary authority to recast delivery systems through monetary manipulation. Clearly, no

financial machinery can be completely neutral in its impact on the delivery system. The larger the program the greater the impact. In a national program the danger is great that conformity to the contemporary conventional wisdom might be irresistible and change difficult to effect. By minimizing the responsibilities of the financing system for the nature of delivery systems and allowing for strong countervailing forces, we are more likely to achieve necessary balance and flexibility.

DO CURRENT PROPOSALS MEASURE UP?

None of the proposals now before the Congress measures up to the standards we have listed, although the shortfalls differ considerably in magnitude. Some of the deficiencies are relatively easy to correct; for example, raising benefit levels where they are ridiculously low. Others are inherent in the basic design. We concentrate on these. These comments must nevertheless be brief, summary and confined to a few illustrative high spots.●

Voluntary, Incentive, Proposals

The voluntary, tax incentive programs fall conspicuously short on most essential points. They are not universal in their coverage. The high probability is that millions will remain uninsured. Under the HIAA proposal the tax advantages to low and moderate income taxpayers would in most cases be negligible. It is not at all clear that small employers would find the tax advantages sufficient to counterbalance the additional cost of buying qualifying insurance for their employees. This bill would establish separate programs for the poor and uninsurable (optional with and administered by states) as well as a series of other means test provisions. (Medicredit also has significant means test requirements.) Even so, substantial gaps are found in coverage. In any case, it is obvious that voluntarism can never cover the whole nation. Many people will fail to buy policies as a result of neglect, ignorance, undue optimism, find-

ing insufficient advantage in the tax incentive and a multitude of other reasons.

Both the Mediredit and HIAA bills are open-ended as to costs. Mediredit proposes no cost controls and no efforts toward containment. It simply provides for pouring more money into the pot to improve access to care. Insurance companies would pay providers on the basis of "usual and customary" charges. Tax credits would apparently be given in full for any level of policy at whatever price, so long as qualifying minimum benefit standards were met. The HIAA bill would do the same with tax deductions. The higher the premium cost, the more the government subsidy.

The HIAA bill does make provision for budgetary review for hospitals and sets a prevailing charge limitation on physician payments. But insurance premiums are no more regulated than at present, except that in state plans for the poor, which receive large federal contributions, the premium rates could be challenged on actuarial grounds. Neither bill contains efficiency incentives for either providers or carriers. Mediredit in particular, and the HIAA bill to a lesser degree, augur at least a continuation and perhaps an acceleration of the rapid inflation we have been experiencing.

The HIAA bill does indicate a concern with the supply side. It makes specific provision for participation of health maintenance organizations. (Mediredit is the only one of the bills we are considering that does not do so.) The bill is an omnibus, including an array of provisions to encourage development of ambulatory health centers, health planning and subsidy of medical manpower for movement to areas of critical need.

Mediredit provides no administrative mechanism for government responsibility to protect its open-ended financial commitment or for controlling the program in any way other than to assure that qualifying policies meet minimum benefit standards, and even in this it would be dependent upon state insurance departments. The HIAA proposal also relies primarily on state agency supervision and operation, not an impressive bul-

wark in most jurisdictions.⁴ The federal government would contribute from 70 to 90 per cent of the cost of state plans, but they would be operated by the states. Shades of Medicaid!

Of course, some plusses can be found in these proposals. The most interesting is that the AMA and the HIAA now accept the unavoidable necessity for a degree of federal regulation of health insurance, at least to the extent of setting national minimum benefit standards and, in the case of HIAA, even to forcing states to remove legal barriers to the establishment of health maintenance organizations. This would have been inconceivable only a few years ago.

The Administration's Mandated Insurance

The Nixon program requires employers to furnish coverage to full-time employees, yet falls far short of achieving universal coverage or equality of access. The proposal attempts to close or at least to narrow the gaps with a set of four additional plans: Medicare is continued. A Federal Health Insurance Program (FHIP) is established for low-income families with children not covered under an employer plan. Insurance companies that underwrite employee plans are required to develop group policies for use by small employers, self-employed individuals and others not eligible under mandated insurance or FHIP or Medicare, on a voluntary enrollment basis. A modified Medicaid is continued.

Despite all this, it is clear that many will fall between the various stools and will have no coverage at all; e.g., migrant workers, part-time and multiple-employer domestics, part-time and casual workers, unemployed single people and childless couples and many of the self-employed. The inevitable movement of persons among categories assures considerable slippage and surely does not provide certainty or continuity.

Benefits are neither comprehensive nor reasonably equal. FHIP is not only a separate means test program, but its benefits fall substantially below the minimum levels established for employer plans. Although both plans offer some benefits in a

large range of different health services, a formidable array of deductibles and copayments erodes any acceptable notion of comprehensiveness. For example, for a relatively typical stay of seven days in an average metropolitan hospital, and a total bill of \$1,020, the patient covered by the mandated plan might be expected to pay \$428 out of pocket,⁵ which may be a prohibitive burden for many consumers and far heavier than they would now pay under typical Blue Cross/Blue Shield coverage. There is such a thing as coverage without protection.

The separate system for the poor suggests the strong possibility of perpetuation of a two-class system of care, one of the major complaints about present arrangements. The substantial benefit limitations, the high premiums, deductibles and copayments, indicate a continued need for a sizeable welfare program for health care, presumably financed by state and/or local governments, which means an even less adequate program than the present Medicaid. The proposed legislation would limit the existing Medicaid program to the aged, blind, disabled and children in foster care.

The financing provisions pose a large number of difficulties. They do not appear equitable or even practical in some instances. The employer is required to pay at least 75 per cent of premiums (65 per cent for first 30 months). For thousands of small employers and employers in low-wage industries, the burden could be staggering. Unlike payroll taxes that are proportionate to wages, premiums are not. For some employers this could mean as much as a ten per cent increase in labor costs. It imposes an inequitable proportionate burden as between different industries, size of establishment and geographic location. It was recognition of such problems that led Congressman John Byrnes to take the unusual step of altering the Administration bill he was entrusted with introducing in the House (companion to the Bennett bill). He added provisions for federal subsidies and special tax deductions for small employers.

The Administration seems also to have been aware of the

problem, but it dealt with it only by making group insurance rates available to small employers and that clearly does not make a sufficient dent in the problem. There will be considerable spur for such employers to evade the program, legally or otherwise, by laying off marginal workers, using part-time workers (not covered) to replace full-time workers, using more "temporary" help or even sheer noncompliance by failing to buy a policy and taking the risk. It will not be easy to detect noncompliance.

The mix of the five different pieces that constitute the Administration's program, the problem of meshing the inescapably imperfect fits, the inordinate complexity of the FHIP provisions and the difficulties of enforcement make the program an extremely complex and difficult one to administer. The Administration recognizes that effective administration will require federal regulation of health insurance. It has promised to develop a supplement to the current bill that will provide such authority, but it is not known what this proposal will contain. If the mandated program has to depend upon state regulation of rates, and other matters, it will fall of its own weight.

The complex range of relationships between the five different income classes that compose the FHIP eligibles and the varying deductible, copayment and premium rates that apply to each—subject to redetermination every six months—will tax the resourcefulness even of modern computer operators. Beneficiaries will be as confused and frustrated as administrators. Apparently, the Administration did not place administrative simplicity, or even workability, high on its priority list!

The Nixon proposal requires that insureds be given at least a dual choice, including an option for enrollment in a health maintenance organization. In fact, the Administration has said that it regards the development and greatly expanded use of HMO's as the "centerpiece" of its program, to achieve economy and control costs. Yet, there is little to indicate that HMO's can or will be created or used at a rate that can have any signifi-

cant impact on the program for years to come. First, even the experts who admire and favor the HMO idea generally agree that the claims being made for it and the apparent expectations of the Administration are grossly exaggerated. At least, there is little present evidence to support such claims and expectations.

Second, experience indicates that HMO-type organizations are difficult and expensive to organize and to make financially viable, especially in the short run. Much as they have been praised, they have not increased proportionately over the past 15 years. The Administration, in separate legislation, is proposing to give financial assistance for development of HMO's through planning grants, limited operational grants in predominantly underserved areas and loan guarantees. The amounts proposed are extremely small relative to the problem; they can hardly be expected to make a real dent. Professionals are in accord that the degree of reliance of the Administration's health insurance plans on the HMO is markedly unrealistic.

The Kennedy Health Security Act

The Kennedy proposal has many strong assets and conforms to a number of criteria, but its shortcomings are pronounced and crucial. It and the Javits proposal appear to be the only ones that really set out to develop a comprehensive national scheme rather than a patchwork of fragmented pieces with varying fits. The Kennedy plan provides universal and equal benefits without distinction; its benefits are comprehensive; and it contains authority for cost controls.

But the bill is fantastically broad ranging in scope, attempting to control and remedy virtually the whole vast sweep of health care problems; it is excessively authoritarian in effecting such control; and establishes cumbersome, monolithic machinery and a labyrinth of complex regulations to administer it.

In addition to undertaking to establish and finance a single national health insurance system for all residents, it attempts a reordering of the delivery system and payment methods through financial rewards and punishments; it attempts to

provide for health resources development, to regulate internal hospital practice (e.g., a hospital cannot refuse to grant staff privileges on grounds other than professional qualifications) and professional licensing standards and to reallocate health resources geographically. However meritorious some or all of these reforms may be, they cannot be performed effectively or democratically through the single authority of the financing system.

Compensation to physicians can be made in several ways—capitation, salary or fee-for-service. Predetermined budgeted funds for physicians' services are assigned to an area based on per capita allocations. Physicians choosing capitation payment or salary will be paid the preestablished amount. The fund available to pay fee-for-service doctors is the per capita amount for the area multiplied by the number of residents in the area for whom no capitation payment is to be made.

Initially the fees would be established by fee schedules and relative value scales. If total bills for fee-for-service should exceed the preallocated amount, the individual fees would be reduced proportionately. It is evident that the burden of short-fall budgets would fall most heavily on fee-for-service physicians and strike disproportionately among individual physicians. Although the bill says it gives freedom of choice, it appears to arrange the risks to be least attractive for patients and doctors who prefer fee-for-service practice.

Budget ceilings and allocations would be the key method of cost control. The plan proposes to rely heavily on such measures, but the mechanism and processes for doing so are vague and apparently regarded as a problem to be left for the administrative process to solve. Each year a national health budget would be established by the Board. The bill includes a statutory ceiling on the amount: it could not exceed the lower of expected program income for the year or estimated expenditure for health services in the preceding year adjusted to population and price changes.

Although a contingency fund is included in the total budget

to safeguard against increased utilization resulting from epidemics and similar emergencies, the question of what would happen if regular and necessary program expenditures were substantially greater than estimated, and program funds were exhausted during the fiscal year, is left unanswered. Even if a reserve fund existed, it is not clear how it could be used in light of the statutory limitation that the budget cannot exceed total receipts for the year. Inasmuch as revenues are derived from fixed percentages of wages and earnings, matched by contributions from federal general revenues, it appears that health care expenditures are peculiarly tied to general business conditions. A recession would, as the bill now stands, represent a major threat to solvency.

Funds would be allocated by Washington to each of ten regions, on a per capita basis, and specifically itemized for institutions, physicians' services, dental services, drugs and so forth. The regional funds would then be further allocated to some 100 local health service areas on a similar per capita and categorical basis. The bill permits the authorities to attempt to eliminate "unwarranted" differences in average costs of health service among the regions by curtailing increases in funds to high-expenditure regions and increasing the availability of services in low-expenditure regions. It appears to be a system in which virtually everything done, or not done, has to have official approval.

The machinery to run this system is unitary and self-contained, headed by a five-member, full-time Health Security Board with full responsibility. Ten regional offices and approximately 100 local health service areas are alleged to constitute "decentralization," but it is the central Health Security Board that obviously has ultimate responsibility and authority. No role is assigned to any private insurance instrumentalities, either Blue Cross or commercial carriers.

Even though the bill protests its concern for innovation and experimentation, it seems that the predetermination of all that is "right" and all that is "wrong" in health care delivery and in

compensation methods, plus the staggering burdens placed on one consolidated immense bureaucracy would, in fact, make change quite difficult to effect. The rigidities of such a system might readily backfire on its good intentions. It could, for example, lead to a considerable amount of care being sought and being given outside the system (physicians are permitted to opt out) and its controls. Because the ability to by-pass the system is obviously more easily available to the rich than to the poor, it could revert to a two-class system.

A major plus for this proposal, in addition to those already indicated, deserves special mention. It does provide the best financing mechanism based in large degree upon social security principles. That method is most efficient, most certain and least costly to administer. It automatically removes almost all administrative complexities of determining coverage eligibility. The particular percentages applied to payroll and earnings can be challenged—e.g., the relative burden on the self-employed is disproportionate relative to employed workers—but the basic method is sound and economic.

Expansion of Medicare—Javits Proposal

The Javits proposal is probably the simplest to understand because it builds largely upon the existing and familiar Medicare program. After combining Parts A and B into one program and enlarging its benefit range, it would make the program available to all United States residents following a two-year “phasing-in” period. Coverage would thus be universal and automatic and benefits equally available.

Administration would be the same as under Medicare with continuation of private insurance carriers acting as fiscal intermediaries for payment of claims, under standards established by HEW. However, if the Department determined that adequate performance required it, a federally chartered quasigovernmental corporation could be established to replace the intermediary. State agencies would continue to determine whether providers meet conditions for participation in the program.

Deductibles and copayments would be essentially the same as at present. Methods of reimbursement to providers would continue the same for a two-year period during which time the Department would be required to study alternative methods that would best control costs, improve organization of health services and assure that providers receive fair compensation. New regulations concerning reimbursement, based on such study, would take effect the third year of the program.

This bill proposes two major departures from Medicare. The first is in financing. Like the Kennedy bill, social security principles are followed; however, the federal general revenue contribution is approximately one-third of the total. The distribution is also different: employees and the self-employed pay the same rates on earnings up to \$15,000 and employers also pay at the same rate except that it applies to total payroll. Nonemployment income is not taxed.

The second important change is in the availability of private insurance options outside the government program. An employer, by contract with the Department, could establish an approved plan that would exempt him and his employees from the regular insurance tax. It does not seem likely that many would elect such an option. To qualify, an approved plan must furnish benefits superior to those under the government program. In addition, the employer must pay at least 75 per cent of the cost. Under the government plan he would generally pay somewhat more than one-third of the cost. The monetary disadvantages to the employer appear to be great.

Private carriers by contract with the Department could also offer alternative policies, meeting specified standards, to the public. But because the bill does not specifically exempt persons under such private insurance plans from payment of the health insurance tax, there may not be a great rush toward this option.

In any case, the options, as formulated, represent an administrative weakness. If they did reach significant proportions they would be extremely difficult to police. The problems of measur-

ing comparability of benefits and costs could be formidable. So would the administrative complexities regarding the coverage of people in transition between jobs, or between a private option plan and the government plan, or in respect to people who had skipped premium payments to private plans.

Another flaw in this proposal is the absence of budgetary controls. Commitments and obligations are open ended with resulting vulnerability to inflation.

The Javits bill appears to be in relatively unfinished form. The Senator has indicated awareness of its shortcomings and is apparently planning to submit a recast version before the end of this session.

COSTS

It is beyond the province of this paper to present cost estimates for the various proposals, but a few words about the problem may be appropriate. Each of the proposals, if enacted, would generate significant additional expenditures for health services. This is consistent with one of the major purposes of the legislation, to remove present financial barriers. It is extremely doubtful that the attempted improvements in efficiency of the delivery system will be sufficient to fully counterbalance the increased demand and prices. In any case, the factors affecting increased costs will take effect promptly; factors designed to improve efficiency can only move slowly.

As might be expected, the figures publicized by proponents of different plans are usually substantial understatements of probable costs, just as figures advanced by opponents often tend to be exaggerations. More important, the advertised figures are rarely comparable, because they often use different definitions of costs, and may relate to differing time periods. Some of the cost figures undertake to state the total cost of the program to the federal government; some express only the net, or additional, cost to government, taking into account that some existing programs will be curtailed or abandoned; others describe

the overall net additional cost to both public and private sectors, recognizing that part of the new governmental cost represents a transfer of expenditures from the private to public sectors. There are other variations.

These varying portrayals of costs do indicate that a useful analysis of program costs, individual or comparative, must provide more than a global figure. In addition to an estimate of prospective direct program costs to the government, meaningful data would also show, among other things, how much represents additional cost to the federal government (whether in tax losses or in appropriations), how much is a transfer from state and local government expenditures, how much is a transfer from expenditures in the private sector (perhaps broken down between insurance and direct consumer expenditures), how much represents new costs generated by the program itself, and the global cost to the economy. Most often overlooked are the new costs, in terms of additional utilization and price effects, that any program undertaking to improve or alter access patterns will generate, offset by any savings from operational economies.

Preliminary examination suggests that the total financial costs to the economy under the various proposals are not likely to vary as greatly as protagonists assert. But the differing incidence of costs, the economic and social effects of transfers and the relative effectiveness of the use of differing channels for expenditure, are all very important.

Programs wherein government contributions take the form of tax credits or deductions tend to conceal the real costs to government; they may also conceal the cost to the economy generated by the legislation. Programs requiring specific appropriations and operating budgets make costs more visible, and visibility is socially desirable. When earmarked taxes are employed to finance a program, it is obviously essential to relate the tax rates to the cost obligations of the program. A tentative analysis of the various plans suggests not only that current estimates tend to be understatements, as has already been indi-

cated, but that the earmarked tax programs are probably underfunded.

Monetary costs, important as they are, should not, however, be a major criterion for program judgment. A cost is high or low in relation to the desirability and value of what it purchases, and possible alternative use of the funds.

DANGERS OF POLARIZATION AND NEED FOR BALANCE

In varying degrees all the proposals examined, and many others, call for appreciable alteration in financing of health services and reflect a widespread public desire for change. Inevitable and legitimate disagreement centers on the nature of desirable change. Public debate is needed. Unfortunately, indications are that with the passage of time and the consolidation of positions, the controversy may be degenerating into a conflict based on ideology more than pragmatic considerations of workability and practicality. The issue is increasingly being presented in terms of government versus private sector. In an era when demarcations between "public" and "private" have in practice become progressively blurred, the symbolism of old ideologies remains strong. Thus doctrinaire position-taking may interfere with pursuit of the most effective pragmatic blend.

In some quarters disenchantment with the shortcomings of private insurance has apparently led to the conclusion that we must now make a complete reversal and turn the entire problem over to government. Increasingly, such advocates blame all the ills in the financing and organization of health services upon the omissions and commissions of private health insurance. This not only vastly exaggerates the powers that the industry has, or should have, but also ignores the social climate. What is now generally demanded in this field was neither acceptable nor even possible only a few years ago. The social milieu of 1971 cannot sensibly be set as a standard to evaluate behavior in an earlier and different context.

These critics tend to forget that the same errors and omissions they attribute to private health insurance were also made by government. The failure to develop effective controls over costs or to restructure the delivery system is just as true of government programs—Medicare, Medicaid, Champus—as it is of private health insurance, and for the same social reasons. The effect of fragmented insurance policies upon fragmentation of health services is as true of Medicare as it is of Blue Cross-Blue Shield. The unhappy consequences of ineffective state regulation of insurance are certainly in large part attributable to the federal McCarran Act. No automatic solutions are to be found in doctrinaire formulas regarding the preferability of public versus private operations.

It has long been known that monolithism contains the seeds of stagnation. Large bureaucracies, in or out of government, tend to become routinized and tradition-bound in method and outlook unless challenged by the enterprise of other forces. Historically, government has been most effective at picking up and advancing ideas and programs that have started elsewhere and won support, or that need assistance against sluggish or inadequate responses in the private sector. The cutting edge of a new movement is usually in the venturesomeness of relatively small and often new organizations. These stimulate government action, just as government stimulates private institutions to change by inducing fear of government retribution.

Too little is yet known about “right” ways of organizing health care to chance the freezing of any particular patterns. Right now the most significant organizational reform being advocated is the nationwide development of prepaid group practice, based largely on the success of the Kaiser Foundation Health Plan. We fully share the enthusiasm for the Kaiser-type program (although the Kaiser people themselves protest that more is being claimed for it than can yet be validated). It should be recalled, however, that Kaiser emerged from small beginnings in the private sector and persisted against the impediments of governmentally created legal restrictions as well

as the stubborn opposition of organized medicine. Had a unitary system existed in the 1940's, it seems doubtful that a Kaiser scheme could have gotten off the ground. Good as the Kaiser plan is, it will undoubtedly not prove to be the final word in health organization for the distant future. From whence will the next generation's innovators, like Kaiser, get their launching leverage?

We do not have to abandon all the assets of private initiative to obtain the advantages of governmental financial strength, social equity or democratic control. Nor is it necessary to bind the hands of government to harness the capacities of the private sector in the public interest. We can assimilate both to mutual advantage.

Government undoubtedly must assume responsibility for financing health care if universal and equitable access are to be assured. The doctrinaires at the other extreme, whose traditional fear of direct government involvement causes them to fabricate patchwork schemes to avoid all government control, end up with programs that are grossly flawed and, if adopted, would likely backfire upon them.

We doubt that there exists in the United States the managerial competence to administer a unitary all-inclusive system of continental dimensions dealing with such sensitive personal services. We doubt that the political system could withstand the strains of the inevitable multitude of complaints, dissatisfactions, demands and misfortunes of the entire health system heaped on it alone. To achieve its objectives, government needs help from the private sector.

It needs the managerial expertise and experience of the private sector, if only for purposes of effective decentralization and exposure to varieties of administrative alternatives.

It needs the diversity and competitiveness that capacity for risk-taking, innovation and experimentation make possible. Rationalization of the system will require such attributes.

It needs the political protection of a spread of responsibility and blame for mishaps.

It needs the involvement of large portions of the private sector to make possible broader understanding and tolerance of the immense difficulties of running such a system.

It needs the support of such groups as a counterforce to the tendency of governmental budgets to be unduly restrictive.

It is equally true that the private sector needs government to provide the necessary financial strength and stability and to assure universal and equitable coverage.

Rigid attempts at categorization of private and public sectors are obsolete. The challenge is to work out mixed structures that can effectively take advantage of the potentials for cooperative action and competitive initiatives. These are not incompatible; at their best they are complementary. Perhaps it might be called a system of "complementary abrasiveness." Progress does not come in neat fully harmonious packages, but more often from the clash of conflicting ideas, approaches and needs. Necessary and flexible "trade-offs" in response to differing needs and desires will prove feasible only if room is permitted for diversity, plurality and private drives in competition for government funds and approbation.

With polarization both sides tend to see less and less merit in the position of the other side and each becomes persuaded that no acceptable accommodation is possible. Last month in a discussion of his and the Administration's plans, Senator Kennedy was quoted as saying, "The most basic difference is that the Administration relies on the private health insurance industry while we rely on the Social Security approach. I don't see how there can be compromise on that issue."⁶ Probably private insurance spokesmen would utter similar sentiments.

The fact is that the social security approach *can* be reconciled with use of private insurance instrumentalities, although obviously some accommodation will be required on all sides. In fact, with good will, an approach can be developed that borrows significant elements from all the major proposals. The following section will undertake to delineate the broad outlines of one such possibility. The plan is built upon the general ap-

proach of the Federal Employees Health Benefits Program, which now covers over eight million people and has been operating for over a decade—a significant practical experience with a vital public-private mix.

We do not attempt to spell out details because it is not our purpose to peddle a particular plan, but rather to suggest a practical avenue of reconciliation that is workable and effective in its own right. It adheres as closely as possible to the principles enunciated in the list of criteria.

A NEW PROPOSAL

A national health insurance program would be established to cover the entire civilian population without distinction as to income or contributions. Such universal coverage would be supported by a single national fund, financed by a combination of (1) taxes on employment and self-employment earnings and individual nonemployment income; (2) employer payroll taxes; and (3) federal general revenue—in approximately equal parts. The program would be administered by a federal National Health Insurance Board or agency.

A national minimum standard of benefits, by scope and amount, would be established based on an expansion of benefits now covered under Medicare. The initial expansion would aim to cover about 60 per cent of an average family's health care expenditures and move, in easy stages, toward 75 per cent. Long-term care in mental hospitals or nursing homes would be excluded. Physicians' and dentists' visits and most prescription drugs would be subject to limited flat-sum copayments.

As in the Federal Employees Program, a limited number of insurance carriers would participate as underwriters and operators of their own plans. Such carriers could include Blue Cross-Blue Shield, prepaid group practice plans, consortia of insurance companies, medical society foundations and others. Participating carriers would have to be approved by the Board on the basis of standards of operation; and participation would be subject to periodic review.

It is probably desirable that among the approved carriers should also be one federal program, similar to Medicare, but available to all. Among other advantages, such a program would serve as a yardstick. Each carrier's plan would be required to meet the minimum benefit standards established by the Board or by law.

All persons would be free to choose any approved carrier, available in his area, for his insurance coverage. Opportunity to change would be available at specified enrollment periods. The Board would have responsibility for supplying all persons with complete and understandable information regarding his options, presenting each available choice in uniform and non-preferential style. Carriers could not advertise or engage in direct selling. They could, of course, sell additional policies.

The Board would allocate, from the central budget for which it would have responsibility, to each carrier an annual sum based on the number of persons (or families) who had selected it. These sums would represent the "premium" payments for all its enrollees. No additional premium charges would be made. This total premium would be related to the demographic and socioeconomic composition of each carrier's enrolled population. The aim would be to provide each carrier with actuarially equivalent capitation payments. The rates would be negotiated between the Board and the carriers.

Each carrier, including the government program, would be free to experiment with reimbursement methods to providers and to develop its own controls. It could, if it wished, contract with medical groups, hospitals, foundations or other plans, for delivery of services. Inasmuch as each carrier would be operating with a controlled total budget, from which it might derive a profit, or loss, or break even, it should have strong incentive to promote maximum efficiency and economy in its own operations as well as among providers. The carriers would also be permitted to join together to negotiate uniform reimbursement rates with health plans or institutions without violation of anti-trust laws.

The carriers would be relieved in good part of their former heavy jobs of direct selling and premium collection, and therefore could concentrate on service functions and provider relations. They could use any surplus to enrich the minimum benefit package and thus provide a competitive incentive for attracting additional enrollees in the next registration period.

The Board's administrative responsibilities would include approval of participating carriers, determination that benefit standards are met, conduct of enrollment elections, determination of the annual national health insurance budget, allocation of annual payments to carriers and provision of an appeals procedure for consumers and providers. It would not operate any specific insurance plans, nor handle claims, nor itself undertake to determine or impose changes in health services delivery. It would, however, in its regulations have to cooperate with the decisions of the appropriate government health agencies regarding the quality, organization and delivery of health services.

Even though the program would be financed from earmarked funds, segregated in a Health Insurance Trust Fund, the amounts to be turned over to the Board for its budget would be subject to a biennial appropriation act of Congress. (The precedent for this is in the social security and unemployment insurance acts.) This will avoid freezing the national commitment for health services or tying the nation to a level of expenditures predetermined by established tax rates. It will require keeping Congress informed, permit Congress to evaluate costs in relation to other social needs and facilitate expression of changes in public preferences.

These are the plan's essentials. As can be seen, it incorporates important elements from most of the major legislative proposals. We do not anticipate that most protagonists of other plans will promptly cry hurray; none will get precisely what he is asking for now. Yet it is a design that all the vital parties at interest can live with.

Labor, the major constituency for the Kennedy proposal, gets a program based on social security financing principles,

nondiscriminatory universal coverage and controlled budgets—all among its top priority considerations. The private insurance industry remains in competitive business with its overall volume significantly increased. The small, fly-by-night, and dubious enterprises that are among the thousand or more current carriers will be virtually eliminated, but that would probably be true under any national program with standards, and could prove a boon to the better companies.

Physicians and other providers remain free of direct government control or having to deal directly with government as their payor—one of their major concerns. Organizational change is not imposed on the delivery system through a government insurance fund. Employers are not faced with a mandatory obligation for 75 per cent of premiums, potentially prohibitive to small or marginal employers, as their portion will not exceed one-third of the premium equivalent. Most consumers are assured enlarged and more meaningful free choice.

Equally important, such a plan reserves maximum flexibility for future change. If underwriting and operation by private insurers should not work out satisfactorily, as we think they will, it would not require any cataclysmic change in design to eliminate that feature and use government instrumentalities exclusively. On the other hand, if the private carriers' role proved salutary under the new conditions, their functions could be broadened. Except for the central financing feature, which is inescapable for any meaningful plan worth the trouble, this design gives no irretrievable hostages to fortune.

The overhead economies in administration should be substantial. Centralized collection of tax contributions, reduction in sales promotion, commissions and also in problems of determining benefit entitlement could result in savings of many millions. Yet this can be achieved without building a new massive federal bureaucracy.

In the important years before such a program takes effect, while its specific provisions are being debated and during its administrative lead-time after passage of the law, anticipation

of such a pluralistic competitive program should be conducive to greater experimentation with improved methods of delivery as well as better insurance techniques. On the other hand, anticipation of a monolithic program would discourage new undertakings and lead to a mood of simply waiting for word on what the government wants, a mood unfortunately already visible in some quarters. Anticipation of a government cop-out, leaving things as they are with a subsidy added, could have similar effects.

It is useful to recall that spokesmen for the Kaiser Health Foundation Plan, the model that most of the present proposals seek to emulate, advocated a general FEP approach for the Medicare law when it was being debated. Its president, Dr. Clifford Keene, in urging Congress to revise the proposed bill along FEP lines, said:⁷

From the viewpoint of promoting sound public policy, the advantages of this approach are substantial. It will effectively implement the concept of significant choices which are fundamental in our society. It will preserve the opportunity for variation and experimentation on which continuing improvements in the organization of health care services depend. It will permit different kinds of health plans to continue covering aged members, and it will permit direct service plans to continue doing this in a manner which stresses quality medical care under a system with built-in incentives for controlling costs.

The general point is even more valid today for effective national health insurance.

A FINAL WORD OF CAUTION

As necessary as health insurance is, too much should not be expected of it. We have already indicated our belief that reform of the delivery system will require action quite apart from the financing program. The same is true of manpower problems and consumer health education.

In the enthusiastic drive for enactment of an insurance plan,

one often reads statements such as "Every American has a right to good health." Perhaps so, but no national insurance program can assure everybody good health or even better health. It is safe to say, for example, that even if we attain full equality in services for the poor, their health status will remain unequal. Health services will not overcome the disadvantages of poverty itself—the consequences of inferior housing, food, recreation and education. For large parts of our population lack of adequate health services is not their most important health problem.

Similarly, any expectation that a national health insurance program will necessarily bring a halt to the steady inflation of health care prices and costs is probably overoptimistic and not in keeping with experience abroad. England and Sweden, which have two of the most generally admired but quite different national systems, have each experienced sharp rises over the past decade—about the same rate as our own in the case of England, and even greater in Sweden. A national program should provide means to exercise more controls than we now have and thus slow down the dizzying pace we have been experiencing. But the multiple factors affecting higher prices and costs cannot simply be regulated out of existence, and it is misleading to make such claims.

Lastly, the prospects are that even a good national program will not be able to meet all demands for all health services. Medical science and technologic capabilities are expanding inexorably in geometric progression. Recent years have seen the rapid development of miraculous cures and procedures, such as renal dialysis, transplants and implantation of artificial organs. Many other "miracles" are in the offing. These not only are enormously expensive but also require fantastic resources of skilled manpower and equipment. The potential demand for such services is incalculable. As a distinguished British critic put it, "Expenditure for medical care is a bottomless pit."

At present rates of increase and at present prices, America's health care bill will exceed \$100 billion before 1975. The nation may be forced to set limits upon investment in health ser-

vices. Not everything that is technically possible is practically attainable. The choices will be hard, but they may have to be made.

It is advisable that too much not be promised, or the system will pay the price of popular frustration. The great and real potential achievements of a proper national program deserve strong support on their own merits; the program need not be oversold. National health insurance is not an apocalyptic cure for all ills, but it would represent a tremendous step forward in American social progress.

REFERENCES

¹ For other attempts at setting goals and criteria, see United States Department of Health, Education, and Welfare, *REPORT OF THE TASK FORCE ON MEDICAID AND RELATED PROGRAMS*, Washington, United States Government Printing Office, 1970, pp. 94-102; Eilers, R. D., National Health Insurance: What Kind and How Much, *New England Journal of Medicine*, 881-886, April 22, 1971; and Burns, E. M., Health Insurance: Not If, or When, but What Kind?, the Melta Bean Lecture, University of Wisconsin, May 10, 1971, to be published in *Journal of the American Public Health Association*, November, 1971.

² For description and documentation of this relevant experience see Somers, H. M. and Somers, A. R., *WORKMEN'S COMPENSATION: PREVENTION, INSURANCE, AND REHABILITATION OF OCCUPATIONAL DISABILITY*, New York, John Wiley & Sons, Inc., 1954.

³ See Somers, A. R., *HEALTH CARE IN TRANSITION: DIRECTIONS FOR THE FUTURE*, Chicago, Hospital Research and Educational Trust, 1971, especially chapter 7.

⁴ An interesting, little noted provision of the commercial carriers' plan is that to receive federal contributions for its insurance program a state must agree to terminate all tax exemptions for Blue Cross and Blue Shield plans.

⁵ This assumes \$100 a day average for hospital charges and \$320 for in-hospital physicians' visits and surgeon's bill. The patient pays the first two days of room and board charges, assumed at \$65, and 25 per cent of the remainder of hospital charges, equaling \$273. He then pays the first \$100 for medical services plus 25 per cent of the remainder, which is \$155.

⁶ *Medical Economics*, May 10, 1971, p. 43.

⁷ *Hearings before the U.S. Senate, Committee on Finance, on H.R. 6675*, April-May, 1965, p. 459 ff.