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U.S. HOUSE OF REPRESENTATIVES

Summary of Testimony
and
Questions and Answers
presented during
National Health Insurance Hearings
before the
Committee on Ways and Means
April-July 1974



JANUARY 27, 1975

Prepared by the staff for the use of the Committee on Ways and Means

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SUMMARY OF TESTIMONY AND QUESTIONS AND ANSWERS PRESENTED DURING NATIONAL HEALTH INSURANCE HEARINGS BEFORE THE COMMITTEE ON WAYS AND MEANS, APRIL-JULY 1974

April 24, 1974

On Wednesday, April 24, 1974, the Secretary of Health, Education, and Welfare and members of his staff appeared before the Committee to discuss the Administration's national health insurance plan, "The Comprehensive Health Insurance Act of 1974, " H.R. 12684. Accompanying Secretary Weinberger were Stephen Kurzman, Assistant Secretary for Legislation; Dr. Charles C. Edwards, Assistant Secretary for Health; Bill Morrill, Assistant Secretary for Planning and Evaluation; Bruce Cardwell, Commissioner for the Social Security Administration; and Dr. Howard Newman, Commissioner for the Medical Services Administration.

Following review of his written testimony, which included (1) a discussion of the principal features of and philosophy behind the Administration's plan and (2) discussion of the Department's views on selected other bills, the Secretary answered questions raised by Members of the Committee. The major points of discussion during the question-and-answer period have been summarized into the following categories:

Cost-sharing

Mrs. Griffiths raised questions about the cost-sharing provisions of the Administration's plan. Mr. Weinberger replied that the Administration's proposed cost-sharing provisions were designed to protect everyone in the Nation against over-utilization of services and to assure that those in need of care do have access to the system.

Mr. Mills asked whether the cost-sharing provisions of CHIP would result in an increase in out-of-pocket health expenses for the Medicare beneficiary. Mr. Weinberger admitted that the cost-sharing provisions of CHIP would result in increases for the Medicare beneficiary and added "the cost-sharing has increase in it because we believe and have said many times that there should be cost-sharing throughout any health program. It is not a matter of avoiding the tax, Mr. Chairman. It is a matter of securing a better use of the system and to prevent overuse of the system...which blocks people who are really ill from getting treatment at the expense of people who don't really need treatment but can get it because there is not a sufficient deterrent against over-utilization."

Administration of CHIP

Mr. Collier asked about the State-Federal relationship involved in the Administration's proposal. Mr. Weinberger replied that under the Assisted Plan, the States would administer the plan by contracting with private insurance carriers to provide coverage to people with low income, people with high health risks, and others who cannot obtain coverage.

Mrs. Griffiths questioned the ability of the States to play the role envisioned for them by CHIP in the administration of the program and to keep track of family income and changes in income. Mr. Weinberger suggested that the States have extensive experience in this field as a result of their administrative responsibilities associated with other income-related programs such as welfare, food stamps, and housing allowances.

Mr. Vanik asked what criteria exist for the Administration to assume that State administration under CHIP would be better than their administration under Medicaid. Mr. Weinberger replied that State governments have done a very good job under Medicaid in cases where they have had an incentive to keep their costs down by eliminating very high charges and over-utilization. The Administration in its Assisted Plan wishes to avoid a program such as Medicare "where there is no incentive to the State and where all the costs, whatever they are, with a few exceptions, are in effect borne by the Federal Government."

Mr. Mills observed later that he doubted that any State operated Medicaid as well as the Social Security Administration has operated Medicare. Mr. Cardwell stated in response, "the Social Security is administering a law where its license is limited. It must reimburse based on reasonable charges and costs and once it finds that it has to settle the bill, the States who have to pay the bill have incentives, though, to get in between the provider and the payment of the bill in an effort to influence the behavior of the provider and his future price. ...Some of the States, California, for example, have actually tried to set prices in advance to indicate the charges that they would honor versus those they would not."

Mr. Vanik inquired about the estimated administrative costs of CHIP -- administrative costs incurred both by the government as well as by private insurance companies. The Secretary answered that both estimates would have to be supplied at a later date. In the case of the administrative costs of the insurance companies, he suggested that competitive forces would keep these at a minimum: "when you have 600 companies or more, all competing to write the same policy, I don't think you are going to have much room for very many inefficient or high overhead or administrative charges." He also indicated that Federal guidelines would continue to allow the States to audit insurance companies and to review their administrative costs.

Mr. Corman asked the Secretary to elaborate upon the States' regulation of insurance companies under CHIP. Mr. Weinberger replied that State regulation currently entails making a determination that there is some reasonable relationship between the cost of providing insurance coverage against health care expenses and the charge for this service. This would continue to be the case if the Administration's plan were enacted. The Secretary added that regulation of this kind would have a beneficial spill-over effect on containment of charges for services rendered by providers; "there will be a double interest to make sure that those charges and these reimbursements that the insurance companies have to pay are reasonable and are not excessive because, to the extent they have to do that, it would interfere with their profit and that is why the fact they have a profit in this doesn't bother me a bit."

Mr. Corman asked if the insurance company would have any influence over the fee schedule in a State. Mr. Weinberger answered that the influence the companies would have over the fee schedule would not be in setting it. This would be done by the States on an individual basis in consultation with providers. The insurance companies would bring influence to bear in their determinations of the reasonableness of charges or the validity of claims.

Mr. Mills asked if his proposal did not contain incentives for efficiency of administration in its provisions for carriers to bid for the role of intermediary. Mr. Weinberger replied that he had no objection to the bidding process. The problem, he added, is "what are they bidding for. They are bidding for the cost of processing the claim, not paying it. Paying the claim is the big charge. ...The cost of paying the claim is under your bill a Federal charge, and under our bill it is the insurance company's charge, and we believe they would do it much more efficiently at a lower cost. ...The whole payment of a claim is a matter of competition."

Employers, Small Business Firms, and CHIP

Mrs. Griffiths and Mr. Vanik expressed concern about the costs of the Administration's plan to the employer, and particularly to the small firm. The Secretary indicated that the Administration believes the increased costs of CHIP to employers would not be much more than the future higher costs they would inevitably incur as a result of the upward pressures of collective bargaining. Mr. Weinberger estimated the average payroll cost of the Administration's proposal to be 16¢ an hour. For small businesses, which have fewer than 50 employees, the Administration has suggested special provisions to mitigate the initial burdens imposed by the plan. The Secretary mentioned the bill's requirement that insurance companies offer standard premium rates for all groups with less than 50 employees. In addition, Federal subsidies would be available to all employers whose premium costs under CHIP exceeded 3 percent of payroll. This latter provision would entail \$500 million of the 5.9 billion additional Federal dollars that CHIP would require, if enacted.

Mr. Mills and Mrs. Griffiths inquired about the greater likelihood under CHIP of employers hiring younger and healthier workers in order to keep their costs for health insurance at a minimum. They pointed out that CHIP requires employers to offer their employees an expensive set of benefits, but fails to provide satisfactory enforcement machinery to assure that employers not discriminate on the basis of health status. Mr. Weinberger replied that the insurance company would not be allowed to take into consideration the individual health history of the employee or his family in setting its premium rate. However, if the insurance company did experience rate an employer group and established a premium rate judged too high by the employer, the employer would be then free to shop the market and obtain a lower rate for his firm. Regarding enforcement machinery against hiring discrimination, the Secretary stated "we believe declaring it an unfair and illegal practice would open the door to proper remedies."

Financing

Mr. Mills questioned the fiscal responsibility of a bill which did not relate the benefit package to the payroll tax. In the Mills-Kennedy program, benefits cannot be increased without tax increases. The Administration plan, on the other hand, would allow improvements in the benefit package by increasing the deficit in the general revenue fund. Mr. Weinberger stated that the Administration had rejected the payroll tax method of financing because of its regressive nature and because there is no inducement for the States "to hold down any of their costs because there is a uniform payroll tax increase levied on everybody and the States have no interest in the administration of the program. ... Furthermore, the increase in benefits is, as you say, financed by an increase in taxes but there is no relationship to the quality or to the necessity. All that is determined is what is the cost of the increase, then we will pay it by an increased tax."

Physician Reimbursement

Mr. Duncan asked the Secretary to elaborate upon mandatory assignment and methods of physician reimbursement under the Administration's plan. Mr. Weinberger replied that States would determine, after consultation with providers, a fee schedule under general Federal guidelines. For the Assisted Plan and Medicare Plan enrollees, participating physicians would be required to accept State-established rates as payment in full for the services they rendered. Under the Employer Plan, physicians could charge higher rates if they wished. If they did, however, they would not have the benefit of having all collection, administration, and billing procedures handled by the insurance companies under the health card. In so doing, they would also run the risk of bad debts.

Mr. Duncan asked why a physician in Tennessee would not be entitled to the same fee as a physician in New York. The Secretary replied that the level of charges is very different in various regions of the Nation. A surgeon in Tennessee might charge \$100 for services he rendered in connection with an appendectomy, while a surgeon in New York might charge \$220 for similar services. "To spread that kind of differential around the country means that you are going to be putting the burden of that geographical differential on a lot of people who should not have to assume it." Mr. Weinberger elaborated that a national health insurance proposal should recognize that variations in charges for services rendered by providers do exist in the country and that there should not be a burdening of the people through the general tax structure because of these variations.

Mr. Mills observed that a requirement in the Administration's proposal that all physicians accept assignment for Assisted Plan and Medicare Plan enrollees would likely to be "an open invitation for second-class medicine for the poor." Mr. Weinberger responded that this would not be the case, since everyone will be entitled to the same benefits under CHIP. He added, "we do think it is essential when all of the health care practically in the country would be delivered under one of these three plans, that it is proper to insure that the poor and aged not have to pay substantial additional amounts over the sums determined to be reasonable by the provisions of the Act and State controls that would be imposed. We think without those you will have the most vulnerable portions of the population having to pay a great deal more. That is the case at the present time. ... We think when the entire mix of population is now under one of these three plans...you would have different factors prevailing than where the doctor has a choice whether he is to serve a Medicare patient or patients not involved in any government program at all. That is the choice now that is exercised by some doctors."

Voluntary vs. Compulsory Plans

Mr. Schneebeli asked why the Administration had chosen to emphasize a voluntary approach to national health insurance. Mr. Weinberger replied that underlying the Administration's approach to legislation in general has been a commitment to assuring a maximum amount of individual freedom of choice. Mr. Weinberger indicated that this approach is not merely good in and of itself. In the case of the Administration's national health insurance proposal, preserving freedom of choice is expected to encourage competition among underwriters of health insurance. This competition in turn would serve to contain increases in health care costs. The Secretary elaborated upon this point by adding that because a large number of insurance companies would be offering the standardized benefit package, individuals would be in a position to compare premium costs for various policies. In such a situation, individuals would be free to choose the policy which best met their needs at the lowest cost; thus, insurance companies would have an incentive to keep their costs as low as possible.

Health Resources Legislation

Mr. Collier asked if the widely expanded "patient market" produced by a program of national health insurance would not require a very substantial expansion of facilities and health manpower, especially in light of our presently overtaxed resources. The Secretary suggested that the Nation's problem is not one of shortages. What is required is a more balanced distribution and efficient use of existing facilities and services. In addition, better planning is needed, and to these ends the Administration has introduced legislation for comprehensive health planning on the local level. Mr. Weinberger continued that a better balance in benefits covered by a health insurance plan would also serve to alleviate dislocations in the availability of services. The present system, according to Mr. Weinberger, is characterized by large numbers of persons covered more than adequately against expenses associated with hospitalization, but inadequately protected against expenses associated with home health care services, physician care, prescription drugs, and the treatment of mental illness or alcoholism. The Administration's bill would offer a better balance of covered services and encourage the use of those services that are less expensive and more appropriate for treatment than costly hospitalization. Dr. Edwards added that in terms of aggregate numbers, the current medical school output of physicians is adequate. There exists, however, a problem in geographical distribution and specialty mix.

Mr. Pettis observed that the maldistribution of health care resources acutely affects remote rural areas in the Nation and asked how the Administration plans to deal with this problem. Mr. Weinberger agreed that this indeed is a serious problem, but suggested that this is a problem not properly addressed by a national health insurance bill. Dr. Edwards indicated that the Administration has proposed expanding the scholarship program of the National Health Service Corps and will propose legislation which would offer special project grants to medical schools to train more primary care physicians. To the extent that the Administration's national health insurance bill does serve to alleviate the shortage and distribution problem, Dr. Edwards cited the bill's reimbursement provisions. The Administration's plan would provide reimbursement to a number of allied health manpower pools for the services they render. In addition, the bill would encourage the development of an outpatient, ambulatory health care system which would utilize allied health professionals in a more efficient way.

Mr. Conable inquired about the Administration's intentions regarding long-term care. Mr. Weinberger indicated that the Administration is aware of the urgent need of the elderly for such facilities and intends to submit to Congress legislation on the subject later this year. Mr. Weinberger added that the Administration has some problems with the design of the long-term care proposal in the Mills-Kennedy bill. In addition, the Administration believes that it is inappropriate and counter-productive to include such a provision in a national health insurance bill; "we think it would warp the system in many ways and that it would add a tremendous amount of unnecessary costs to the total costs of health insurance for everyone."

Effect of the Administration's Proposal on Existing Programs

Mr. Duncan asked how the Administration's bill would affect the various programs administered by the Veterans Administration. Mr. Weinberger replied that the status of these programs would not be affected by the plan.

Mr. Mills inquired about the effect of CHIP on Medicare. Mr. Weinberger stated that the Medicare program would continue as a Federal program financed and administered in the same way but with increased benefits. Mr. Mills asked if the cost-sharing provisions of CHIP would not increase the out-of-pocket expenditures of the Medicare beneficiary. Mr. Weinberger agreed that they would.

Mrs. Griffiths inquired about the effect of CHIP on Medicare's special provision for kidney care. Mr. Weinberger replied that treatment for kidney disease would be a covered service in each of CHIP's three plans and would be subject to the deductible and coinsurance amounts of those plans.

State Savings

In response to a question by Mr. Collier about the State-Federal relationship involved in the Administration's proposal, Mr. Weinberger provided information on savings to the States under CHIP. The cost of the Assisted Plan to State governments was estimated to be \$4.2 billion. State and local governments now spend \$5.8 billion for Medicaid and general assistance. Their savings under the plan would then be about \$1 billion.

Mr. Brotzman asked why State expenditures would be \$1 billion less under CHIP. The Secretary replied that many of the medical and health services which States either provide directly or finance under such programs as Medicaid would be covered under the various insurance programs proposed by CHIP.

Mr. Clancy asked if Ohio and Oklahoma would each incur annually \$20 million more in health care expenditures under CHIP. Mr. Weinberger replied that he would have to submit at a later date the estimates of each State's expenditures under CHIP. He added that due to variations in the design of each State's Medicaid program, some States could be expected to increase, and other States decrease, their expenditures under CHIP.

Cost Estimates

Mr. Corman inquired about the costs of the Administration's plan. Mr. Weinberger stated that for those services that would be covered under CHIP, the Nation is currently spending \$82 billion. Of that total, about \$52.5 billion can be attributed to private sector spending, \$29.5 billion to public sector spending. CHIP would require an additional \$6.5 billion over and above the \$82 billion currently spent by the Nation for CHIP's package of benefits.

The Administration estimates out-of-pocket expenditures by insured and uninsured individuals would decrease by \$7 billion (from \$20 to \$13 billion). Federal government expenditures would increase by \$5.9 billion (from \$20.5 to \$26.4 billion). State and local government expenditures would decrease by \$1 billion (from \$7.3 to \$6.3 billion). Insurance companies would pay out in benefit expenditures \$36 billion, as opposed to the \$31 billion they currently pay out. Of the \$88.5 billion spent for health care under CHIP, Mr. Weinberger estimates that private sector spending would be \$49.5 billion and public sector spending \$39 billion.

Mr. Gibbons requested a comparative cost analysis of the Mills-Kennedy bill, the Administration bill, Medigap, and the Griffiths-Corman bill. Mr. Weinberger replied that the Department would provide such an analysis. He suggested that recognition be given the fact that total costs of each plan were not strictly comparable. He stated, "we have to bear in mind that in our bill the private sector spending is voluntary and in the other bills it comes through taxation, namely the payroll tax." He elaborated later in response to an observation by Mr. Mills that the estimated costs of the Mills-Kennedy and Administration bills were nearly identical, "we don't believe that a voluntary program can bring you out to the same kinds of costs that a program that is compulsory can. We believe that a program that is fully Federally financed and fully Federally administered has not only a different initial but a different potential cost than a program that takes advantage of the competitive features of the private system."

Mr. Mills observed that any discussion of the costs of various national health insurance proposals must assume that any one of these plans will be accompanied by a redistribution of national health care expenditures and that these redistribution costs are not necessarily new costs. It is important therefore to focus on induced costs, i.e., additional costs that are not represented in a redistribution of costs.

In the cost analysis to be provided by the Department, Mr. Corman requested that differences in costs be related to variation in each plan's benefit structure.

April 25, 1974

On Thursday, April 25, 1974, the Chairman of the Senate Finance Committee, Senator Russell Long, and another member of the Finance Committee, Senator Abraham Ribicoff, accompanied by members of their staff, appeared before the Committee to testify in support of H.R. 14079, the Catastrophic Health Insurance and Medical Assistance Reform Act of 1974, introduced by Congressman Joe Waggoner as a House companion to S. 2513, the bill introduced by Senators Long and Ribicoff.

Following the presentation and questions submitted to Senators Long and Ribicoff, the Committee heard testimony from representatives of the American Medical Association, the American Hospital Association, and the Federation of American Hospitals. Spokesmen for the American Medical Association were Dr. Russell B. Roth, President; Dr. Malcolm C. Todd, President-Elect; Dr. Ernest T. Livingstone, Chairman, Council on Legislation; and Harry N. Peterson, Director, Department of Legislation. Speaking on behalf of the American Hospital Association were John A. McMahon, President; Dr. Leo J. Gehrig, Vice President; and Paul W. Earle, Director, AHA Management Services. The viewpoint of the Federation of American Hospitals was presented by Michael D. Bromberg, Director, National Offices, accompanied by Dr. Samuel L. Berson, President, and Mark S. Levitan, President-Elect of the Federation.

1. *Hon. Russell B. Long, a U.S. Senator from the State of Louisiana and Hon. Abraham Ribicoff, a U.S. Senator from the State of Connecticut*

In a review of his written testimony, Senator Long described the major features of the Catastrophic Health Insurance and Medical Assistance Reform Act and the problems which the bill (H.R. 14079) would seek to correct. Senator Ribicoff followed with some observations on the complexity of the health system, the desirability of avoiding a "huge bureaucracy" in the management of the program, and the need to find a practical approach, developed on an incremental basis. Senator Ribicoff also emphasized that, in shaping a program, the members should keep in mind the cost taxpayers would be willing to spend on health care, in view of the fact that "the social security tax has reached its limit."

Following their presentations, the Senators answered questions raised by Members of the Committee. The major points of discussion during the question-and-answer period have been summarized into the following categories:

Incremental Approach

Mr. Waggoner, sponsor of H.R. 14079, commented on the significance of the incremental approach to implementation of a national health insurance program and the need to avoid polarization among advocates of differing proposals: "I think we would be wrong if we want to improve our delivery of health care to our people to polarize ourselves and not recognize that there might be bits and pieces of all these proposals which can, in an incremental way, be made part of a workable plan." Senator Ribicoff also urged the Committee "not to polarize our thinking," with regard to what could be the "most revolutionary social program devised

for the United States." Later, in a discussion with Mrs. Griffiths, Senator Ribicoff warned: "if you don't do it a step at a time, you are going to collapse not only what you are trying to do, but I think you will collapse the whole health delivery system we have.... If we are going to do a health insurance program, let's not do a program that is completely indigestible but do a program that we can fold in a step at a time and see if it works. Once it works, let's go to the next step, but let's not try to do it altogether or you will just destroy the health system we have in America today."

Mr. Vanik observed that "it would be unfortunate to miss the chance to get these two essential parts that you have in Title I and II [catastrophic insurance and medical assistance reform] under way as a base on which we build a total health program." In response to commentary by Mr. Vanik, Senator Long remarked that he had been dismayed by "the type of opposition that this [type of] proposal has": on the national health insurance advocacy side, we hear people saying that if this bill passes that this might be the last letter, nothing else might happen and since they could not get the remainder of their national health insurance proposal, they advocate it should not be passed now. On the other side, we hear the private health insurance industry urging that you not vote for the bill for exactly the opposite reason, that it would not stop here, that this would be a basis on which Congress would go further and do more."

Mr. Collier commended Senator Long for his efforts on behalf of a catastrophic health insurance program, noting that it seemed "almost inexcusable that in a nation like this that we have not long ago done something about catastrophic illness." He voiced his fear that "in our efforts to perfect legislation, and particularly new legislation that we are embarking on here, that we seek to do too much at the beginning."

Mr. Collier went on to voice the hope that Congress would not adjourn this year without doing something about catastrophic health insurance, even if the entirety of the bill was delayed in other aspects.

Senator Long estimated that more than one million families a year would benefit from the catastrophic insurance program alone, and that families who are not low-income but who do have catastrophic expenses might qualify for the medical assistance title of the bill through the "spend-down" provision.

Likelihood of Senate Action on a House-Passed Bill

Mr. Rostenkowski questioned Senator Long regarding the likelihood of Senate passage of a House-passed compromise between the Mills-Kennedy bill and the Administration's proposal. Senator Long replied that he felt the differences between those two bills were irreconcilable and that he doubted whether those differences could be resolved. Mr. Chamberlain continued to pursue the question of Senate action on a national health insurance bill by asking Senator Long for his assessment of the possibility of action before adjournment on any bill the House Committee might report and send to the Senate. Senator Long replied that "if the House

will pass a health insurance bill, that bill will not die in the Senate. We will certainly consider what you have recommended and we wanted you to have our thoughts before you when you were doing your deliberations, because we think that might help us to resolve our differences insofar as we change the bill when we act on it."

In response to a similar question raised by Mr. Duncan, Senator Long reiterated this point by saying "I am here to tell you that if you pass a bill, it will not die in the Senate. We will pass our version of it and ask for a conference. I am confident that it would go to the President's desk." Senator Long went on to indicate that he felt the Senate could pass a bill within two months after House action, and that such a bill would be considered a priority item for consideration before Finance Committee and "should go ahead of some of the other things the Senators might want to vote on."

Mr. Green asked Senator Long to elaborate on an earlier suggestion that it would be helpful for members of the two Committees to get together prior to the conference stage to discuss differences in proposed legislation. Senator Long agreed that such informal discussions could be fruitful, saying "it seems to me if we have a chance to have more interplay of ideas at the take-off point, we might not be nearly as far apart when we try to resolve our differences in conference and they might not appear to be so irreconcilable as they are now." He added "I don't want to make anyone mad, but you know some of those good people in the press cadre... make it appear sometimes that some of us are at sword's point, when

actually we are not that far apart, make it appear that under no conditions would we accept your amendment or under no conditions would you accept ours, when all we really want to do is negotiate with you on that matter."

Ethical Questions Involved in a Catastrophic Program

Mr. Conable voiced a concern about catastrophic illness coverage in general, suggesting that the government might be put in a position of "playing God" with respect to determining who is going to be permitted to live "when we have such marvelous life sustaining facilities now, that it is possible to keep people technically alive long beyond the period when their brains are clinically dead." Senator Long agreed that such concerns were serious and that his proposed program would indeed reduce the economic pressures connected with such decisions. He added that in most cases, decisions of such a nature would still remain a matter of moral and social judgment and that this ethical problem would arise under any of the major health insurance bills the Committee was considering.

Coverage Under the Catastrophic Plan

Mr. Brotzman wondered why Senator Long's bill did not provide universal coverage. Senator Long answered that the ultimate intention was to cover everyone under the catastrophic portion, but that certain technical difficulties were involved in picking up the few persons not eligible through social security status. Senator Long also indicated that "there is a jurisdictional question with the Post Office and Civil Service [Committee], certified employees and things of that sort. It is a technical and drafting problem. The purpose is to take care of all."

Deductibles Under the Catastrophic Program

Mr. Archer asked Senator Long whether his bill had any provisions for inflation regarding the \$2,000 medical deductible under the catastrophic health insurance plan. Senator Long described the dynamic deductible feature which would cause the deductible to go up as the cost of living goes up or as the value of the current situation depreciates. Mr. Archer also questioned whether the deductible could be income-related rather than a fixed amount. Senator Long responded that an income-related deductible would be more difficult to administer and that it would also be difficult to design private basic health insurance policies to mesh with a variable deductible.

Immediate vs. Long-Range Benefits Under Payroll Tax Financed Program

Mr. Corman discussed with Senator Ribicoff the difference between a payroll tax used to finance immediate benefits, i.e., for health insurance, and a tax to finance future, long-range benefits, as under social security retirement and medicare. Mr. Corman indicated that he felt people would be more willing to pay such a tax to obtain relief from an immediate expense, than for a benefit they must wait years for. Senator Ribicoff stated in response that "People don't want to pay taxes whether it is for benefits today or 20 years from now. The taxes are so high at the present time you are adding onto it, and I think they are just going to revolt against the huge tax you are paying, especially raising the base to \$20,000, 5.85 and then another one percent as suggested by Mills/Kennedy." He added that "the withholding tax to the average person on social security is much higher than his Federal income tax."

Income Testing Under Title II (Medical Assistance Reform)

Mrs. Griffiths asked Senator Long what mechanisms would be used to check on incomes of persons potentially eligible for the proposed Medical Assistance program. Senator Long replied that the social security record would be used, as under the proposed Mills/Kennedy bill.

Mrs. Griffiths questioned the fact that the Long/Ribicoff bill does not count food stamps in determining income, noting that "we are now paying more in food stamps for a family of four than the original FAP program would have paid in cash." Mrs. Griffiths also voiced a hope that the spend-down provision in the bill for the medical assistance plan could be more smoothly worked out than it presently is under medicaid.

Costs

Mr. Gibbons mentioned that Secretary Weinberger and Chairman Mills had previously indicated that in establishing base points to deal with escalating costs, it would be advisable to start with the current situation, rather than what might occur after wage-price controls were removed. He asked Senator Long whether this was a reasonable basis on which to start. Senator Long responded that such a viewpoint certainly should be considered, pointing out that the problem of costs would be much greater under a complete national health insurance program, that in spite of contingency reserves cost estimates almost invariably are exceeded, and that an enormous inflationary spiral might be touched off by any program which was more ambitious than the one he proposed.

Mr. Burlésou questioned Senator Long regarding the issue of general revenue financing of such a program. Senator Long pointed out that general revenues are being spent in the Medicaid area and that the Administration, in its health insurance bill, proposes to use general revenues: "The Administration says they can finance their recommendation which includes a \$6 billion general revenue cost without a tax increase. Now how they are going to do it, I don't know. Once they figure out, I am going to do the same thing for our \$5.2 billion [cost for H.R. 14079/ S. 2513]." Mr. Burleson continued to say that without a tax increase the Administration program would be financed with borrowed money. Senator Long replied that that was the reason he felt this Committee should be handling this type of proposal: "the committee who has to pay for all this ought to be the one that recommends it,...jurisdiction ought to stay with the committee that will pay for it."

Mr. Clancy questioned Senator Ribicoff regarding the extent of increase in administrative costs to operate at full capacity a national health insurance program as set forth in some of the bills. Senator Ribicoff stated that the costs would be a huge additional increase, that "if we don't face up to this clear-eyed...we may find out we get worse health care instead of better health care."

Mr. Duncan raised the question of estimated costs under the Long/ Ribicoff proposal. Senator Long replied that costs would be \$8.9 billion total, 5.3 billion for helping the poor and near poor under the Medicaid substitute, and \$3.6 billion for the catastrophic program. Later,

responding to a commentary by Mr. Vanik, Senator Long stated that enactment of either the Administration proposal or the Mills/Kennedy bill would "so overload the delivery systems that it would run the cost up somewhere between 50 and 100 percent."

Mr. Archer asked Senator Long to differentiate between his bill with regard to financing and administration and the original Kennedy health plan (S.3/H.R. 22). Senator Long answered that while both bills were financed by a payroll tax, S. 3 would require a great deal of additional cost. Mr. Archer indicated his personal disagreement with the deficit spending implied under both the Administration and Long/Ribicoff bills in that both proposals would use general revenues for part of the program without adding on a tax increase to raise additional revenues.

2. *American Medical Association, Dr. Russell B. Roth, president and Dr. Malcolm C. Todd, president-elect*

Physician Fee Increases/Cost Controls

Mr. Conable questioned Dr. Roth regarding the likelihood of physician fee increases once the wage/price controls are removed, particularly in light of Secretary Weinberger's testimony on the previous day of hearings about a 22% annual increase in physicians' fees as reflected in March 1974. Dr. Roth indicated that the rate of increase in physician fees during the control period was smaller than the rate of increase in any of the other service components of the CPI and that while the profession would not expect more favorable treatment under economic controls than other professions, they should not be subject to less favorable treatment. Dr. Roth also stated that the AMA was prepared to exercise a leadership role in the profession to assure responsible behavior on the part of physicians with regard to fee increases.

Dr. Todd elaborated upon this point by informing the Members that the AMA was disseminating information through its State societies requesting that physicians demonstrate self-control as they did under Phase 2 and 3, and that they consider guidelines and suggested rate changes developed by the AMA. Dr. Todd stated that "it is predicted that physicians' fees would rise to 9 percent. We are certainly asking our profession and individual members to hold below that point if they possibly can." In response to a further question by Mr. Conable, Dr. Todd said that physician costs "are around the neighborhood of 13 cents out of the health dollar."

Mr. Corman asked Dr. Roth whether there was any particular advantage to leaving cost control authority in the hands of a State agency or an insurance carrier. Dr. Roth replied that the AMA feels such activity can best be done within the medical profession and that the profession's approach "is to adhere to a system of usual and customary fees, the guidelines by which they may be determined to be reasonable, and the judgment to be left to peer review committees within the profession." Dr. Roth reviewed for the Committee experience with negotiated and published fee schedules under the CHAMPUS program. In all States which published the negotiated fee schedules, these amounts became the floor of charges. In the one State (Indiana) which did not publish the negotiated fee schedule, physicians' charges stayed at about 50 percent of tolerance.

Endorsements for "Medicredit" Approach

Mr. Vanik asked Dr. Roth whether a wide base of American people have indicated support for the AMA's "medicredit" approach to a national health insurance plan. Dr. Roth answered that although the approach has a lot of widespread editorial acceptance, no attempt has been made by the AMA to solicit extra-professional endorsements.

Incremental Approach

Mr. Schneebeli asked Dr. Roth for his opinion of the incremental approach to national health insurance, as embodied in the Long/Ribicoff proposal. Dr. Roth answered that the AMA is in concurrence with the catastrophic approach Senator Long originated in the last Congress and as testimony to the acceptance of the important nature of catastrophic insurance, the AMA has added a catastrophic element to its bill. Dr. Roth did indicate, however, that he had some "marked reservations about the administerability and the percentage of the problem areas which will be addressed by a pure catastrophic free-standing approach.

Mr. Vanik also questioned Dr. Roth regarding the AMA's views on alternative health insurance measures. Dr. Roth replied that "we are happy with those programs that....build on what we have, and that keep the private health insurance industry involved." Dr. Todd indicated his personal feelings that he could accept a great portion of the Long/Ribicoff proposal and that the bill least attractive to the medical profession would be the Kennedy/Griffiths proposal.

Dr. Roth also stated that the organization was opposed to social security financing of any health insurance plan, therefore, definitely against the Kennedy/Mills bill, but could see where the element of social security financing in the Long/Ribicoff bill hopefully might be negotiable. Dr. Livingstone elaborated upon the AMA's views of the Long/Ribicoff bill by adding that if the bill had a basic benefit package requirement beneath the catastrophic program and if there was a sliding scale between that basic package and the catastrophic components, then it would be more acceptable to the Association.

Health Care Corporations

Mr. Conable asked Dr. Roth for the AMA's position on the concept of the health care corporation, embodied in H. R. 1. Emphasizing that the AMA has always held for the pluralistic approach, Dr. Roth stated that "we have recognized that this approach [HCCs] is a valid contender and should be tried for size under stressed situations of needing to meet the real problem areas in our country to see what it will do for access, for quality, and for cost. We have opposed the HMO philosophy, for example, only when it was represented that this should be an option available to 90 percent of the population by 1980 and that it should be given subsidization which gave it a leg up over any other form of health care financing or delivery." Dr. Roth later stated that the AMA would oppose government forcing a pattern through subsidization or regulation, but that the organization would not oppose an HMO option. Dr. Todd also indicated that the State Health Commission provided for in H.R. 1 introduced "an aspect of the public utility approach to health delivery which I think the Association is on record strongly opposing."

Malpractice Insurance

Mr. Corman raised a number of questions regarding malpractice liability and insurance, indicating that he had a "growing uneasiness about it as a reliance, because for one thing, you [doctors] all insure yourselves against a mistake and that worries me when I think how much you are willing to bet that you will make a mistake." Dr. Todd pointed out that much of the cost associated with malpractice insurance has been due to the defensive medicine physicians have to practice and the high cost of settling law suits. Dr. Roth also noted that two problem areas were actually involved in such a discussion -- quality control and malpractice liability -- and that the two areas were only tangentially related: "if you improve quality of care, one would hope that there would be a lesser incidence of malpractice suits. But I think that even if PSRO were to work perfectly, it would not have much impact on the professional liability aspect of the problem." Dr. Todd also cited the fact that in Southern California, a general surgeon must pay \$4,600 a year in malpractice premiums, even if no claims have been filed against him.

Foreign Health Care Systems

Mr. Pettis asked Dr. Roth to comment on health delivery systems in other countries and whether they were experiencing problems similar to those in the U.S. Dr. Roth noted that socialization of medicine appears to be a prime issue in the upcoming election in Australia, that the British National Health Service has recently undergone a total administrative reorganization, and that Sweden is experiencing terribly high cost problems in its system. Dr. Todd also pointed to the maldistribution of health manpower as a problem common to all countries of the world. He further noted that the U.S. imports approximately 10,000 foreign medical students each year and that the vast majority prefer to remain in this country: "It is a testimonial to their satisfaction with the system we have in this country."

Underserved Areas/Physician Manpower

Mr. Gibbons asked Dr. Roth whether any of the national health insurance proposals would adequately meet the need to make health services available in underserved areas. Dr. Roth replied that "none of the legislative proposals of this committee offer any sovereign answers to this vexing problem of having additional services in underserved areas, whether they be rural or center city." Dr. Roth went on to say that the AMA, in connection with the AAMC, was studying several different approaches to this problem and that the answers to the problem were in part motivational, only in a small part economic. He also suggested possible "trade-offs" through the use of technological advances in communication, improved highway systems, and transportation vehicles, etc.

At a later point, Mr. Duncan asked whether the AMA felt there would be sufficient manpower to meet the needs under any of the proposed national health insurance plans. Dr. Roth replied that over the last 5 years, 50,000 new physicians have been produced, thereby eliminating what has previously been an oft-quoted shortage of 50,000 doctors. Dr. Roth went on to say:

Now, we are producing physicians at a rate which is three times greater than the rate of increase of the overall population. It is now getting to the point where some knowledgeable people in the field are beginning to express concern that if our importation of foreign physicians increases steadily at the same rate and if our projected increase in the number of medical schools and the size of classes in the medical schools goes on as a projection of its present rate of increase, that by the 1980s we are going to have an overproduction of physicians.

Foreign Medical Graduates

Mr. Duncan asked whether any problems are posed by the fact that 1 out of every 5 practicing physicians in the U.S. is a foreign medical graduate. Dr. Roth concurred that this was indeed a problem but one that the medical profession had little control over because of the immigration policies: "the best we can do is to do our best to try to assure that they [FMGs] meet certain minimum standards and qualifications so that our public will be as well served as possible."

Medicredit

Mr. Brotzman asked Dr. Roth why the AMA has settled on the tax credit approach to health insurance financing. Dr. Roth answered that "it was born looking at what happens from the economic point of view when it is necessary to collect a dollar as a tax, to run it through administrative agencies including the collection agency in Washington, and then pass it over to another agency, and then send it back to a community and to the individual as a benefit." In addition to the efficiency and "economic validity" of the medicredit approach, Dr. Roth cited precedents to the approach in investment credits for business, retirement income credits, and some incentive work credits.

Independent Department of Health

Mr. Clancy asked Dr. Roth for the AMA's position on the establishment of an independent cabinet level department of health. Dr. Roth cited an official AMA position of support for this idea.

3. *American Hospital Association, John Alexander McMahon, president*

Hospital Beds

Mr. Duncan raised a number of questions with Mr. McMahon regarding hospital costs, lengths of stay, insurance coverage for in-patient care, etc. In particular, Mr. Duncan asked Mr. McMahon if the nation currently has enough beds to implement any of the various NHI bills the Committee is considering. Mr. McMahon answered that "at the present time, while there will be some increase in demands for health care with the new health insurance plan, certainly in some places there are beds there to take care of that anticipated increase, but there are certainly some communities where additional beds and modernization will be necessary." In this context, Mr. McMahon recommended continuation of the Hill-Burton program, and a reimbursement mechanism in any health insurance program that would, "through insurance borrowings or borrowings from traditional interests...give us the wherewithal to develop these necessary facilities."

Cost Controls

Mr. Gibbons questioned Mr. McMahon regarding cost controls in the hospital area, asking whether AHA economists had made any estimates as to what would be a reasonable increase in cost over the next year. Mr. McMahon answered that he had "discouraged them from doing so...for a very clear reason....The key will not be problems in the hospital itself. The key will be what happens in the rest of the economy on both wages and prices." He continued that providing an indication of such an average amount of increase might tend to establish a floor, rather than a ceiling, for future increases and that the average would then automatically increase.

State Regulation

Mr. Gibbons also questioned Mr. McMahon regarding a report on bureaucratic malpractice in hospital regulations in the State of New Jersey. Mr. Gibbons asked Mr. McMahon that, since AHA was apparently in favor of regulation of hospitals at the State level, how would they propose eliminating the kind of bureaucratic malpractices cited in that report. Mr. McMahon indicated that if the responsibility is handled by the State, "regulation will take place closer to the scene of the impact of those regulations and that assures some flexibility." Flexibility is needed, Mr. McMahon contended, because of variations among States with regard to the formulas used for hospital reimbursement.

Mr. Gibbons expressed skepticism regarding the advisability of joint State-Federal responsibilities in the regulatory area: "every time we go to the State agencies like the State Board of Health, the welfare people, and talk to them about what they could do to save money and everything else, they would say, well, we can't do it because it is against Federal law. Then you would finally dig out that it was not against the Federal law and they would say, well, it is against the guidelines. Finally, if you ever got a copy of the guidelines and read them, all you would find is it was not against the guidelines, but it was their interpretation of the guidelines."

Mr. Gibbons also asked Mr. McMahon to explain why, according to the previously mentioned report of bureaucratic malpractice in New Jersey, the Perth Amboy General Hospital paid its only radiologist

\$262,000 and its only pathologist \$482,000 in 1972. Mr. McMahon responded that "the problem with many hospitals in a situation like that is the need in a relatively tight market of getting the kind of assistance from physicians to continue to operate."

4. Federation of American Hospitals, Michael D. Bromberg, director, national offices

Mr. Burleson asked Mr. Bromberg whether he was familiar with H.R. 5200, a health insurance proposal introduced by Mr. Burleson, and whether he had any criticisms of that approach. Mr. Bromberg stated that he had no serious criticisms of that approach but would urge revision of the section dealing with hospital reimbursement. Instead of the bill's provision for State commission review and establishment of hospital rates, Mr. Bromberg suggested a more flexible approach, and experimentation with other kinds of prospective payments. Mr. Bromberg also expressed concern regarding the relative degree of expertise within the different State commissions and the possibility of wide disparities in effective enforcement on a State by State basis.

April 26, 1974

1. *National Association of Manufacturers, Matthew I. Cotabish*

THE NATIONAL ASSOCIATION OF MANUFACTURERS stated that "the major goals of any new health program should be first to fill the gaps left in coverage and delivery and to bring the costs under more stable control". They were not precise as to benefits under a NHI program except to state that the benefit package should be enough to "meet a person's reasonable needs" and must include catastrophic coverage. Coverage should be voluntary and carriers should continue to function in their present role. Necessary funding should be through general revenues and not through payroll taxes. The money should be spent primarily to "fill in the gaps," i.e., for those people who cannot now afford coverage and are not covered by employer plans. The NHI plan should be operated principally through the private sector, and where governmental administration for public programs is required, it should be done principally by the States. Cost sharing between the employer and employees should be left to those parties, as opposed to assigning an arbitrary proportion to be borne by each.

2. *Group Health Association of America, Jeffery Cohelan, executive director*

THE GROUP HEALTH ASSOCIATION OF AMERICA was concerned about the payment arrangements under H.R. 13870 (Mills/Kennedy) and H.R. 14079 (Waggoner and Long/Ribicoff). The cost-related prospective reimbursement language removes the incentives from the HMO to achieve savings because the savings would be returned to the government. GHAA argued that the HMO should retain the savings between community and HMO costs to be used to expand benefits or absorb part of the deductibles and coinsurance of members.

GHAA stated that it had received encouragement from Congressional staff working on the Mills/Kennedy bill that HMOs would receive the same amount as other carriers receive, irrespective of the actual cost. They nevertheless advocated that the language should specifically authorize what they understood the staff considered the interpretation to be. GHAA stated they preferred the language in the Administration bill which provides that HMOs be reimbursed the same amount as insurance carriers under the Employer Plan.

GHAA stated they had problems with the Long/Ribicoff bill which provides catastrophic coverage. Their objection: HMOs lower the incidence of cases which exceed \$2,000, therefore the HMO delivers these services at a lower cost. These savings are used to lower premiums and expand benefits, thereby providing a competitive edge to HMOs. If this cost is removed from both insurance carriers and HMOs, this competitive advantage is lost.

3. Association of American Physicians and Surgeons, Donald Quinlan, M.D., president

THE ASSOCIATION OF PHYSICIANS AND SURGEONS were opposed to all provisions of all national health insurance proposals. Their position is that government intervention should be minimal, and if necessary, be done at the State level and that financial assistance should be only for medical indigency. Mr. Corman asked the witnesses if, in their opinion, services would increase without deductibles and coinsurance. The witnesses said yes. Mr. Corman also questioned the witnesses on the matter of malpractice, and what steps, if any, they might suggest. Mr. Wooley responded by describing the problem. Mr. Corman suggested there might be some penalty to the physicians beyond raising the malpractice insurance premiums, which are merely passed on to the patient. He suggested considering deductibles on malpractice insurance.

He did not rule out leaving the system as is, where the patient seeks relief in the courts.

4. *American Congress of Rehabilitation Medicine and American Academy of Physical Medicine and Rehabilitation, William Spencer, M.D., member, legislative committee*

THE AMERICAN CONGRESS OF REHABILITATIVE MEDICINE and THE AMERICAN ACADEMY OF PHYSICAL MEDICINE were concerned with the following:

that financial barriers for low-income persons may exist in the current proposals because of deductible and coinsurance provisions;

that the reimbursement of rehabilitation centers was currently inadequate under Medicare, because it does not take into account changes in treatment approaches which call for accelerated and more intensive therapies;

that there currently exists a problem in coordinating benefits, citing evidence at the Texas Medical Center that each patient had an average of 2.8 sponsors or payers;

that the language in the major NHI bills might restrict rehabilitation services outside the hospital.

Mr. Archer asked Dr. Spencer if patients who were injured and requiring rehabilitation were moved quickly enough to rehabilitation services. Mr. Archer said he had information that they were not. Dr. Spencer agreed and added that the Emergency Care Assistance Act had adequate provisions to handle this problem legislatively. He noted that one third of spinal cord injuries occur when the injured person is being moved from the accident. He did concur that it might be helpful to include language in an NHI bill emphasizing early movement to rehabilitation, where indicated.

5. *American Psychiatric Association, Robert W. Gibson, M.D., secretary*

THE AMERICAN PSYCHIATRIC ASSOCIATION objected to the limited mental health benefits; urged special care to protect the confidentiality of records; opposed the preferential reimbursement treatment afforded community mental health centers; and objected to the Mills/Kennedy provision excluding psychoactive drugs.

APA cited evidence that under the Federal Employees Health Benefits Program, which has a comprehensive mental health benefit structure, the mental health benefits were 7.3 percent of total benefits. Mr. Pettis questioned the group about the large number of foreigners who take their residencies in psychiatry. Group response to this question was only an expression of appreciation of the problem.

The issue of training grants for psychiatrists came up, and Mr. Conable stated that the Government did invest sufficient money to meet the professions' initial targets and that he thought that was enough.

6. *American Association of Psychiatric Services for Children, Inc., James N. Sussex, M.D., president*

THE AMERICAN ASSOCIATION FOR PSYCHIATRIC SERVICES FOR CHILDREN raised the following points:

the mental health benefit should be increased to reach parity with other benefits;

the age limit for preventive services to children should be raised from 6 to 9;

psychoactive drugs should be included;

the favorable payment arrangements for CMHCs should be eliminated;

the definition of CMHCs, as that in the CMHC law, is restrictive because it leaves out Children's Mental Health Centers:

JCAH is developing accreditation criteria for children's psychiatric facilities which should be considered when developing final bill language.

7. *American Psychological Association, Dr. Albert Bandura, president, and Association for the Advancement of Psychology, Allen V. Williams, chairman, operations committee*

THE AMERICAN PSYCHOLOGICAL ASSOCIATION and THE ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY raised the following points:

psychologists want to be reimbursed directly and be free to deal with NHI eligibles without being controlled through referrals from physicians;

also advocated the broadening of mental health benefits to reach parity with other benefits.

8. *Doctor's Commission for American Health, Dr. Donald S. Ellis, member, board of directors*

THE DOCTOR'S COMMISSION FOR AMERICAN HEALTH was against national health insurance but, in the event it were enacted, raised the following points:

NHI should be restricted to catastrophic coverage starting with selected categories of diseases and phasing in additional categories;

they advocate the establishment of Catastrophic Illness Boards appointed by medical societies;

DHEW should administer the NHI program directly;

If NHI includes other than catastrophic coverage, insurance for persons between the ages of 21 and 65 should be voluntary except for catastrophic;

they advocate a Federally sponsored malpractice insurance program with ceilings on malpractice awards;

the financing method for NHI would be one third each, for the Federal Government, employers, and employees. There should be a \$50 deductible and 20 percent copayment. The limit on out-of-pocket expenses would be \$1,000 with premium payments counting toward satisfaction of the limit.

9. *Council for the Advancement of the Psychological Professions and Science, Dr. Rogers H. Wright, president*

THE COUNCIL FOR THE ADVANCEMENT OF THE PSYCHOLOGICAL PROFESSIONS AND SCIENCE raised the following points:

psychologists should be treated as independent practitioners and not be limited to providing treatment through referrals and under the supervision of a physician;

they advocated parity with other benefits and expressed particular concern over the absence of catastrophic coverage for mental illness;

Mr. Pettis expressed concern about the subjective nature of need in mental health and how it might be measured and quantified. Dr. Wright responded by saying there are tests for screening for illness and that the threat of over-utilization is exaggerated because there is a stigma attached to seeking psychological services. In addition, Dr. Wright stated, in his opinion, that better access to psychologists might cut down on medical utilization, primarily in the diagnostic areas.

May 3, 1974

1. *Blue Cross Association*

Walter J. McNerney, President of BCA, presented a summary of his formal testimony before the Committee and responded to questions on the following issues:

Relationship with AHA/Cost Control Experiences

Mr. Ullman asked Mr. McNerney to respond to publicly expressed criticism of Blue Cross as being too closely connected with hospitals and inadequately concerned with cost control mechanisms. Mr. McNerney explained that BCA's relationship with hospitals has changed in recent years, and that BCA no longer has an interlocking board with AHA, that AHA no longer has the seal of approval over Blue Cross plans, and that there is far less joint policy formulation between the two organizations. Mr. McNerney also pointed out that BCA can now be said to be representative of the community, having a majority of board members who are representative of the public rather than the providers of services. With regard to cost controls, Mr. McNerney stated that BCA is now developing 51 HMOs, has 23 incentive reimbursement experiments underway, is developing utilization review and auditing of providers "energetically," and is supporting areawide planning.

Administrative Costs

Mr. Ullman asked Mr. McNerney for an estimate of BCA's administrative costs under Federal programs. Mr. McNerney stated that in private markets over the past 10 years, the average has been somewhere between 5 and 6 percent, this figure including both administrative costs and any underwriting gains. Percentages under medicare, medicaid, and CHAMPUS would be less, since the nature of the work is different. In response to a later question by Mr. Collier, Mr. McNerney stated that 95 cents out of every premium dollar collected is returned in the form of benefits.

Cost of a Castatrophic Program

Mr. Collier asked Mr. McNerney to estimate the average per person cost of a catastrophic health insurance policy. Mr. McNerney explained the difficulties in arriving at such an estimate, pointing out that the cost of the program would depend to a certain extent on the nature of the basic package beneath it, since the bulk of expenditures comes on first dollar coverage. He then noted:

Having said all that, given the horsepower in our current private markets of the basic programs, one could put a good catastrophic program on top of it for something like say \$6 a month, as opposed to the cost of \$45 or \$40 a month for a strong basic program.

Regulation of the Health Industry

Mr. Burke questioned Mr. McNerney regarding the latter's testimony on potential regulation of the health industry and insurance carriers. Mr. McNerney replied that "the carriers that participate under any of the three major components here should be regulated and it should be good regulation. I think the public has a right to feel that those that participate are responsible, accountable institutions."

Mr. McNerney explained that he felt regulation should include approval of rates, concern with carriers' capacity to institute utilization review programs, ability of carriers to give the low income and disadvantaged a fair shake, etc. He said, as a personal opinion, I would say that the Federal Government should get interested in providing the States, if they are to be the implementers, with guidelines and with standards so that throughout the 50 States there is a threshold below which you couldn't go."

Health Care Corporations

Mr. Ullman asked Mr. McNerney for his opinion of the health care corporation concept in H.R. 1. Mr. McNerney indicated that he didn't feel the imposition of a nationwide HCC system on a non-competitive basis was practical, but that the HCC model might serve a useful purpose "as a pattern that could be implemented to play against other patterns as a model of how continuity of care could be achieved." Mr. McNerney also stated that "if you were to rule out all fragmentation, you would be in a compulsively tight framework at some expense to innovation and change and discontent."

2. *Americans for Democratic Action*

In his testimony, Representative Donald Fraser, National Chairman of the ADA, underscored his organization's continuing support for the Health Security Act (H.R. 22/S. 3) in preference to all other bills before the Committee. However, he noted that the Mills/Kennedy proposal contains one "long overdue" provision -- long term care for the elderly -- lacking in even the Health Security proposal. Mr. Fraser expressed the hope that whatever other action the Committee may take this year, it will include the essential concepts of the long-term care provision. However, he questioned whether the financing provisions in the Mills/Kennedy bill were adequate to finance the long-term care benefit.

During the question and answer period, Mr. Conable suggested that the net costs of implementing the long-term care provision might not be as much as Mr. Fraser implied, due to the offset savings obtained through home care services of aged persons who might otherwise have to be institutionalized due to lack of alternative care services. Mr. Fraser then described the operations of a prototype community long-term care center in Minneapolis, concurring with Mr. Conable that cost savings have been realized in this project when measured against "the costs that would have been incurred had that person been required to be institutionalized."

3. *Veterans of Foreign Wars*

Mr. Francis W. Stover, Director of the Legislative Service of the VFW, testified to his organization's concern as to the impact or relationship which any of the national health insurance proposals might have on the Veterans Administration medical and hospital care system. He stated that the VFW "opposed the utilization of veterans hospital and medical facilities for beneficiaries other than veterans." Mr. Stover also referred to a HEW staff memorandum which suggested that once NHI was a reality, VA facilities could either be restricted to veterans with service-connected disabilities or sold to the private sector, transferred to local communities or used for other governmental purposes. Mr. Stover indicated that the VFW would strongly oppose such action and that the present system of VA medical benefits through the separate and independent VA system be maintained, regardless of which national health insurance proposal might be adopted.

Mr. Ullman, Mr. Collier, and Mr. Burke expressed their concurrence with Mr. Stover's statement regarding an independent VA system, Mr. Burke adding that it would be unfair to impose a social security tax on wage-earners to finance VA health care since "this burden is a moral obligation of the United States Government."

4. *Robert J. Myers, Professor of Actuarial Science, Temple University*

Mr. Myers directed a part of his testimony to the provision in the Mills/Kennedy bill providing for administration of the national health insurance program, medicare, and supplementary security income through a newly independent Social Security Administration. Mr. Myers stated that, on the whole, he strongly supported this proposal but also believed that the new agency should be responsible for all social insurance activities of the Federal Government, such as unemployment insurance and workmen's compensation. He also had reservations about the fact that the terms of office of the bi-partisan SSA Board members would not be concurrent with that of the President, thereby making it possible for control of the Board to be in the hands of members of the opposite political party, in essence creating a "fourth branch of government."

Mr. Myers also indicated his support for the following aspects of the various national health insurance bills:

- Separation of social security operations from the general budget (H.R. 13870)
- Continuation of diversity and competition in health insurance coverage as provided through private carriers (H.R. 1 and H.R. 12684)
- Reasonable cost-sharing provisions with adequate catastrophic coverage (all three)
- Initial deductible on outpatient drugs, to cut down on administrative expense associated with vast amount of small claims (H.R. 12684)
- Benefits to be payable as a right and not involving a means test (opposes means test in H.R. 12684)

Mr. Myers criticized several aspects of the financing provisions of both H.R. 12684 and H.R. 13870, pointing out his belief that in both bills the social security tax rates and premium rates were inadequate for the proposed benefits. With reference to the long-term care title of the Mills/Kennedy bill, Mr. Myers raised the possibility of anti-selection, since no extra premiums for delay would be charged to enrollees.

Mr. Archer asked Mr. Myers how he would design a free-standing catastrophic health insurance program. Mr. Myers indicated that he would favor higher deductibles than are incorporated in any of the current bills, deductible levels which would be income related, with financing of the program completely out of general revenues:

In the case of a catastrophic program where relatively few people will draw benefits, it seems to me much better to take it out of general revenues. Otherwise, if people are paying a payroll tax even a small one, there seems to me to be inevitable pressure to raise the payroll tax so as to pay higher benefits and eventually the program would expand or snowball into a comprehensive plan and not merely a catastrophic plan.

5. *American Osteopathic Association*

John C. Taylor, D.O., President of AOA, stated his association was "opposed...to some proposals for national health insurance heretofore introduced which have addressed themselves merely to providing more public funding to meet the cost of care," without guaranteeing that health services will be available, acceptable, and accessible to all people.

Dr. Taylor testified that the Association would support the following:

- Use of private health insurance industry, as provided in H.R. 12684
- Sliding scale principle should be applied to cost-sharing amounts in both H.R. 12684 and H.R. 13870
- Language of H.R. 13870 which spells out and reaffirms basic rights of physicians, regarding location and type of practice, setting standards for peers (PSRO, etc), and assures the patient free choice of physician.
- Insurance against catastrophic illness or accident.
- Provisions for coverage of preventive medicine.
- Augmented Federal support to medical education to insure that adequate numbers of competent medical practitioners are available.

Dr. Taylor expressed the Association's opposition to a provision in the Administration's bill mandating the reimbursement rate for prescription drugs to be at the same level as that of the lowest comparable drug. He stated that the "practical effect of non-reimbursement will be to discourage the prescribing of the most efficacious drug."

6. *American Podiatry Association*

Dr. Charles H. Johnson, President, outlined the Association's NHI policy objectives as follows:

- NHI must be accompanied by further remedies for deficiencies in existing public health and assistance programs;
- NHI program must recognize need to improve organization and delivery of health services
- Should include provisions to counteract adverse cost trends;
- Payroll taxes shouldn't bear full burden of NHI; should consider additional, alternative financing methods;
- As a minimum, government should finance a system which draws heavily on the private sector in managing and providing health care services;
- Should contain provisions to guarantee freedom of choice for both patient and practitioner.

Dr. Taylor also expressed the Association's concern with the following:

- Providing a consistent definition of the term "physician" to avoid present confusion with different definitions for Medicare and Medicaid;
- HMO's should be reimbursed at the same level as all other providers, with incentives for cost savings;
- Pluralistic delivery and financing system should be continued;
- Tax incentives and other economic measures should be considered as a means to encourage doctors to practice in rural and ghetto areas;
- Action must be taken to improve situation in malpractice area.

7. National Medical Association

Dr. Emery L. Rann, President, testified that the Association does not favor total Federal financing and control of health care, as would occur with enactment of H.R. 13870. He indicated the NMA supported "improvement and expansion of mandated comprehensive coverage under the private health insurance system," but that the Association questioned the following provisions under the proposed Administration plan:

- Permitting individuals choice of selecting or rejecting coverage, as might allow "subtle influence from unscrupulous employers," and would not assure universal coverage;

- Cost-sharing amounts applied to the poor (Mills/Kennedy cost sharing more suitably scaled to ability of poor to pay than under Nixon plan);
- Cost sharing on preventive services (Mills/Kennedy far preferable on this point as reduces cost-sharing on such services); preventive services should also be expanded to include pap smears, routine injections and immunizations for all ages, sickle cell tests, etc.;
- Imposition of Federal tax on welfare and veterans benefits, as places undue hardship on poor;
- Partnership with States in administering program advisable only if:
 - Power over rates and costs held by Congress, not delegated to HEW;
 - Standby Federal authority becomes automatically applicable in the event a State fails to participate;
 - There is Federal preemption of any States' regulation, should that regulation prove ineffective;
 - Congress reaffirms full applicability of Title VI of Federal Civil Rights Act of 1964.

Mr. Pettis asked Dr. Rann for possible answers to the problem of physician maldistribution. Dr. Rann suggested Government subsidizing medical education in return for practice in specified shortage areas. Dr. Andrews added that recruitment efforts should be aimed at minorities and persons from rural areas, with stronger commitments to retain as well as enroll such students.

8. *American Association of Blood Banks*

Dr. Klaus Mayer, President of the Association, emphasized for the Committee the AABB's long-standing position with regard to reimbursement for blood and blood services:

Our Association is in favor of full payment under national health insurance for all costs involved in the collection, laboratory processing, (including typing and crossmatching), distribution, and infusion of blood and blood components, but, I reiterate, we are not in favor of payment for the blood, as such.

Dr. Mayer indicated that a nonreplacement penalty fee, similar to a "blood deductible" could be a useful incentive to encourage voluntary blood donations. Dr. Mayer added that health insurance plans which make payment for the blood itself tend to defeat the purpose of the nonreplacement fee, namely an incentive for recruitment of blood donors: "payment means that instead of voluntary blood donations, the blood bank is receiving monetary payment which cannot be transfused."

Mr. Duncan asked Dr. Mayer for his thoughts on commercial, for-profit blood banks. Dr. Mayer stated that he hoped within the next two years, that "we will be able to have blood from voluntary donors only," that the reason for the existence of commercial blood banks would therefore cease. He also noted that "blood obtained in such commercial blood banks may have a hepatitis incident up to 10 times as high as a population of voluntary donors."

Mr. Burke asked Dr. Mayer for his opinion of a proposed bill which would allow a \$25 tax credit for blood donors. Dr. Mayer stated that this bill mistakenly equates blood with money, something the Association wants to avoid, and that although people might be motivated to donate under such a program, there would still be problems with some people being untruthful about their medical histories in order to qualify as blood donors.

9. National Council of Health Care Services

Mr. B. Huston McCeney, President of the Council, presented his organization's view that "proprietary enterprise, by its very nature, is structured to provide the incentives which are absent in the non-profit field." He continued:

The entire philosophy of discriminating against or even eliminating participation by responsible, proprietary, tax-paying enterprises, as some proposed legislation seems to do, is built on a series of false premises, most of them centered around the concept that profit motivation has no place in health care.

Mr. McCeney indicated the Council's strong opposition to the definition of Health Care Corporation in H.R. 1, providing for organization of all HCCs only on a non-profit basis, and to a similar "non-profit" restriction in the long-term care title of the Mills/Kennedy bill.

Mr. McCeney summarized the Council's other concerns with regard to national health insurance as follows:

- artificial and arbitrary barriers to appropriate use of health resources ought to be removed (i.e., no limit on alternative modes of care when hospital days unlimited, no prior hospitalization requirement for ECF care, etc.);
- payment mechanisms for providers must include real incentives for increased efficiency, not simply set standards;
- cost reimbursement system should be avoided, as it encourages and rewards inefficiency;
- payment mechanism must provide fair compensation for services;
- supports Sec. 2042 of H.R. 13870, providing for development and utilization of diverse incentive payment formulas and management incentive payments, and demanding recognition of "return on equity invested" in the case of for-profit providers;
- recommends that Sec. 2042 be amended to set specific time limit within which SSA must develop and implement actual incentive reimbursement methods;
- recommends coverage of long-term medical care (not custodial care), outside the hospital setting, for all ages covered under NHI;
- does not believe NHI is appropriate vehicle for meeting the social and welfare needs of the elderly, so opposes open-ended social benefit in H.R. 13870;
- supports coordination of long term care proposal with rest of H.R. 13870, particularly with regard to payment mechanisms.

10. *National Association of Professional Administrators*

Mr. Solomon G. Lipman, General Counsel of the Association, explained to the Committee that his organization was composed of persons "who are engaged in the administration of so-called Taft-Hartley health and Welfare trusts," as an adjunct to the collective bargaining system. Mr. Lipman noted that the Association was very opposed to one provision in the Mills/Kennedy bill which would limit administration of the non-institutional portion of the plan to large insurance carriers, therefore, by definition eliminating the professional administrator. This provision would also, according to Mr. Lipman, eliminate the possibility of administration by labor unions. Mr. Burke suggested that this aspect of the bill could perhaps be easily straightened out to the satisfaction of the Association.

11. National Council of Community Mental Health Centers

Jonas V. Morris, Executive Director of the Council, stated that his organization strongly supported the program set forth in the Health Security Act, particularly with regard to delivery of mental health services (which would be covered under H.R. 22/S. 3 without limitation when provided in community mental health centers). With regard to H.R. 13870, Mr. Morris proposed that in order to give greater weight to outpatient services provided through a community mental health center, there could be a reduction or further limitation on coverage of inpatient psychiatric services, and that consideration should be given to reducing or eliminating the deductible and coinsurance on outpatient mental health services provided through community mental health centers.

May 10, 1974

1. *United Auto Workers and Health Security Action Council, Leonard Woodcock, president, UAW*

If Congress decides to act in only one area of health care needs, financing for example, its action will aggravate problems in the availability, comprehensiveness, and organization of health care. "The problems must be attacked concurrently, and basic reforms must be created under the national health insurance program if the plan is to succeed. To do less than needs to be done will only assure that more billions of dollars will be pumped into a non-productive system."

The Administration's proposal represents a retreat from its plan of 1971. "It would provide Swiss cheese coverage full of holes, exclusions and onerous costs for the average American.... And worst of all, it relies on the commercial insurance industry and State government to fulfill our aspirations as a people for better health care, now and for the future."

Mr. Woodcock took exception with the Administration's contention that medical costs would be controlled by cost-sharing provisions designed to induce cost consciousness in the public. "No amount of 'cost consciousness' on the part of patients will control costs to a significant degree. It is the physician, not the patient, who orders services. It is the physician who orders x-rays and lab tests. It is the physician who decides when to hospitalize and when to discharge. It is the physician, not the patient who makes the cost decisions."

Regarding the Mills-Kennedy bill, Mr. Woodcock found its Social Security financing and administration, its relatively broad scope of benefits commendable. Despite these features, he maintained that it "falls too far short." He included among its weaknesses the following: It is not universal; it is inflationary and would provide insufficient cost controls; it would continue to use the private insurance industry as fiscal intermediaries in a manner similar to Medicare; its deductibles and co-insurance are so high that they go beyond the means of average working people; it would do little to create basic reforms in the organization and delivery of services.

Commenting on H.R. 1, Mr. Woodcock praised a package of benefits more comprehensive than some of the bills, its provisions for Health Care Corporations and national quality standards. Among the bill's deficiencies he included the use of employment status and a complex system of means tests as a basis for determining eligibility for coverage; its reliance on private health insurance and the delimiting of Federal responsibility; and its provisions for deductibles and coinsurance.

Mr. Woodcock questioned several assumptions underlying the Long-Ribicoff-Waggoner proposal. Its "first imperfect assumption is that people already have coverage of basic health care costs. The April 1974 issue of the Social Security Bulletin shows that 26 percent of all full-time employed persons in the private sector have no group health insurance whatsoever. And even those who have insurance are so poorly covered that private health insurance meets only two-fifths of all personal health care costs. Imperfect assumption number two is that a catastrophic illness is the same to all people. It is not. What is a catastrophe to an average working man may not be a real problem at all to a wealthy man." In addition, Mr. Woodcock maintained that catastrophic insurance would serve only to exacerbate an undesirable trend and "further skew physicians away from primary care and from rural and inner-city practice. It would place high premiums on exotic treatment and low priorities on prevention and primary care. It would rapidly feed inflation of the costs of personal health services."

Studies by the Technical Committee of the Committee for National Health Insurance show that in fiscal year 1976 total costs for personal health care services in the nation will be over \$115 billion. The Health Security Act, H.R. 22, would cost \$76 billion in that year.

Mr. Burke observed that legislation entails compromise and asked if the Mills-Kennedy bill would represent an acceptable improvement on the present health care system, once it had become clear that the Committee could not report H.R. 22. Mr. Woodcock replied, "we have indicated that Mills-Kennedy is certainly better than the Administration bill and it is better than we have now. We are wedded not necessarily to the precise detail of H.R. 22, we are strongly wedded to the principles set down, the principle of universality and the principle of comprehensiveness and other principles, and consistent with those we are willing to look at any reasonable way of trying to do this job for the American people."

2. American Dental Association, Dr. Carlton H. Williams, president

In his testimony Dr. Williams made the following major points regarding the ADA's position on national health insurance:

The ADA opposes the use of public funds to provide health care for persons who are financially able to pay for health services themselves. Deductibles and coinsurance at levels that do not seriously hinder accessibility are generally desirable but should not be applied to basic dental services such as periodic examinations, diagnosis, prophylaxis, fluoride topical applications, plaque control programs, and emergency treatment.

The Administration bill's reliance on private sector financing with a continuing and competitive role for private carriers and State-Federal funding from general revenues for low-income and high-risk categories is preferable to the payroll tax financing mechanism of the Mills-Kennedy proposal. The ADA believes that Medicredit's use of a tax credit system, graduated on the basis of income, deserves careful consideration.

With regard to dental benefits in a program of national health insurance, Dr. Williams indicated that comprehensive dental services for children should have priority in any such program and that there should be provision for emergency dental care for all. Of the several bills introduced, Medicredit offers the most desirable package of dental care benefits.

With regard to any proposal's provisions for administration and regulation, the ADA could not support what it perceives to be the "massive and needless" administrative structures and regulatory mechanisms that the Administration and Mills-Kennedy bills would entail. Dr. Williams testified that Medicredit's approach of beginning with a financing mechanism alone has much to recommend it; it builds on an "existing system that has a number of counterbalances already incorporated into it and it is not intended to be a proposal for totally replacing the existing system."

On the subject of payments to and standards for providers of services, Dr. Williams observed that the usual, customary, and reasonable fee concept should be given priority in the dental component of a national health program. The preferred carriers for the reimbursement of dental care services should be nongovernmental agencies. Review of the quality of professional services should be under the control of licensed dentists. In instances where the physician or dentist is trained and licensed to provide a required service, the ADA believes that is inequitable for Federal law to limit payment only to the physician. In addition, dentists should be permitted to admit patients to hospitals for treatment.

3. American Society of Oral Surgeons, Dr. I. Lawrence Kerr, chairman, Committee on Legislation

Dr. Kerr wished to associate the Society with the position of the American Dental Association on national health insurance. In addition, he registered the Society's objection to provisions in Title XVIII of the Social Security Act (Medicare) which denies the beneficiary coverage for diagnostic care, non-surgical treatment of oral infections, and pre- and post-operative care associated with surgery of the jaws -- if these services are provided by a qualified dentist or oral surgeon, but which permits reimbursable coverage for such services if they are provided by a physician. Dr. Kerr indicated that this policy would be

perpetuated by several of the national health insurance proposals; among those cited were H.R. 14079, H.R. 13870, H.R. 12684, and H.R. 2222. The Society would recommend that Title XVIII and the NHI bills be amended to read: "A duly licensed and qualified dentist is authorized to provide any covered services that legally may be performed by such dentist under the laws of the State in which he practices."

In a related matter, Dr. Kerr wished to direct the Committee's attention to the Society's concern with a "professionally unsound limitation that a physician must certify the need for a patient's hospitalization for dental care." Provisions in Title XVIII and the various NHI proposals which stipulate "the presence of a 'medical' condition as a prerequisite for hospitalization of a patient for dental care ignores other equally important criteria that must be considered in the professional determination of whether a patient should be hospitalized." Dr. Kerr testified that the American Society of Oral Surgeons also desires to see the PSRO law changed to mandate the participation of dentists in the review of the appropriateness of dental care provided in hospitals.

4. *American Society of Internal Medicine, Dr. William Campbell Felch, immediate past president*

Dr. Felch presented and updated several of the views of the American Society of Internal Medicine on national health insurance:

Regarding reimbursement, the ASIM would favor incorporation of the usual, customary and reasonable concept in any national health insurance plan and would favor retention of the individual assignment option.

Because of limited economic resources, the ASIM would urge that benefit priorities be established with gradual and methodical implementation. According to Dr. Felch, "it appears logical to extend coverage [under Medicare] to all others having catastrophic medical problems, and we favor this step as the next principal priority."

If a basic benefit package approach were chosen as a subsequent priority the ASIM would recommend that major preventive care benefits such as periodic examinations be deferred until suitable cost-benefit studies are made. Dr. Felch indicated that the ASIM would favor the continued use of deductibles and coinsurance, except for the poor.

Dr. Felch questioned the "practicality of any system which insists upon referral of a patient to a specialist by a general or family practitioner. Internists are qualified specialists, offering referral services. But, in addition, they function as physicians rendering primary care and, in this capacity, often themselves refer to other specialists."

On the subject of the administration of a program of national health insurance, Dr. Felch indicated that the ASIM would recommend the utilization and improvement of existing mechanisms in the private sector which have proven to work well in the past.

5. *American Optometric Association, Dr. Bernard J. Shannon, president-elect*

The major points of Dr. Shannon's statement included the following:

Any program for national health insurance must include comprehensive vision care as a primary health service and must recognize the optometrist as a qualified provider of these services.

Any national health insurance bill reported by the Committee should include (at a minimum) vision care benefits for the elderly. Dr. Shannon indicated that such coverage is not included in H.R. 13870, H.R. 12684 or H.R. 1.

The American Optometric Association commends H.R. 12684 and H.R. 13870 for their inclusion of vision care benefits for children.

A plan for national health insurance must assure the professional the freedom to practice in the setting of his choice, whether this be solo, group, clinic, or HMO.

Dr. Shannon emphasized the importance of the participation of optometrists in peer review. "Like must evaluate like. Optometrists must be reviewed by other optometrists; they alone can competently determine the quality of care."

By 1980 the nation will need about 20,000 additional optometrists. Despite the establishment of two new schools of optometry, Dr. Shannon testified that "under the present educational institutions, we will not come close to that."

6. *Jay W. Friedman, D.D.S., M.P.H., dental director, quality assurance program, United States Administrators, and clinical professor, Department of Community Dentistry, School of Dentistry, University of Southern California and James W. Dunning, D.D.S., M.P.H., emeritus professor of ecological dentistry, Harvard University School of Dental Medicine*

Drs. Friedman and Dunning proposed expanded utilization of dental auxiliaries, working under limited dental supervision at reduced fees, and the establishment of school-based clinics. Specifically, they would recommend the development of a special auxiliary -- the School Dental Nurse -- who could perform preventive care services in facilities located on school grounds.

Drs. Friedman and Dunning envision the school-based dental clinics to serve several functions: they will bring preventive dental care to children in dentist-deprived areas; they may be culturally more acceptable to certain populations than are private offices; they will facilitate classroom and chairside dental education, leading to an increased demand for private care; they will act as referral agencies to private practice for cases beyond their capacity to treat.

Drs. Friedman and Dunning observed that their recommendation for a school dental nurse does not represent a radical innovation, but rather the adaptation of a system developed over the past half-century in New Zealand, and in Australia and the United States within the past decade. Drs. Friedman and Dunning estimated that a school-based program would save up to 65 percent of the cost for the same services provided by private dentists."

In a national health insurance program, Drs. Friedman and Dunning would recommend inclusion of a provision designed to encourage the States to develop school-based dental clinics staffed by auxiliaries. They proposed, "if a State will develop a program of providing basic dental care for its children under 13 in a school-based program utilizing school dental nurses, that is, semi-independent people who will prepare cavities as well as fill them, then the Federal legislation will provide for the payment of the dental care for all the children in that State through age 17. This is an inducement to States to save money and to extend services as a result of the savings."

7. American Federation of Physicians and Dentists, Dr. Stanley S. Peterson, president

In his testimony, Dr. Peterson emphasized the importance to the physician union movement of guaranteeing the right of collective bargaining for physicians and dentists. Dr. Peterson indicated that "when a National Health Program is enacted which affects the terms and conditions of the professional employment of physicians and dentists in such a way as to make the United States or its fiscal intermediary a party in interest in the individual doctor-patient relationship of Federation members, then the Federation will demand recognition from appropriate government agencies as the exclusive collective bargaining agent for all physicians and dentists in the United States." Dr. Peterson added that the various bills for the national health insurance "presume as a sine qua non, that every American physician and dentist is subject to conscription, servitude, and submission to the popular will as expressed by proponents of these bills."

According to Dr. Peterson, "collective bargaining to doctors involves more than bargaining for fees to doctors. It means to bargain for better care and services to the patient. When government becomes the payor of medical services it will control not only doctors' fees but more importantly the manner of delivery of their services.... Doctors have a professional responsibility to protect their patients from any interference

by the Government in determining the quality of medical care necessary to meet its patients' needs...."

8. *InterStudy, Health Policy Group, Walter McClure, associate director*

Mr. McClure outlined InterStudy's analysis of deficiencies in the nation's health system and offered several recommendations for remedies to these problems:

The nation's serious problems in terms of the cost, availability, and effectiveness of medical care can be traced to "serious organizational defects and powerful misdirected incentives in the system." One of the more serious structural deficiencies in the health system has been the growth of insurance, both public and private, contributing to an apparent insurance-cost spiral: the more insurance expands, the more it aggravates the rise in medical care costs; the more costs rise, the greater the pressure to expand insurance coverage. Unless such basic, underlying structural defects are corrected, "national health insurance will be a disaster. That is, we will be able to protect people from large medical bills if we pass national health insurance, but unless we get at these underlying problems... we are going to have massive cost escalations, worsened availability of care, and maldistribution of physicians and resources."

Mr. McClure stated there are three ways to approach the problem of structural defects. One is regulation, i.e., external controls imposed by the Government, such as has occurred in England: "I am not sure it is politically acceptable yet to introduce that kind of powerful control" in our medical care system, and I am not sure they would work in this country because it is so much larger and so much more heterogeneous than England."

A second approach suggested by Mr. McClure would restructure the health care system and build into it improved organization and incentives for performance in the public interest, an approach ultimately permitting a reduction in ongoing Government intervention in the system.

"The third approach is to do nothing. It is simply to pass a financing bill and allow the system to go as it will.... The experience of this country and in Canada is that the resulting cost escalation and distortion of the system dragged the Government step by step, piecemeal, into massive ineffective regulation of the system."

Mr. McClure suggested methods in which the present system might be restructured "so that we have a private pluralistic system with built-in improved incentives to behave in the public interest." This might be

accomplished by encouraging the development of competing alternative delivery systems, "that is, improved comprehensive care organizations which have intrinsic incentives very different from the traditional fee-for-service system."

To encourage the development of competing alternative systems in the framework of national health insurance, Mr. McClure offered three recommendations: 1) There must be no single public monopoly insurer. In addition, there must be competing oversight bureaucracies, "one over the fee-for-service provider, and one over the alternative delivery system, in order to create incentives for the bureaucracy to encourage improved systems." 2) There must be strong measures to contain the costs of catastrophic health care. Mr. McClure pointed out that "the most expensive one percent of episodes nor consume more than 16 percent of the health care dollar, and that percentage is rising rapidly." 3) The incremental approach to national health insurance is advisable. "If we act too fast, if we impose on the country tremendous new administrative methods and tremendous new benefits, the pressure on both the medical care system and tremendous new benefits, the pressure on both the medical care system and the national health insurance program will be immense."

9. *Association for Hospital Medical Education, Dr. Woodley Perkins, president*

Dr. Perkins indicated that community teaching hospitals are particularly concerned with two aspects of national health insurance: the quality of care as a function of the educational process and the cost of medical education to the institutional provider. The Association recommends in this regard:

Educational costs, both direct and indirect, should be recognized as a legitimate part of the operational overhead in the teaching hospital.

Failing to protect quality of care through the educational process and focusing rather on cost containment will ultimately contribute to increasing costs of health care in the nation. When the quality of training deteriorates because the community teaching hospital can barely continue to absorb the costs of education, then the quality of care delivered will suffer. When the quality of care deteriorates, we can expect an increase in acute, expensive disease, more hospitalization, and greater consumer dissatisfaction.

To group hospitals on the basis of bed size, geographic location, and rural or urban status (as proposed by Section 223 of P.L. 92-603) does not distinguish the special fiscal burden of the teaching hospital. Individualized prospective budgeting rather than cost allowance retrospectively decided, is a more equitable and effective method of reimbursement by which community teaching hospitals may plan educational and service programs.

10. *Association of American Medical Colleges, Dr. James F. Kelly, chairman, Task Force on National Health Insurance*

Dr. Kelly presented a summary of the revised and expanded national health insurance policy statement of the AAMC. The principles which the Association believes should guide the development of any program of national health insurance include the following:

- 1) First priority should be universal coverage on a mandatory basis, because voluntarism will never produce universal coverage.
- 2) Program should finance the most comprehensive package of benefits that available resources will permit. As a general rule, all necessary health care expenditures should be covered without quantity limits, and exclusions from coverage should be narrowly defined.
- 3) Ideally, the program should include no cost-sharing provisions. If, however, cost-sharing mechanisms are included they should be minimal, should be waived for low income persons, and should not be applied to essential minimum services.
- 4) The Federal Government has a responsibility to safeguard the public by effectively regulating private insurers. A single Federal agency should license, monitor, and regulate insurance underwriters.
- 5) Regulation of provider reimbursement and health care costs would best be performed at the State level under Federal guidelines.
- 6) A reimbursement policy which is fair and reasonable should meet the financial needs of the institutional providers of services and allow for the replenishment of capital, depreciation of capital assets, the amortization of debt, and the accumulation of an adequate operating margin. The reimbursement policy should also stimulate efficiency and cost constraints by mandating that provider institute effective utilization review.
- 7) The program should finance graduate medical education both with respect to inpatient and ambulatory care. In its financing of graduate medical education, the national health insurance system may justifiably be used to influence the numbers and kinds of medical generalists that are trained.

In the question and answer session, Mr. Pettis inquired about the projected supply of health care manpower, particularly physicians and physician assistants. The Association outlined for him the nature of the progress which has been made in this area.

11. *American Occupational Therapy Association, Dr. Jerry A. Johnson, president*

Dr. Johnson outlined certain inadequacies in the provisions of several of the bills -- as these are perceived from the point of view of the Association.

Occupational therapy for ambulatory patients in organized outpatient settings should be included as a covered service.

Occupational therapy as provided by a home health agency should be included as a reimbursable service.

Any requirement that only "intermittent" home health services be reimbursable should be eliminated. The Association indicated that single home visits by occupational therapists might be sufficient in many cases.

The provision for outpatient physical therapy in various bills should be clarified and expanded to include "outpatient occupational and physical therapy and speech pathology and audiology."

Since many of the occupational therapists' clients are the disabled with tractable impairments or permanent disabilities, experience-rating would adversely affect them. Experience-rating should not be permitted to any degree under a national health insurance plan.

12. *Hospital Service Inc., Thomas H. Brown, vice president and treasurer*

Speaking for Hospital Service, Inc., a non-profit health plan, Mr. Brown indicated that "our citizens need help in planning and paying for the catastrophic costs of a serious illness or accident case," and endorsed the provisions of the Long-Ribicoff-Waggoner bill. According to Mr. Brown, this bill provides "the type of benefits and coverage which seems reasonable as at least a starting point in a national health insurance experiment," and does so at a cost which is "moderate in comparison to other bills." In addition, it would "take advantage of the talent and expertise of the existing health insurance companies who have been building their knowledge and experience for nearly forty years."

May 17, 1974

1. *American Federation of Labor—Congress of Industrial Organizations*

Andrew Biemiller, Director of the Department of Legislation, made the following statements, highlighting the AFL-CIO position:

- "In conclusion, Mr. Chairman, let me reiterate that the AFL-CIO strongly supports the Griffiths-Corman bill, National Health Security."
- "There is room for give and take. There is room for agreement. But if Mills-Kennedy is this Committee's idea of 'compromise,' then I must say in all candor we will oppose it."
- "We believe national health insurance should be a major issue in the fall elections."
- "The 94th Congress can then take up national health insurance as its number one priority."

Mr. Biemiller also stated that the AFL-CIO:

- 1) Is opposed to application of a means test to cost-sharing on covered benefits and that universal entitlement would eliminate the need for a means test;
- 2) Is opposed to deductibles and coinsurance and opposed to the concept of satisfying individual deductibles;
- 3) Believes program should be financed through Social Security;
- 4) Believes fee schedules for physicians should represent payment in full for all fee-for-services physician services to all groups;
- 5) Believes employers should be taxed through social security mechanism on total payroll;
- 6) Supports the elimination of a role for carriers or intermediaries;
- 7) Feels that preventive services for adults should count toward the deductible;
- 8) Believes that the Health Resources Fund should be an integral part of the system and larger than called for in H.R. 13870;
- 9) Feels that catastrophic coverage can be inflationary and would have little impact on financial barriers to the great majority of people.

Mr. Burke responded to Mr. Biemiller's testimony by indicating his personal opposition to the position of the AFL-CIO that catastrophic insurance, by itself, would be unacceptable. Mr. Clancy stated that there is a need to go back to the voters in the fall with an enacted bill of some type and that his constituents were very interested in catastrophic coverage. Mr. Duncan took issue with the witnesses regarding local union opposition to the means test, citing application of the means test to VA beneficiaries and local union member resentment of wealthy people receiving medicare benefits. Mr. Karth stated that, according to testimony given to the Committee, catastrophic illness hits one million families a year, adding that "we ought to at least do something to cover the millions of families who are literally ruined financially during the rest of their lifetimes." Mr. Karth also asked the AFL-CIO if they would delineate areas where they would be willing to compromise.

2. Council of State Chambers of Commerce

John Zupko, Chairman of the Health Insurance Subcommittee, testified that 21 State and 3 local Chambers of Commerce endorsed the following principles with regard to national health insurance:*

- 1) Any bill adopted should have comprehensive benefits;
- 2) There should be Federal and State financing of care from general revenues for the poor and near poor;
- 3) There should be no increases in social security taxes;
- 4) There should be maximum use of the private sector, namely, private insurers;
- 5) Employers should be allowed income tax deductions for premiums beginning with 125 percent of the total amount and decreasing annually by 5 percent until it reaches 100 percent, at which point the amount of the tax deduction would be fixed;
- 6) Opposition to the public utility concept as applied to health care;
- 7) Would support H.R. 2222/H.R. 1/H.R. 12684/ and H.R. 5200 in principle.

3. Kaiser Foundation Health Plan, Inc.

James Vohs, Executive Vice President, presented Kaiser's position as follows:

*Reason given by witnesses for absence of endorsement from some State Chambers was that time had not allowed them to make a decision (pg. 935 of transcript).

- 1) Americans should have a choice of health plans;
- 2) System should be modeled after the Federal Employees Health Benefits program;
- 3) HMO's and health insurers should be paid the same amount to allow for competition in terms of price, cost-sharing features, and the scope and characteristics of the health services provided;
- 4) Any national health insurance system should protect against skimming of better risks.

4. *Union of American Physicians and American Federation of Physicians and Dentists*

Dr. Sanford A. Marcus, President of the Union and Vice President and Secretary of the Federation, outlined the position of these two organizations as follows:

- 1) Support for measures that "direct themselves to improving access to health care of those unable to provide it for themselves";
- 2) Support for a law to "protect Americans from costs of catastrophic illness";
- 3) Opposition to bills such as Mills/Kennedy, the Administration and Ullman bills because they introduce "rationing," a term used in this case to describe oversight actions such as pre-admission certification, hospital re-certification, limitations on certain services, etc;
- 4) Federal government should have co-responsibility in questions of medical malpractice and law should contain a no-fault type of insurance or compulsory arbitration;
- 5) Present PSROs should be split into lay-controlled Cost Control Review Organizations to review costs and physician-controlled PSROs to review quality;
- 6) Doctors should have the right to bargain collectively.

When asked by Mr. Karth whether physicians would strike in event a plan was adopted not to their liking, Dr. Marcus answered that physicians would provide emergency care but might effect numerous "slow down" approaches.

5. Physicians' Forum

Dr. Bernard Challenor, President, indicated his organization's support for H.R. 22. The Forum would be in favor of a national health system emphasizing the following:

- 1) Federal financing and administration;
- 2) Regional networks of facilities and resources;
- 3) Emphasis on prepaid group practice with salaried physicians;
- 4) Consumer participation in review of quality;
- 5) Financing by a "steeply progressive" income tax surcharge for health, eliminating all deductibles and coinsurance provisions;
- 6) Expansion of benefits over the level set forth in H.R. 12684 and H.R. 13870;
- 7) Establishment of a separate Fund and Department along the lines of either H.R. 13870 or H.R. 1;
- 8) Universal coverage and no means test.

6. National Union of Hospital and Health Care Employees (AFL-CIO)

William Taylor, Executive Vice President of the Union, described the Union's position as follows:

- 1) Opposed to coinsurance and deductibles for benefits;
- 2) Supports evolution from fee for service to "full service system financed by the prepayment mechanism," HMO's being a step in the right direction;
- 3) Wants stronger quality controls than are present in any of the bills, and opposes control of PSROs by local medical societies;
- 4) Predicts greater emphasis on ambulatory service and calls for Federal programs to retrain hospital personnel;
- 5) Supports financing of program through general revenues and payroll taxes;
- 6) Supports creation of local health centers operated by elected community boards;
- 7) Favors creation of medical and dental group practices.

When questioned by Mr. Archer regarding the right of health workers to strike, Mr. Taylor responded that health employees should have the right to organize and to strike.

7. *United Hospital Fund of New York*

Joseph Terenzio, President, testified that voluntary hospitals in New York were having deficit problems with emergency rooms because 50 percent of the patients had no third party coverage. Voluntary hospitals in NYC were losing \$60 million a year because of this problem.

Mr. Terenzio stated that his organization supported the following:

- 1) Financing for poor and near poor through a special trust fund to assure payment to hospitals;
- 2) Assurances that reasonable and substantiated costs of hospitals would be fully reimbursed;
- 3) Certification of facilities and services of hospitals by local comprehensive health planning agencies;
- 4) Controls on hospital occupancy, more economical staffing mixes, more emphasis by hospitals on primary care, and greater emphasis by hospitals on encouraging patient self-care and home health services.

8. *Executive and Employee Benefits Plans, Inc.*

Richard Perkins and Carmon E. Cobe presented the organization's position as follows:

- 1) In favor of the encouragement of employer self insurance:

"There are thousands of companies across the country who utilize the technique of self insurance of health insurance plans. There are at least 20 million Americans now covered under such plans. Some of them date back to the 1920s."

- 2) Rejects Trust Fund approach in H.R. 13870;
- 3) Opposes requirement in H.R. 13870 that approved carriers would be those that had underwritten or administered 3 percent of the total premium volume of group health insurance in 1973, as this would preclude all but 7 companies.

The witnesses further cited documentation that the costs of self insurance, using their company, which provides administrative services to direct insurer companies, are lower than BC/BS and commercial carrier administrative costs and compared favorably with the Canadian experience.

9a. *Maternity, Infant Care-Family Planning Projects for the City of New York*

Dr. Edwin F. Daily, Director, asked the Committee for \$100 million per year for 5 years in addition to the current annual appropriation of \$386 million for Title V programs of health services for mothers and children. With regard to national health insurance proposals, Dr. Daily indicated the following:

- 1) Support for coverage under H.R. 13870 of preventive services without application of a deductible;
- 2) Recommended co-insurance of no more than 10 percent of the cost of delivery, newborn, and post-partum care;
- 3) Support for the Health Resources Fund as an essential element of the plan and funded at a level of \$400 million for the first year;
- 4) Support for provision which would delegate substantial responsibility to State Health Departments to assure acceptable levels of quality;
- 5) Suggested the following changes in language of H.R. 13870 to include under sec. 2051, page 120 of the bill:
 - (a) Line 6, after "physician's assistant," add "nurse midwife."
 - (b) Line 11, after "geriatrics," add "obstetrics and gynecology, pediatrics."

9b. *Association of Children and Youth Project Directors*

Dr. Fred Seligman, Director of the Association, and also speaking on behalf of the Ambulatory Pediatric Association, summarized his views with regard to an NHI program as follows:

- 1) Should contain no deductible or coinsurance for maternal and child health for preventive services for pregnant mothers and for specified preventive and therapeutic services for children (such as dental and vision care, hearings exams, well-child care for children under age 6);
- 2) If the bill calls for specific types of extender services, then OB-GYN and Pediatrics should be included; should also include RNs, PHNs, nurse midwives, nutritionists, dieticians, and social workers;

- 3) Interns and residents should be included so that their services can be reimbursed in a primary care setting, whereas current reimbursement is restricted to hospitals;
- 4) Proposes the inclusion of a more precise and extensive definition under Part E, Sec. 205(u) and (v): Definitions of Eye and Vision Examinations, Hearing Aids, and Examinations;
- 5) The National Health Insurance Formulary is not sufficient for children under age 13 and should include:
 - (a) antibiotics
 - (b) phenobarbital as an anti-convulsive agent
 - (c) pharmaceuticals to treat...
 - cystic fibrosis
 - phenyleketenuria and other enzyme deficiency diseases
 - parasitic conditions
 - specific behavior disorders in children
 - specific nutritional deficiencies, including iron deficiency
 - electrolyte replacement therapy on an ambulatory basis
 - inexpensive mist vaporizers.
- 6) Suggests specific language in sec. 1416(c) to allow for the expansion of children's programs "to serve more enrollees or a larger clientele," and to make children's programs eligible for planning and developmental grants;
- 7) Wants waiver for children on following benefit limitations:
 - (a) 100 post-hospital days in SNF
 - (b) 30 days inpatient psychiatric care
 - (c) limitations on outpatient mental health services
- 8) Recommends a national medical record system by family and social security number.

10. *East of the River Health Association (Washington, D.C.)*

James T. Speight, Jr., President, testified that the Association advocated:

- 1) Greater emphasis on preventive services;
- 2) No deductibles or coinsurance for family units with incomes less than \$12,000 per year;

- 3) Deductibles and coinsurance be applied as a family unit, and not for each family member;
- 4) Consumers should be included in monitoring and evaluating services, and in writing regulations;
- 5) Provider peer review should have a variety of health professionals;
- 6) Family units with incomes of less than \$12,000 a year should get free eye glasses and hearing aids;
- 7) More mental health services should be provided in initial years of Act;
- 8) Preventive services age limitation should be raised from 7 to 12 years of age;
- 9) Certain types of cosmetic surgery (e.g., unsightly scars and warts) should be considered.

May 23, 1974

1. *Health Insurance Association of America, American Life Insurance Association, and the Life Insurers Conference, Frederick E. Rathgeber*

In his testimony, Mr. Rathgeber indicated that the above-named associations strongly endorse the National Healthcare Act, H.R. 5200.

Mr. Rathgeber also responded to issues raised by those who advocate an all-government approach, who oppose a partnership concept because of "three basic weaknesses" of the private health insurance industry: its efficiency, its profits, and the practice of experience rating. Regarding administrative efficiency, Mr. Rathgeber stated that "the Medicare expense ratio is about six percent--of which 3.9 percent is incurred by the fiscal intermediaries and carriers and 2.1 percent by SSA itself," and suggested that this be compared with "the three percent administrative expense ratio of the privately-run Federal Employees Indemnity Benefit Plan which has an annual claim volume of less than \$200 million, or with the 2.9 percent average for large group cases covering 50,000 or more employees. Even the average administrative expense ratio for all size groups, the very small and the large, insured by private companies is only eight percent. These ratios are exclusive of State premium taxes."

Mr. Rathgeber indicated that profits of private health insurance companies during the last five years have "averaged less than one percent (0.9 percent of premiums). Profits during 1967-1973 were 0.35 percent for group health insurance and 3.14 percent for individual health insurance. . . . But some profit, no matter how modest, is vital to a free enterprise economy. It stimulates growth. It leads to efficiencies. It encourages innovation in products and services."

With regard to the practice of experience rating, Mr. Rathgeber stated that "this is an essential and desirable practice in a free, competitive market. The large employer wants to pay only his own cost and not part of other employers' costs. More importantly, experience rating encourages employers to support cost control measures."

Mr. Rathgeber offered the associations' views on several of the other national health insurance bills before the Committee:

Comprehensive Health Insurance Act of 1974, H.R. 13870

- Would "dispossess Americans of one more freedom, namely, the right to choose how they will finance their health care costs."
- Would cause economic hardship for most, and outright unemployment for many of the half million Americans employed in the private health insurance industry.

- Would impose a burdensome tax on much of the public--adding 4 percent to the present 11.7 percent Social Security payroll tax. This level would "diminish the government's ability to raise taxes to finance the other essential needs of the nation."
- The actual tax increase needed would exceed the 4 percent payroll tax called for by the bill. The Association's actuaries estimate that the first year cost of H.R. 13870 would be 22 percent greater than the cost estimate provided by the proponents of this bill and, as a result, "the initial payroll tax should be set at 4.9 percent, rather than four percent."
- Would require those residing in States with lower health care costs to subsidize the health care bills of those who reside in higher cost areas.
- Although the benefits design of H.R. 13870 makes substantial use of deductibles and copayments, the scope of services covered is more comprehensive than the present health care system is equipped at present to deliver; as a result, the proposal is inflationary.
- A single governmental health care insurance agency would be involved in vast number of decisions as to the quality, effectiveness, and efficiency of care rendered. "What is needed is full participation by people at the local level--people, consumers, and providers, with a knowledge of, and interest in health care at the local level."
- Would discriminate against the small businessman and his employees. Employees of smaller firms would not be as likely to be provided private supplementary coverage by their employers, as would employees of major corporations.

Catastrophic Health Insurance and Medical Assistance
Reform Act of 1974, H.R. 14079

- No incentives are provided to encourage the public to purchase basic coverage.
- Medicaid would best be improved if benefits were insured and handled in the private sector.
- Catastrophic coverage should be financed through the private sector rather than through Social Security. Private catastrophic illness coverage already protects over half the population; substituting a government plan would destroy this private system and would be economically wasteful.
- Private insurers are willing to establish special pools from which the government could purchase catastrophic coverage for the poor and the near-poor.
- Scarce tax revenues should not be used to provide coverage that most people can afford to purchase on their own from the private sector.

Comprehensive Health Insurance Act of 1974, H.R. 12684

In spite of many desirable features, this bill is deficient in several ways:

- The bill would do little to address the problem of health care delivery.
- It could increase cost through the bad debts its health care credit card would create.
- The bill would provide several competitive advantages to the Assisted Health Insurance Plan and would place an unnecessary burden on private insurance companies underwriting the Employee Health Insurance Plan.

National Health Care Services Reorganization
and Financing Act of 1973, H.R. 1

- This bill is in many respects comparable to H.R. 5200. It would seek to assure access to quality health care, improve the delivery system, afford pluralism, and by phasing in benefits provide an opportunity for services to become available. It would accomplish these objectives by building upon existing private health insurance and without a burdensome, additional tax on the public.
- However, the bill not only substitutes the untested HCC for the partially-tested HMO, but also places too much reliance upon it and provides it with an unfair competitive advantage via a 10 percent government subsidy to its enrollees.

Health Care Insurance Act of 1973, H.R. 2222

- This bill provides access to health care and builds upon existing private insurance. However, it has several deficiencies.
- The bill does not deal with the issues of cost and quality of health care.
- The bill does not address itself to the need for improvements in the health care delivery system.
- Its Federal voucher system for the purchase of insurance by low-income individuals and families would be very expensive to administer.

In the question and answer session, Mr. Burleson asked for a detailed breakdown of the estimated additional Federal costs of H.R. 5200. Mr. Pettengill, Vice President, Aetna Life and Casualty, replied that these would involve \$8.1 billion. Of this total, \$5.7 billion would be required for benefits for the poor and near-poor. \$600 million would be proposed for Federal funding of ambulatory care centers, for the training of people needed to administer and provide care in such centers, and for the incentives included in the bill to encourage health care personnel to practice in areas of acute need. The Federal government could also be expected to incur a loss

of \$1.8 billion in tax revenues as the result of larger income tax deductions allowed employers and employees for the premium expense of improved, more expensive health insurance policies.

Mr. Waggoner observed that the tax reform legislation before the Committee proposes to eliminate tax deductions for the premium expense of health insurance policies. Mr. Hemry, President of the Health Insurance Association of America, replied that such a proposal "we find very undesirable and would hope before you reach a final conclusion you will go back to the original law."

Mr. Collier asked if employees, who at present consider their health insurance coverage adequate, should be required to participate in a national program of health insurance. Mr. Rathgeber replied, "I think there are many, many people happy with their present plans. They are getting very good coverage and I think it would be a great mistake to force them to have to put their financing in some other mechanism and we believe building on that base, taking where we are now and making slight changes to those people, is a much better way than to change all those people over to a different financing system."

2. United Mine Workers of America, Dr. Lorin E. Kerr, director, occupational health

Dr. Kerr outlined for the Committee the UMWA's views on basic requirements for a program of national health insurance:

- Benefits must be comprehensive. All services--preventive, diagnostic, therapeutic and rehabilitative--must be readily available and easily accessible.
- All persons must be eligible for coverage with no barriers to services.
- The program should be financed by a progressive income tax surcharge for health.
- Administration must contain interrelated quality and cost control and provide meaningful involvement for the consumer in the development, implementation, and operation of the program.
- Medical services can best be provided by non-profit prepaid group practice.

Regarding the UMWA's views on H.R. 1, H.R. 12684, H.R. 13870, and H.R. 14079, Dr. Kerr offered the following observations:

- None of these bills meet the UMWA's basic requirements.
- Compulsory cost-sharing via deductibles and coinsurance are formidable barriers which too often preclude provision of essential services on a continuing basis, such as prevention and early detection of disease.

- None provide truly comprehensive benefits. In the absence of preventive services, these plans would restrict care to episodic illness.
- Enactment of any of these bills would mean that the poor and middle class would continue to be denied their right to medical care.
- H.R. 13870's proposal for the administration of national health insurance by an independent Social Security Administration is commendable. It is likely to be more effective and economical than the alternatives in other bills.
- The UMWA is strongly opposed to private insurance coverage and employer-employee contributions with private insurers acting as primary underwriters.
- These bills, with the possible exception of H.R. 1, would neither initiate nor stimulate changes in the organization and distribution of services essential for cost containment.
- The absence of quality controls combined with the retention of a major administrative role by private insurers, either as underwriters or intermediaries, assures a continuing escalation of medical care costs.
- None provide for the meaningful involvement of the consumer. The UMWA recommends the creation of local and regional community-controlled health boards with responsibility and accountability for personal and environmental health services.

The bill which most nearly meets the UMWA's criteria for an acceptable national insurance program is H.R. 22.

3. American Association of Clinical Urologists, Dr. Harold Kay, president

The Association recommended to the Committee the following considerations for national health insurance legislation:

- The present method of financing and delivery of health care is an effective method. Its commendable features should not be radically disturbed.
- Catastrophic health insurance coverage is necessary and should be provided only to those not financially able to provide it for themselves.
- The catastrophic illnesses which involve the young with physical defects, and the aged with their long and financially devastating diseases, require insurance protection and, for this coverage, financial subsidy through government assistance. This can best be provided by the government making it possible for those who require such assistance to obtain their insurance through the private sector. The Association recommends that Medicredit's mechanism for providing catastrophic illness coverage be given serious consideration.
- Government intervention in the provision of health care would be disastrous.

4. *American Nurses' Association, Rosamond Gabrielson, president*

The American Nurses' Association offered the following observations on H.R. 13870:

The ANA finds acceptable this bill's arrangements for administration and funding, as well as its provisions for an independent federal Social Security Administration and a Health Resources Development Board.

The bill's scope of benefits the ANA finds less acceptable. "Many essential health care services would not be covered . . . and the structure of benefits . . . is so complex as to be incomprehensible to beneficiaries and providers alike."

Its deductibles and co-insurance provisions would work to the disadvantage of those with moderate incomes, the unemployed, and the poor and are an inappropriate means of controlling utilization of health services if they inhibit entry into the health care system. "Rather, national health insurance should facilitate entry into the system so that there is early detection of illness and maintenance of health."

The consumer is not the principal cause of expensive over-utilization. "In the main, this is a problem generated by the character of benefits, and by providers; and can be most effectively contained through systems of utilization review."

The ANA recommends that the bill's provisions for utilization review be amended to provide that review be made by a staff committee composed of two or more physicians with participation of other professional personnel, including two or more registered professional nurses; or a group outside the institution similarly composed and which is established by the local medical society and the district nurses' association.

The ANA supports the concept of H.R. 13870's National Health Insurance Benefits Advisory Council but recommends that its provision for the composition of this Council be amended to ensure appointment of persons who are representative of organizations and associations of professional personnel in the field of health and not simply in the field of medicine.

The reimbursement provisions of any national health insurance bill should facilitate effective and efficient use of the knowledge and skills of qualified professional nurses as providers of primary care services. The ANA recommends that H.R. 13870's definition of "medical and other health services" be expanded to include the services of qualified independent nurse practitioners who are certified by the American Nurses' Association, the

American College of Nurse Midwives, or the American Association of Nurse Anesthetists. In addition, the definition of covered benefits should permit payment for primary care services rendered by nursing service agencies, or by professional nurses who are practicing their profession in structured health care agencies meeting acceptable professional standards.

The ANA urges that no institution be considered a hospital for purposes of reimbursement unless it has an organized nursing service under the direction of a registered professional nurse, and unless all nursing care is rendered and/or supervised by registered professional nurses 24 hours each day.

Private duty services by a registered professional nurse should be a covered benefit when required by the nursing needs of the patient.

Every skilled nursing facility should have a registered professional nurse responsible for directing nursing care services and for execution of policies established to govern skilled nursing care and related health care services. H.R. 13870 should be amended to require that such facilities have one registered professional nurse on duty 24 hours a day, seven days a week.

Reimbursement for home health care services should not be contingent upon prior hospitalization or prior confinement in a nursing care facility.

The proposal for a long-term care program is an effective arrangement for the delivery of health care services which should be available to all insured beneficiaries of a national health plan, not just for the aged.

Licensure of individual health care practitioners is best performed by State governments. The current system of State licensure for the practice of nursing places the regulating agency close to the practitioners and the public.

5. American Mutual Insurance Alliance, Andre Maisonpierre, vice president

Mr. Maisonpierre outlined for the Committee those guidelines which the American Mutual Insurance Alliance--an association of property and casualty insurance companies which provide workmen's compensation, automobile and other property casualty coverage--considers essential in the structuring of a national health insurance program.

The AMAI urges the adoption of a plan based on the broadest possible access to health care as can reasonably be supported by the health delivery system. To insure that such benefits are made available, the AMIA would support a forcing mechanism: "our companies have for many years administered a variety of compulsory insurance programs, and no major complications are foreseen with a compulsory national health insurance program."

A national health insurance program should include coverage for catastrophic illness or accident; however, "there is no logical reason to establish such protection as a separate, and in some cases, a competing program with existing coverages."

The AMIA recommends a major role for private insurers in the financing and administration of a national health insurance program and stands "unalterably opposed to federalization of the health insurance field."

A national health insurance program should be implemented in stages and at a rate equivalent to improvements in the capacity of the delivery system.

Of the several bills before the Committee, H.R. 5200 most closely corresponds to the AMIA's guidelines for legislation. However, this bill, like all others with the exception of H.R. 1, fails to address itself to the relationship between national health insurance and other insurance systems which play a major role as distributors of medical benefits.

Any mandatory health insurance benefits should not duplicate other government mandated medical benefits. To avoid the waste and inefficiency inherent in such duplication, insurance benefit coverages must be made mutually exclusive of each other. A provision similar to that in Title XVIII of the Social Security Act, which bars payment of Medicare benefits to the extent that workmen's compensation benefits are also payable for the same condition to the beneficiary, should be included in any NHI program so that national health insurance benefits may be coordinated with other government mandated, first-party insurance programs. Of the proposals before the Committee, only H.R. 1 recognizes the necessity for such coordination.

National health insurance benefits should not replace medical benefits provided by casualty insurers for the additional reason that casualty insurers have developed well-articulated and smooth functioning methods for controlling medical costs.

Federal regulations of health insurance carriers should be carefully constructed so as to neither overlap nor replace existing State property and casualty insurance regulatory programs.

6. National Association of Independent Insurers, Arthur C. Mertz, executive vice president

In his statement Mr. Mertz indicated that the NAII urges that two principles be observed in any health program adopted by Congress:

1. State-regulated, competitive insurance business, and not the federal government, should be assigned the basic insurance role under any such program.

2. The primary source of compensation for medical/hospital expenses arising out of automobile accidents should continue to be the automobile insurance system. The primary source of compensation for employment-related medical/hospital expenses should continue to be the workmen's compensation insurance system. If these systems of compensation continue to prevail, duplication of benefits will be avoided and the cost of any national health insurance program will be reduced.

With guidelines such as these for NHI legislation, the NAIH finds three bills before the Committee--H.R. 22, H.R. 13870, H.R. 14079--would result in "totally unwarranted intrusions by government into areas which can and should be served by the private insurance business."

H.R. 1 and H.R. 12684 have "one important and meritorious feature in common: generally speaking, they seek to retain and build upon the private health insurance system."

The proposal which the NAIH believes has the greatest merit is H.R. 5200. It would have the support of the NAIH if "one very serious deficiency were corrected." Mr. Mertz stated that the bill should be amended "to coordinate its benefits with the automobile insurance system in essentially the same manner as it has already coordinated those benefits with the workmen's compensation system. It should provide that national health insurance benefits should not be payable for any items and services to the extent payment has been made or can reasonably be expected to be made under an automobile insurance policy affording direct benefits for such items and services."

7. International Association of Health Underwriters, Edward A. Bray, legislative chairman

Mr. Bray indicated the Association endorses the National Healthcare Act, H.R. 5200. Among its features that the IAHU finds commendable, Mr. Bray singled out: 1) its orderly, systematic, incremental approach to assuring the availability of quality health care for everyone; 2) its attempt to deal with problems of shortages of health manpower and the maldistribution of that manpower; 3) its provisions for improved health planning; 4) its emphasis on ambulatory care and maintenance of health; 5) co-payment requirements which will minimize over-utilization; 6) protection against the expenses associated with catastrophic illness or accident; and 7) federally-mandated minimum standards within a short period of time.

8. *National Association of Life Underwriters, Michael Kerley, Committee on Health Insurance*

Mr. Kerley delineated two major shortcomings in the nation's health care delivery system and methods of financing: 1) health care is expensive and a great many Americans cannot accommodate the cost; and 2) medical personnel are poorly distributed, leading to a condition in which care is not always available when it is needed.

The NALU endorses H.R. 5200 and believes that this proposal can redress these shortcomings in the following ways: 1) making maximum use of individual initiative at a cost of only \$7 billion additional tax dollars each year, 2) emphasizing preventive as well as curative medicine, 3) making maximum use of paramedical personnel, 4) phasing in benefits, so that supply will be adequate to meet anticipated greater demand; greater inflation of medical costs will in this way be avoided, 5) providing incentives for health professionals to practice in areas of scarcity, 6) proposing a stated level of benefits available to all, 7) allowing an individual to choose his own benefits above this stated minimum level, 8) promoting health planning, 9) providing catastrophic illness coverage, and 10) utilizing peer review to assure quality medical care.

9. *American Association of Bioanalysts, Bernard I. Diamond, chairman, Government and Professional Relations Council*

The major points of Mr. Diamond's statement included the following:

1) Representatives of independent laboratories should be invited at the outset and not after the fact to participate in the deliberations of ad hoc and advisory committees which will draw up rules and regulations which carry out Congressional intent with respect to the delivery of health services.

2) The bioanalyst should be consulted in the development of the Health Maintenance Organizations' laboratory services; qualified allied health professionals must be permitted to provide input at all levels for all services; "health care standards can no longer remain under the sole charge of the physician."

3) With regard to PSRO's, the AAB accepts the leadership of physicians "in developing standards for the practice of medicine. We will not accept that position in many of the allied health areas where the physician has little expertise."

4) Mr. Diamond observed that "only independent laboratories are subject to the stringent Federal standard of Medicare and interstate laws in terms of personnel qualifications, on-site inspections, compulsory proficiency testing and adequacy of facilities." The AAB recommends that under any system of national health insurance, the same standards apply to all who perform laboratory tests--whether these be independent, hospital, or physicians' office laboratories--and who are reimbursed for such services by any governmental or private health insurance program.

5) The term "laboratory services" should be routinely used in legislation to cover all qualified facilities and personnel in the laboratory disciplines.

6) Because the independent laboratory faces "economic and competitive disadvantages" relative to hospital laboratory facilities, "every effort should be expended by Congress to insure fair competition in the marketplace."

7) The benefits package should include out-of-hospital testing, multi-phasic screening procedures, together with physician-ordered laboratory studies with emphasis placed on outpatient care and services in the independent laboratory, in nursing homes, rehabilitation centers, and extended care facilities.

8) Providers of services must be subject to ongoing quality control at all levels--services, costs, management.

9) The AAB supports coinsurance as a method of inducing cost-consciousness in the consumer.

10) The costs of laboratory operations in all facilities and especially in nonprofit hospitals should be carefully reviewed by Congress.

11) Programs and grants in continuing education should be developed for licensed and supportive laboratory personnel.

10. *American Physical Therapy Association, Royce P. Noland, executive director*

The APTA subscribes to the following principles and priorities for a program of national health insurance:

- A program should stimulate new and innovative approaches to the delivery of health care; special consideration should be given to H.R. 1's health care corporations.
- Preventive care is vital to any NHI program.
- Manpower training legislation is a prerequisite to legislation which would provide for all individuals in the nation access to health care.
- H.R. 13870 is the bill most consistent with the APTA's position. However, the collection and disbursement methods inherent in H.R. 5200 deserve special attention.
- The APTA supports coinsurance and deductibles for episodic care so long as they do not produce an unfair barrier.
- To ensure that physical therapy services be available in all treatment settings in all geographical areas, the APTA proposes that legislation before the Committee be amended to provide reimbursement to free-standing physical therapy service facilities which are not connected with hospital facilities.

11. *National Council for Homemaker--Home Health Aide Services, Dr. Ellen Winston, chairman, Social Policy and Legislation Committee*

Dr. Winston presented the National Council's views on selected aspects of three NHI bills--H.R. 1, H.R. 12684, and H.R. 13870.

1) H.R. 12684 and H.R. 13870 "not only would perpetuate the current inadequate health service delivery system but also would greatly extend the present over-utilization of costly in-patient care, especially hospital care, as compared with out-of-institution care."

2) The term "home health aide" in the three bills should be changed to "homemaker-home health aide," trained in both personal care and home maintenance.

3) The regulation of homemaker-home health aide services, as proposed by these bills is inadequate. One set of basic national standards should be applied to homemaker-home health aide services or any aspect of the service in order to assure quality, cost-effectiveness, and appropriate use.

4) Homemaker-home health aide service should be provided only through a responsible community agency accountable for the service provided: "homemaker-home health aides do not receive the kind of training which enables them to be individual practitioners, as do nurses or social workers."

5) The term "skilled" before "nursing" in the present Medicare program is "particularly troublesome in the delivery of homemaker-home health aide services since it has not been interpreted to mean supervision of a homemaker-home health aide. It has been so narrowly interpreted that the nurse herself must perform a task which involves a 'laying on of hand.'" Dr. Winston submitted that "supervision of a homemaker-home health aide when personal care tasks are involved is indeed one form of skilled nursing service."

6) Home health services should be exempt from coinsurance and deductibles.

7) The National Council "strongly approves the principle of in-home service which undergirds the long-term services program under Title II of H.R. 13870." Dr. Winston expressed concern, however, that the voluntary nature of the program and its monthly enrollment fee of \$6 might mean that "many older people who are most in need of the program will not have the funds to take advantage of it. Therefore, it would be desirable to waive the enrollment fee for those persons whose annual income falls below a certain level."

12. *American Society for Medical Technology, Annamarie Barros, president*

Mrs. Barros presented ASMT views on national health insurance, as this issue relates to the clinical or medical laboratory:

- There is a need for much closer legislative scrutiny of the regulations and requirements for both laboratory services and practitioners than is contemplated by H.R. 1, H.R. 12684, or H.R. 13870.
- The medical laboratory represents a particularly difficult area in which to contain costs.
- Peer review activities are particularly important in the laboratory setting as a way of determining the necessity and appropriateness of tests, along with their quality. Each health profession should be held directly accountable to the public for the development of its own standard of practice which would ensure that any care or service rendered is both necessary and appropriate.
- The lack of uniform standards more than any other factor results in the impairment of laboratory performance. "The Federal Government must either commit itself to the acceptance of a uniform regulatory framework for medical laboratories as an essential component in any national health insurance program or acknowledge, by its inaction, that it is content to perpetuate sub-standard, duplicative, and uneven laboratory performance."
- NHI legislation should require all health professionals, including laboratory personnel, to demonstrate continuing competence for care or services reimbursed under national health insurance.
- There is a need for national standards for licensure and certification of health care personnel.

13. *Insurance Economics Society of America, John B. O'Day, president*

Mr. O'Day's statement contained the following major points:

- The IESA endorses H.R. 5200.
- The consequences of financing a national health insurance program through the Government sector and Social Security taxes would be different from those associated with financing through the private sector. The IESA contends that "a Government health insurance fund is destined to increase at a much faster rate than a primarily private sector fund," for the following reasons: 1) Under H.R. 5200, every employer, self-employed individual and wage earner would have a personal monetary incentive to keep health costs at a minimum, 2) competition among insurance companies, Blue Cross, Blue Shield, HMO's, and other health insurers would continue to provide another essential cost controlling factor, 3) Social Security funded health care costs would not be subject to the forces of competition in the free-enterprise marketplace, 4) the Federal Government does not possess a demonstrated and proven capability to administer a national insurance program which would be responsible for processing and paying claims for 200 million Americans.

14. *Homemakers Home and Health Care Services, Inc., Edward J. Wilsmann, president*

As President of the nation's "largest single deliverer of home health care," Mr. Wilsmann outlined several concerns of his proprietary organization:

1) Despite its service capability, Homemakers is permitted to serve Medicare-Medicaid patients in only eight States, because of Section 1861(o) of the original Medicare law. The Federal government should either mandate State licensing or certification procedures for proprietary and non-proprietary home health agencies on a uniform basis or establish Federal certification.

2) The 100-visit limitation for home health services should be rescinded. "Study after study has proven the cost savings of home health care compared to institutional care. To open-end institutionalization--the high-cost segment of health care--and close-end home health care is illogical, and wasteful of both facility utilization and tax dollars."

3) The scope of home health services should be broadened to include every type of service which will obviate the need for reinstitutionalization of the patient.

4) Home health agencies should not be reimbursed on a cost-plus basis.

May 31, 1974

1. *Chamber of Commerce of the United States, Roger C. Sonnemann, chairman, Special Committee on the Nation's Health Care Needs and E. S. Willis, consultant, legislative liaison, General Electric Co.*

Mr. Sonnemann indicated that the National Chamber of Commerce has reviewed the various NHI proposals pending before the Congress and has found several of them unsatisfactory for the following reasons:

--Most would mandate a comprehensive health insurance benefit package which would require, if enacted, additional areas of coverage crease their costs significantly. Proposals compelling employers to pay 75 percent of the cost of a comprehensive health insurance benefit package would result in substantial increases in premium costs and would aggravate inflationary pressures already prevalent in the health care industry.

--The financing provisions of several bills are of major concern to the National Chamber. The Chamber "seriously questions the feasibility and prudence of any proposals imposing billions of dollars of new payroll taxes on top of a growing tax burden that many Americans already regard as excessive."

--The penalty provisions, i.e., tax penalties and the loss of business expense deductions for health insurance premiums, are unsatisfactory as a means of encouraging employers to offer their employees health insurance coverage. "A tax penalty represents poor public policy. It would apply only to those employers with health insurance coverage for their employees and not to those employers not offering health benefits to their employees, thus acting as a disincentive for employers to provide coverage for their employees."

The National Chamber believes the following should be included in any national health insurance program:

--universal financial access to health care through both private and public means. "Employers, employees, and the self-employed should pay the entire cost of the private program through health insurance premiums. Where the employer-employee relationship

exists, the employer should not be required to pay more than 50 percent of the cost of the coverage... The program for the poor and near-poor -- essentially non-working groups -- should be financed from the general funds of the Treasury."

--a comprehensive benefit package and protection against medical catastrophies.

--cost-sharing on the part of beneficiaries, including both deductibles and coinsurance. "A \$100 calendar year deductible for an individual with a maximum payment of \$200 a family is reasonable and realistic. In addition, the enrollee should pay a 25 percent coinsurance for all covered services up to a maximum out-of-pocket expenditures of \$2500 a year."

--a "benefit equivalence" provision. Employers should not be required to change their group plans to reflect every single benefit in a recommended package. Instead, employers should be permitted to offer a plan which is equivalent in value, on an actuarially determined basis, to the recommended plan.

--coverage for the self-employed and small employers through insurance pools, in order to make economies of mass purchasing available to them.

--public financial assistance for the poor, near-poor, and high risk individuals. Pools should be established in each State with the Federal government paying all or part of the cost of the premiums for these individuals.

--administrative and judicial review to encourage employers to provide their employees coverage. "If an employer willfully and knowingly fails to comply, he should be assessed a civil penalty of not more than twice the annual health insurance premium cost, and he should be required to reimburse his employees for their out-of-pocket hospital and medical care expenses, including the cost of health insurance, through a court action instituted by the State attorney general through due process of law."

--effective measures to help contain spiraling costs, such as peer and utilization review, claims review and audit, prospective budgeting for purposes of reimbursement, local health planning, etc.

Mr. Sonnemann stated that these principles are embodied in one bill pending before Congress -- S. 3353, the National Health Standards Act.

Mr. Willis offered the National Chamber's views on selected other bills:

H. R. 13870

--Opposition to the designated role of the Federal and State governments, and private insurance industry. Any national health insurance proposal should have a clearly limited role for the Federal government and major roles for State governments and private health insurance companies. "The present third party coverage system of financing health care is workable and far better than a full government operation."

--Opposition to its financing provisions. According to Mr. Willis, it is "highly undesirable to impose \$40 billion of new Federal taxes on top of a tax burden that is already regarded by many as excessive." In addition, the Chamber questions the bill's provision to tax unearned incomes, including governmental benefit programs such as Unemployment Compensation, Social Security benefits, Aid to Families with Dependent Children, etc.

H. R. 12684

--Opposition to allowing an employee to opt out of coverage. "Employees should be required to avail themselves of health insurance coverage if employers are obligated to offer it."

--Opposition to requirement that employers pay at least 75 percent of premiums.

--Opposition to its system of penalties. "Civil penalties, incorporating stiff fines and other provisions, would be superior."

H. R. 14079

--Purely catastrophic protection is "incomplete and ... does not represent an adequate response to the needs of the population."

--Catastrophic expense protection should be achieved "primarily through private enterprise, using private underwriting and administration, and not through a government operated program. Any public program should supplement -- not supplant -- private efforts in this field and be financed by Federal appropriations rather than payroll taxes."

H. R. 1

--Health Care Corporations could lead to monopolistic control of the delivery system and stifle innovative change.

--Regulation of providers through State health commissions would "probably create more problems than it would solve... It certainly will be very costly to administer, and to superimpose this structure on the present system would be an almost insurmountable task at any time." In addition, since there is no provision for the representation on these Commissions of major purchasers of health care, such as business and labor unions, "the medical providers [might] eventually gain control of the State health commissions and, in effect, become the regulators."

--Rate regulation provisions are questionable. "Public utility commissions tend to set rates on a cost-plus basis including an approved rate of return... This type of reimbursement system does not generate any degree of incentive to contain or reduce costs."

--Opposition to requirement that employers pay at least 75 percent of the premium cost.

H. R. 22

--"A nationalized health insurance program would eliminate private enterprise participation and would not permit individual freedom of choice. Private health insurance has many achievements to its credit and it would be better to build upon our existing system than to replace it with an untested program as visualized in H. R. 22."

--No provisions for coinsurance or deductibles which would encourage cost-consciousness and discourage overutilization.

--Opposition to financing through payroll tax increases.

--Opposition to provision requiring employers to pay a cash difference to employees, former employees, and survivors of employees if the sum of the employer-employee combined tax is less than outlays for existing health insurance plans.

H. R. 5200

--Opposition to tax penalties for employers whose health insurance plan does not meet the requirements of the bill.

--Opposition to the establishment of "quasi public utility commissions in each State which would be charged with the responsibility for setting rates of reimbursement and charges for hospitals and other health care institutions."

H. R. 2222

--Medicredit is principally a financing mechanism. "Any national health insurance proposal must contain provisions to make the delivery of medical care services more efficient and economical."

--Objection to tax penalty for non-complying employers.

In the question-and-answer session, Mr. Burke asked how the National Chamber would react to any bill which proposes to finance the voluntary purchase of health insurance coverage through reductions in Social Security taxes for the employer and employee. Mr. Sonnemann replied, "it seems to the Chamber would be opposed to any such bill as that, for the reason that we are diverting funds from one program, using them for another program and then getting from the general revenues the replacement for the Social Security cost which ultimately winds up in more taxes which are harder to fingerprint... It is harder to earmark the exact costs of the health insurance program if you have such diversions."

Mr. Burleson observed that an incremental approach in which a maximum level of benefits are phased-in gradually over a period of time would be a desirable method of initiating a national health insurance program. Mr. Sonnemann replied "we could certainly support that. The phase-in of benefits would certainly be supported by the Chamber. As a matter of fact, I think it is safe to say that the business community is not cast in concrete on the very narrow limits outlined in the specific bill... We could support several portions of several bills."

Mr. Karth asked how S. 3353 would affect the cost of health insurance coverage of the 100 largest corporations in the nation. Mr. Sonnemann replied that it would "increase the costs because practically none of the companies in the first one hundred provide well-child care." Mr. Willis added that if his company (General Electric) were mandated "into picking up each little piece, we would have added costs." However, if a benefit equivalency provision were included in the legislation, "we would come out about even." By how much S. 3353 would increase the health insurance costs of these one hundred companies, Mr. Sonnemann replied that this information would have to be supplied at a later date.

2. *Pharmaceutical Manufacturers Association, C. Joseph Stetler, president*

Mr. Stetler presented the PMA's views on prescription drug coverage under H. R. 13870:

--The bill's restrictive national formulary for out-of-hospital drugs

is "likely to distort prescribing decisions. There would be a tendency to prescribe a covered drug, if at all appropriate, even though another drug might be preferable. And for those patients requiring anti-infective or psychotherapeutic drugs, there would continue to be an incentive to hospitalize some who might have been treated at home, merely to assure their access to covered drugs. This may not be considered a major problem under existing programs, but by expanding the total population covered by medical and hospitalization insurance, the bill would sharply increase the number of cases potentially subject to this wasteful and unnecessary overutilization of high-cost institutions."

--Implicit in the bill's mechanism for setting price ceilings on product acquisition costs is "the dangerous assumption that the price of each product must bear a relatively fixed relation to its direct costs. And most importantly, it rests on the assumption of therapeutic equivalence of all versions of the same drug entity. The PMA believes that this approach is hazardous from a medical viewpoint because the FDA is not now, nor will it be in the future, in a position to assure the nation's physicians that all drug versions containing the same active ingredient are equal in biological availability and therapeutic effect... We also reject the implicit assumption that there would be significant savings to consumers in restricting choice to the lower or lowest cost versions of multiple-source drugs. Evidence to support such an assumption does not exist."

--In considering a Federal formulary as a mechanism for controlling costs, the Federal government should examine the experiences of those States which have attempted to control the costs of their Medicaid programs through restrictive drug formularies. According to Mr. Stetler, these States have failed to lower their overall health care costs because "slightly lower drug costs were associated with, and we believe directly connected with, a significantly higher expenditure for drugs and doctors combined," and have experienced higher administrative costs for their programs as the result of a need to enforce and police such restrictions.

--The PMA questions the wisdom of a policy which would permit "a small Formulary Committee to supplant the judgments of the nation's doctors about the relative efficacy of entirely different drug compounds for treating a particular patient with a given disease, or set of disease conditions. Any practitioner knows that the 'drug of choice' for most patients may not be the drug of choice for a particular patient, whose idiosyncracies, allergies and sensitivities are unique."

--The PMA believes that there are more effective ways of reconciling the objectives of quality and economy than those proposed by H.R. 13970. "Instead of using price control, leading to distortions, and to increases in the utilization of more expensive services, we would urge the Committee to rely on a proven competitive system, reinforced by better price information and by utilization review."

--H.R. 13870 could substantially reduce the scope of pharmaceutical benefits presently available to the poor and medically indigent under Medicaid.

In the question-and-answer session, Mr. Karth asked if a Federal law repealing the prohibition of advertising of retail drug prices would stimulate competition in the drug industry. Mr. Stetler replied that the PMA has taken the position that "there should be more price information available to physicians because they, in effect, make the decision as to the drug to be used by the consumer. Rather than suggest that this be a matter of advertising, which does have its limitations and pharmacy has good reason for opposing that, we had not fault with the posting requirements and I think pharmacy has no fault to find with that... It is hard to suggest how that gets to them...possibly it could be made available through the Social Security mechanism, that pharmacists and industry be required to give this data periodically to Social Security..."

3. *National Association of Blue Shield Plans, Ned F. Parish, president*

The National Association of Blue Shield Plans recommends the following in the development of national health insurance legislation: Maximum participation by the private sector, "which has developed nearly all of the capacity which now exists for the actual administration of health benefits."

--Avoidance of excessive regulation and controls not directed at quality and efficiency.

--Government should play a role in assuring that all Americans are eligible for health insurance. "But the vast regulatory and taxing power of government should be used judiciously. It should be tailored to the real problems. Availability of health insurance for the general, working population is not a real problem. The problem is assuring that coverage is reasonably priced, adequate, and not unduly discriminatory against individuals and small groups, high risks, and the unemployed."

--Coverage of catastrophic illness. However, "the most efficient administration of catastrophic coverage is through the same carrier that maintains the history and eligibility files for basic coverage. It would be a duplicative and unnecessary expense to establish any entity to pay catastrophic claims separate from the entity that pays basic claims."

--State-level regulation of carriers with respect to both benefits and retentions. However, "Federal guidelines will be needed, and the Federal Government should be intervention authority if the States fail to act."

--Recognition that H.R. 14079 has inherent potential for drastic change through very simple amendments. "The \$2000 medical expense requirement could be dropped in stages to virtual elimination. The government would then be underwriting essentially all health care coverage... This proposal, which looks so unlike a comprehensive bill, can be viewed almost as the Mills-Kennedy proposal with a higher deductible."

--Concern that not one Blue Shield Plan would qualify as a carrier under H.R. 13870 due to its provision that carrier qualification be granted only to those companies underwriting 3 percent of the nation's health insurance business.

--Questions H.R. 13870's assumption that "a new administrative system could go into effect without testing, without phasing, without assurance of effectiveness or operating efficiency, and without retaining a back-up system."

--If experience-rating leads to employer discrimination against older, handicapped and high-risk workers, then requiring all groups below a given size to be community-rated and limiting differentials in premiums would be an appropriate countermeasure.

--A mandated access program should be implemented by requiring all employers to offer both basic and catastrophic coverage (with a minimum level and scope of benefits) to all their employees and to pay at least a percentage of the premium. Participation by the employee should be voluntary. In addition, the basic program with required catastrophic coverage should be offered to the self-employed at a premium not to exceed a maximum percentage of the group rate.

--Coverage of the temporarily unemployed should be accomplished through the existing unemployment compensation program in each State.

--The public should have free choice of health care delivery systems, including 1) a program utilizing deductibles and coinsurance, or 2) first-dollar coverage, or 3) a health maintenance organization, or 4) other forms of prepayment.

--Federal financing will be required for coverage of the poor and the medically indigent. "Private industry is unable to provide them with high quality programs without government assistance. This is the most urgent need facing the Committee."

--Benefit package should be implemented in phases to avoid a sudden additional burden on the health system and on those who must pay for benefits. Ultimate specifications should be spelled out when the program is initially legislated.

4. *National Association of Retail Druggists, William E. Woods, Washington representative and associate general counsel*

Mr. Woods' statement contained the following major points:

1) Medicare benefits should be broadened to include outpatient prescription drugs. Any national health insurance program should include a similar benefit. "We question the value of a program that makes the services of a physician available to assist the physician, if after these procedures and services are completed the necessary drug therapy indicated to properly treat the illness is not also available... There is even less justification for institutionalizing a patient to assure that drug therapy indicated will be provided."

2) NARD recommends H.R. 13695 as a model of desirable prescribed drug coverage under a national health insurance program.

3) Drug benefit under H.R. 13870 is far too narrow to be meaningful. Limitations to the 19 therapeutic categories in this bill is "a serious mistake that should be corrected... It may be that the 19 therapeutic categories represent a significant percentage of the [drugs required by] the elderly with chronic diseases and conditions. But we suspect that these categories represent only 9 percent of the aged's expenditures for prescribed drugs. Additionally ... the younger segments of the population, particularly children, will have small need and hence receive little benefit from a drug benefit limited to medications for chronic conditions." Furthermore, NARD is particularly concerned with the effect this bill's drug benefit limitations will have on Medicaid beneficiaries and their needs; "while Congress might

assume that the States will unilaterally finance the void for drug therapy created by H.R. 13870, our experience would lead us to be most pessimistic."

4) H.R. 13870's method of determining a reimbursable pharmaceutical dispensing charge presents "a realistic opportunity for the overwhelming number of pharmacies to participate and receive fair and equitable compensation."

5) Whether H.R. 13870's reimbursable price level should be "150 percent of the average cost, or some other lesser percentage, is essentially a policy determination to be made. Program experience would reveal the appropriateness of the 150 percent approach. NARD members could function well and the competitive market for drug products should not be unduly affected by adopting any reasonable percentage."

6) The function of H.R. 13870's Formulary Committee should be limited to scientific and medical judgments, not responsibility for publishing or disseminating price lists or other economic information.

7) NARD opposes the copayment principle embodied in H.R. 13870 for each of its proposed home drug programs. "For those with adequate financial means, the \$1 copay represents a minor utilization deterrent at best. For those with limited financial means, it often discourages proper and appropriate utilization. The copay mechanism in drug programs -- unless mandatory that it be collected -- is more attractive to the predatory discounters and grocery store pharmacies than anyone else." In addition, "the administrative costs may exceed the amount of money taken from recipients... The copay at least ought to be waived or reduced in each case where the deductible and coinsurance payments are waived or reduced."

8) Section 2043 (a)(2)(B) of H.R. 13870 should be amended to provide that "the pharmaceutical service charge would be reimbursable in all events where the only disqualification of the services rendered was the cost of the product prescribed... Where State ant substitution laws exist, and the more expensive product is prescribed either by brand name or by specifying the product source, the pharmacist and the patient are powerless to dispense any product than that prescribed. However, the disqualification is completely unrelated to the pharmaceutical services rendered by the pharmacist."

9) None of the proposals before the Committee permit or assure the providers of pharmaceutical services an adequate role or voice in the design, operation, and administration of the programs. "What we envision here is a panel of distinguished retail pharmacists, who would not be full-time government employees, to act as a pharmacy commission responsible for pharmaceutical benefits. NARD recommends that H. R. 13970 be amended to include the following provision: "For purposes of facilitating the implementation and administration of the drug and biological benefits, it shall be lawful for pharmacists and pharmacies, through pharmaceutical associations or equivalent organizations, or otherwise, to jointly negotiate, propose, or recommend the terms and conditions to be included in participating pharmacy provider agreements."

10) The vendor drug approach under Medicaid is more consistent with the free enterprise system than a Government service delivery drug program with Government pharmacies or mail order firms which cannot provide quality service.

11) In some States, participating pharmacies have been dealt with "unfairly and inequitably because of slow payment or inadequate payment." For this reason, NARD recommends that a provision be included in H. R. 13870 "requiring that pharmacies receive an additional eight percent on all claims not paid by the Government or carrier within 45 days."

During the question-and-answer session, Mr. Burke inquired and about NARD's position on prescription drug price advertising. Mr. Woods replied, "the concern our organization has with advertising prescription prices relates to the fraud, misrepresentation and deceit that could be imposed on the consumer where prices are advertised." Mr. Woods added that the services pharmacists can and do provide might be reduced to the lowest common denominator if persons are led to believe that "the cheapest price is the best way to have your prescription filled."

5. National Association of Chain Drug Stores, Michael Zagorac, vice president

Mr. Zagorac outlined NACD's views on various aspects of drug coverage under NHI bills before the Committee:

1) A comprehensive drug program must be included in any national health insurance program. "A limited drug coverage program almost insures that some patients will later require expensive medical care and hospitalization."

2) Vendor System. The present drug distribution system should be preserved and no single portion of the distribution channel should carry an unfair burden as a result of drug reimbursement regulations under national health insurance.

3) Drug Reimbursement. Pharmacy reimbursement should include two components: product cost and the dispensing charge. The product cost portion should be based upon the acquisition cost of the product in standard package sizes from a drug distributor and insure that incentives for efficient purchasing are present and result in program cost savings. The Mills-Kennedy bill "clearly recognizes the need for a simple, efficient means of monitoring drug product cost. However, it appears that the pharmacy's reimbursement for product cost will be limited to the actual price or acquisition cost of that product into the drug store. As such, the Committee must recognize that this would eliminate incentives for efficient purchasing by the retail pharmacy." A standard or basic reimbursable dispensing charge should be permitted to provide appropriate geographical basis; and pharmacies should be permitted to provide additional services which would be eligible for reimbursement over and above the basic dispensing charge. A system employing a variable pharmacy service charge appears to reward the inefficient and penalize the efficient; "if the pharmacy is to be reimbursed only for its actual service charge, no incentive to raise it."

4) Cost-sharing. Deductible, copayments or coinsurance should be included in any program's drug benefit in order to "insure patient involvement, expedite provider reimbursement, and maintain competition among providers."

5) Administration. The private sector can best respond to the challenges of administration. Provider reimbursement review boards, as envisioned by H.R. 13870, or any advisory committee, should include pharmacists and businessmen.

6. American Pharmaceutical Association, George D. Denmark, president

The APA outlined its views on several NHI bills before the Committee:

--With regard to H.R. 13870, therapeutic categories for covered drugs should be eliminated or expanded. The pharmaceutical service charge ceiling should be amended to the 90th percentile of such charges in the same locality. Its copayment requirement should be eliminated or alternatively made mandatory and collectible by the same method as for deductibles and coinsurance.

--H.R. 12684's scope of drug coverage is appropriate. Its provisions for deductible cost-sharing are preferable to copayment, but the levels set are too high. The bill should contain provisions for a method of establishing rates of reimbursement for pharmaceutical services or, alternatively, authority for representative negotiations.

--H.R. 1's drug benefits are preferable to H.R. 13870's, but not as desirable as H.R. 12684's. Its copayment provision should be eliminated and the bill should contain provisions for establishing rates of reimbursement for pharmaceutical services, or, alternatively, authority for representative negotiations.

7. American Association of Colleges of Nursing, Evelyn R. Barritt, R.N.

The AACN offered general comments on national health insurance, as well as H.R. 1, H.R. 12684, and H.R. 13870.

--The AACN strongly supports the concept of a national health insurance program. "If we could maintain the population in an adequate state of health rather than attempting to provide a delivery system for sickness, there would be less need for funds for medical care, unemployment compensation, welfare, food, housing and other subsidies."

--H.R. 1, H.R. 12684, and H.R. 13870 do not adequately address the issue of health maintenance but reflect "the traditional concepts of insuring for the inpatient cost of sickness."

--The proportion of nurses with advanced education and preparation is increasing and these nurses must be permitted to practice at levels of independence which utilize their skills and abilities. "Duly certified professional nurses, dietitians, psychologists, physiotherapists, and other should be able to practice and receive just fees through prescribed fee schedules for service at their level of skill in their discipline without being encumbered by having to obtain a permit from a physician to do so." Furthermore, "professional nurses should be able to bill the insurance plan directly as would other health practitioners and not just receive salaries through institutional budgets... Private practice nurses, consultants and other nurse specialists would be the nurses initially billing through this process."

--"Only when professional nursing observations, judgments and skills are available around the clock should a facility be labeled a skilled nursing facility."

--Utilization review committees should include representatives of various professional practitioners.

--Those proposals which require transfer agreements between hospitals and nursing care or extended care facilities should allow waivers in those cases when a patient is hospitalized out-of-state and must be transferred to a community where no previous financial connections among institutions have been established.

8. *United States Pharmacopeial Convention, William M. Heller, executive director*

Mr. Heller presented USPC suggestions for the establishment of a Federal formulary under a program of national health insurance:

--The USPC has created a "unique and remarkable organization, representative of all of the organizations concerned with drugs, yet impervious to control by any single interest group. Only an organization of such a nature should have responsibility for selecting the drugs for a Federal formulary."

--NHI bills which propose a formulary committee consisting of "only a few persons, only a bare majority of whom have to be physicians, none of whom has to be an active practitioner, and some of whom must be Government employees holding specified offices -- all appointed by a government official... cannot possibly have the expertise needed."

--Since drug selection for the formulary will be difficult and controversial, it would be helpful if the U.S. Pharmacopeia were written into the law as in the case of the Food, Drug, and Cosmetic Act. Or that the legislative history specify that USP should be consulted for technical assistance.

--A formulary committee can not turn only to the FDA for the technical assistance it needs, excluding the private medical community; "judgments of relative efficacy and other considerations of a practical nature in medical and pharmaceutical practices are not part of FDA's current responsibilities...FDA has had comparatively little success in obtaining hard data from practitioners once a drug is marketed. Here again it is an awareness and knowledge of what practitioners are doing and thinking that USP can provide for the smooth operation of the Formulary."

9. *National Ethical Pharmaceutical Association, William J. Colley*

Mr. Colley presented the following NEPA views on the drug coverage provisions of the various NHI bills:

- 1) An out-patient prescription drug benefit should be included in any national health insurance program.
- 2) The formulary concept in several bills threatens to force the small drug company out of the competitive arena and out of business.
- 3) The practicing physician should have the right to prescribe the drug of his choice for the treatment of his patient, taking into consideration the quality of the product, the manufacturer, and his past experience with the particular drug entity.
- 4) A program should be designed to better educate physicians on drug pricing information.
- 5) Any NHI program should begin with a limited drug program that could be readily evaluated and expanded as experience dictates before undertaking a full-scale program that might do irreparable harm to the drug industry.

10. *National Protestant-Catholic Joint Action Committee, L. Rush Jordan, chairman*

On behalf of the Action Committee, and the American Protestant Hospital Association and the Catholic Hospital Association which this Committee represents, Mr. Jordan expressed concern with four aspects H.R. 13870:

- 1) The bill does not adequately ensure that hospitals will be reimbursed for their cost of providing covered services if the prospective payment does not do so. If SSA, in setting the hospital's prospective rate, miscalculates a hospital's costs, there must be a mechanism for ensuring that the hospital will be compensated for providing the covered services. In addition, a prospective budgeting system must make adequate provision for retroactive adjustments in unexpected and unpredictable increases in hospital expenses resulting from increased prices charged by suppliers, increases in minimum wage rates, increases in public utility rates, etc.

2) The bill would prevent "not-for-profit hospitals from receiving revenues in excess of costs and thus force them into a hand-to-mouth existence, totally dependent upon the amount of prospective payment the Social Security Administration may award, and totally devoid of discretionary funds... The rates of not-for-profit hospitals have always included an element of allowing them to earn more than they incur in expenses. They must continue to have such revenue which provides a vital source of discretionary funds, and has permitted us to have some of the great advances made in health care in this country."

3) The bill does not explicitly protect the right of hospital management to take whatever actions may be necessary to reduce costs and to keep within the prospective payment schedule. If the amount of a hospital's reimbursement is to be limited to the amount prospectively determined by SSA, hospital boards must be "legally able to take whatever action is necessary to keep costs within their prospective payments. Specifically, the bill must state that hospital management may close facilities or terminate services which are a financial burden, or are operating at a serious loss."

4) The bill would effectively terminate voluntary donations to hospital. SSA would be permitted to reduce the amount of donations received or expected to be received by it. "Voluntary donations are a major source of community involvement in its hospital. They permit hospitals to undertake new projects and to provide the types of facilities needed by the community... If donations were not taken into account in determining prospective payments, hospitals could use them for items the Government did not wish to fund -- such as experimental projects for medical breakthroughs, management innovation, services which the community wished to provide for itself, and seed financing for capital projects."

Mr. Jordan's statement contained the following additional points:

--Endorsement of the principle of incentive payments be structured so that "it encourages the Board to allocate payment of the incentive funds to individuals within the hospital, including members of the medical staff, on the basis of the contributions they have made in improving the total quality of the hospital program in all its aspects, not just in moderating costs."

--If H. R. 13870's intent is to prevent the Social Security Administration from interfering with the patient's medical care, "it is equally important to make certain that the same intent is expressed with respect to the patient's hospital care." The Action Committee

recommends that this bill be amended to read: "Neither the Board of the Social Security Administration, nor any of its agents, shall make medical judgments with respect to a patient's health and hospital care; this function is reserved solely to the physician, his peers and the hospital."

--A hospital Board's ability and authority to enter into contractual arrangements with physicians for such services as family practice clinics, or emergency room care, should be strengthened in H.R. 13870 by a statement encouraging such arrangements and through the provision adequate discretionary funds.

11. *Texas Health Security Action Committee, Candy Lockhart, R.N., State secretary*

The THSAC presented its views on national health insurance as follows:

--Plan should offer a new direction for health care in the nation and a shift from a fee-for-service system to a system of preventive medicine, as provided for in H.R. 22, the NHI bill which THSAC supports.

--Medicare should be combined with the national health program so that "we have one administrative mechanism, one payroll deduction, and one set of benefits for everyone as outlined in H.R. 22."

--In availability of health care to all Americans is a significant problem demanding immediate attention. "There is a variety and mix of existing public and private programs all with different requirements and different benefits;" this situation has produced inequities in availability.

--There is need for more than catastrophic health insurance. "At this point in time, a far-reaching program is needed, not one that will require additional help in ten years when the shortcomings of the proposal is realized."

--Coinsurance and deductibles are not appropriate means of controlling the utilization of health services when they inhibit entry into the health care system.

--"All health care disciplines take equal roles in health maintenance, and therefore all professions should be reviewed by a utilization committee."

--H. R. 13870 falls short of its intention to create a system of NHI that would make comprehensive health care available to all Americans. Many essential benefits would not be covered. This bill is to be commended for its proposal to establish program administration and funding in an independent federal Social Security Administration as well as a Health Resources Development Board.

--The Administration's plan would not stress preventive medicine "because it retains the present private health insurance system as we now know it," and the bill "would do nothing for the reorganization of the health care system." In addition, this bill would "buy health insurance for the poor, but the traditional health insurance plans are frequently not able to handle the significant problems of the lower socio-economic groups."

--H. R. 1's benefits are limited in scope; important benefits, such as tuberculosis, mental illness, alcoholism and drug abuse treatment are not covered except in an acute phase. The proposal offers no real economic incentives for providers to reorganize delivery. Peer review is relegated to professional societies.

12. University of Pennsylvania Health Law Project, Andreas G. Schneider, staff attorney

On behalf of the Health Law Project, Mr. Schneider wished to raise for the Committee's consideration two issues "critically important to the consumer of health care": 1) the need to eliminate the "dual track" pattern of health care delivery, and 2) the need for consumer accountability.

According to Mr. Schneider, "the health care system in this country has been, and continues to be, characterized by a 'dual track' pattern of delivery of services... in which the poor receive care, if at all, from a 'track' of providers, both individual and institutional, separate from that to which the mainstream of society turns for its care... The services in the poor people's track tend to be those received by the more affluent."

Medicaid did not substantially alter this situation for the poor. "Instead, the scope of the dual track pattern has expanded. The major negative elements of the charity medicine track increasingly characterize the health care received by substantial sectors of the middle class: fragmented, crisis-oriented care; rushed, impersonal treatment; a scarcity of family-oriented practices; and barriers to access created by high costs and shortages of providers."

To avoid a similar result with the enactment of a program of national health insurance, the Health Law Project recommends that eligibility for the program be universal, with no distinction among eligible consumers regarding the scope, quality, administration, or financing of program benefits. In addition, provider participation in any program should be conditioned on the willingness of the provider to serve all those eligible for the program's benefits, regardless of income or race.

With regard to consumer accountability, Mr. Schneider observed that "as national health insurance dollars flow into the health care sector, critical resource allocation decisions must be made. These decisions clearly entail social value judgments -- judgments on which the consumer perspective often differs from that of organized medicine, institutional and individual providers, and health insurers. Because consumers are directly affected by such decisions, their interest should be broadly represented in the program's policy-making processes. Such consumer participation will in turn enhance the program's legitimacy among, and acceptance by, the public."

13. Hospital Association of New York State, George B. Allen, president

Mr. Allen outlined for the Committee the Association's position on national health insurance and offered comments on three bills submitted for consideration -- H.R. 1, H.R. 12684, H.R. 13870.

--Any program must cover all U.S. residents without qualification.

--Benefits must be comprehensive.

--Any bill providing catastrophic benefits alone would be a mistake.

--Multiple sources of financing, as provided in H.R. 1 and H.R. 12684, would be preferable to the centralized trust fund approach as provided in H.R. 13870.

--The health benefit card system and the method of collecting deductibles and co-insurance as provided in H.R. 12684 and H.R. 13870, both from the point of view of the consumer and the provider, is most desirable.

--A State Health Commission, as envisioned by H.R. 1, operating under Federal guidelines, is in the best position to effectively integrate the functions of planning, rate setting, and quality control.

--A bill should include provisions to encourage the development of alternative delivery systems.

--Prospective reimbursement can work if the prospective rate is realistic and actually meets the reasonable costs of the provider.

--There should be a variety of reimbursement-payment system operations; one should be budget review.

--A bill should allow for adjustments in reimbursement rates as a reflection of unanticipated increases in the costs of goods and services.

14. *Paul E. Rumbaugh, Louisville, Ky.*

On the basis of a personal experience with "the heavy emotional, physical and financial weight of a tragic and catastrophic event," Mr. Rumbaugh urged the Committee to include in a program of national health insurance a catastrophic illness benefit. In addition, he recommended that this benefit apply to individuals and families incurring catastrophic illness expenses at the date of enactment and that coverage include the costs of all services specified as necessary by the attending physician.

15. *Marvin H. Edwards, Oklahoma City, Okla.*

Mr. Edwards, who is a director of the American Conservative Union to editor of Private Practice, has served as a consultant on health care legislation to several members of the House. He stated that "today no serious student of health care in the United States believes there is a health crisis... If there is any problem, it exists not in care or its availability, but in its cost -- and the increases in its costs is direct result of the inflation caused by excessive Federal spending, and in the case of increased hospital costs since 1965, due in part to the Medicare and Medicaid programs."

Mr. Edwards acknowledge that private insurance policies do not cover the entire cost of many illnesses, but "that was not always the case. It is not that the policies are deliberately or inherently inadequate, but that there is no way insurance or anything else can keep up with the unbelievable rate of inflation which will persist until Congress stops debating whether it favors a \$40 billion program or a \$70 billion one, and instead holds down its own spending and allows inflation to subside."

He urged the Committee to consider a change in tax laws to permit tax credits for expenses incurred during the year by the individual or family for "health care, health insurance premiums, catastrophic or major medical premiums, preventive checkups, etc. This, of course, also encourages the taxpayer to take the preventive measures so many Members of Congress have been concerned about... It will eliminate the need for a number of bureaus, agencies, and expensive middlemen."

June 7, 1974

1. *American Nursing Home Association*

Mr. Thomas G. Bell, Executive Vice President, directed his remarks particularly to the Comprehensive National Health Insurance Act (H.R. 13870, S. 3286) and the Catastrophic Health Insurance and Medical Assistance Reform Act (S. 2513). He stated he believed any NHI proposal should include provision for long term care, and currently long term care was covered only under Medicaid for those persons that would qualify. He supported provisions for home health and homemaker services, nutrition services, and day care, as it applied to the elderly.

Mr. Bell emphasized that there should be no "artificial barriers" erected against any class of providers in providing these services:

"ANHA believes that payment to both proprietary and non-proprietary providers of long term care should be under a system which allows for the development of alternative prospective payment methods. These methods should be developed by providers and State governments under Federal guidelines."

The ANHA supports the general approach set forth in Title II of the Mills-Kennedy bill with the following suggested amendments:

1. It appears that no provision was made for long term mental health care for the mentally ill and retarded.
2. There is uncertainty regarding eligibles who fail to enroll, and those disabled persons who have not met the two-year waiting period before they can receive Medicare benefits.
3. Inpatient mental health benefits should be added.
4. The role of community long term care centers should be not to provide care nor administer funds but to review health needs and provide education and outreach services to persons to provide them better access to services.
5. All providers who meet a uniform, public system of standards should be eligible to participate.
6. Prospective payment systems under Title I should also apply to Part D of Title II.

7. The rate of return should be measured against total investment rather than "equity invested."
8. Prior hospitalization requirement before a person can be admitted to a skilled nursing facility should be deleted.

The following changes are suggested for the Long-Ribicoff/Waggoner bill:

1. Long care benefits should be extended to all Medicare beneficiaries.
2. Prospective payments should be mandated rather than allowed.
3. Days in a skilled nursing facility should be counted on a two for one basis in meeting the 60 day hospitalization prerequisite to obtaining catastrophic benefits.
4. Insurers offering Federally certified private health policies under Title III should be required to offer the first 120 days in a skilled nursing facility.

2. American Public Health Association

The statement of Arden Miller, M.D., President-Elect, was restricted to a statement of the following principles:

- Opposed to vesting in the private sector control over the funds and processes of national health insurance
- Support for the concept of national health insurance as a device to guarantee delivery of preventive health care to all Americans
- There should be no financial barriers, i.e. coverage for preventive services should be on a first dollar basis

Dr. Miller indicated that the preventive health care package should include:

Prenatal care
 Obstetric and Midwifery services
 Homemaking assistance and mother-craft
 Post-natal care for mothers and infants
 Family planning services
 Well-child and development check-ups
 Routine immunizations and anticipatory guidance
 Preschool screening and school health services
 A mandate to treat and correct identified defects
 Genetic counselling
 Special outreach programs for children

In addition, it should include:

Home health services, including payment for homemakers, nurses, podiatrists, and other providers for the disabled, aged, and chronically ill

Periodic examinations of all adult women for early signs of cancer of the breast and cervix

Periodic and early treatment of hypertension

Preventive mental health services and family counseling

Dr. Miller cites evidence that the health care system in Quebec was not overburdened when health care became free. He further suggested the following:

"Something more than money is needed. The need includes setting standards for monitoring, for compliance, and directly providing the services not otherwise provided."

"We must provide from the Federal level those essential services that private and local mechanisms even with financial inducements fail to provide."

Congressman Mills expressed support for the tone of the statement with its emphasis on preventive services and asked APHA to provide guidance as to how a national health insurance program might be structured "to redirect our whole emphasis rather than continuing our emphasis on doing something for a person after the person becomes sick." Congressman Mills referred to a program that he had favored in the past whereby "every child, prenatal until six years of age, received adequate medical attention as well as proper food."

Dr. Miller commented as follows: "There are good data that suggest that the number of chronically disabled children that acquired their disability after birth outnumbers tenfold those entering the world with some kind of disability."

Congressman Mills asked Dr. Miller if he thought the role of medical departments of large companies was an effective one in keeping employees healthy and if that resource should be harnessed. Dr. Miller answered yes to both questions. Dr. Miller, however, emphasized the need for "absolute government guarantees for the people not covered by those programs."

Dr. Miller, responding to questions from Congressman Brotzman, pointed out that (a) there had been a substantial drop in infant mortality for the U.S. as a whole, but the disadvantaged still had infant death rates in the "50's or higher" and (b) Maternal and Child Health Programs, where applied, had reduced death rates to where they "compare favorably with the death rate anywhere in the world."

Regarding State Administration of NHI, Congressman Mills stated:
 "I know in my own State where the Medicaid program is administered at the State level, it is totally inadequate."

3. Arkansas Committee for National Health Insurance

Mr. W. Guy Delaney, Chairman, reiterated support for the Health Security Act and made the following specific comments about the Comprehensive National Health Insurance Act (H.R. 13870):

- Objects to the permanent and important role given to private health insurers
- Objects to the level of coinsurance and deductibles
- Objects to allowing professionals to unilaterally determine fee schedules and feels laymen should have a role in setting fees.
- Objects to means test
- Objects to States paying part of the bill for poor families
- Objects to the failure to include national standards for licensure and certification of health professionals
- Objects to relatively small increases in Medicare benefits and the continuation of present cost sharing provisions under Medicare
- Objects to the limited funds in the Health Resources Development Fund (less than one-tenth the amount under the Health Security Act)

4. Colorado Committee for National Health Security and West Virginia Committee for the Health Security Act

Mr. John Stencel, Executive Secretary of the Colorado Committee, presented the following view: "it is the consensus of the Colorado Coalition [for Health Security] that none of the bills under consideration by this committee will be of substantial benefit to the citizens of our State [Colorado]."

Mr. Stencel stated his opposition to the Administration, Ullman, and Mills-Kennedy bills on the following grounds: cost sharing provisions, limited rather than comprehensive benefits, use of insurance companies, lack of quality controls, failure of the bills to do anything about the maldistribution of physicians. He emphasized that only the Griffiths-Corman bill (Health Security) is considered adequate.

Mr. Stencel also presented a statement prepared by Dr. Steve Barnett of the Colorado Advisory Committee which contained the following major points:

- National health insurance proposals do not address themselves to the problems of transportation and communication in the health system.
- There is a strong need for continuing education for isolated rural physicians.
- The present payment system rewards provision of sick care to the detriment of preventive care.

Speaking on behalf of the West Virginia Committee, Reverend Richard Bowyer, Chairman, reiterated the inadequacy of all the bills except the Health Security Act and emphasized the following points:

- Benefits should be universal and comprehensive.
- Present delivery system must be reformed; in this context, Health Resources Development Board in H.R. 13870 is a "must".
- There should be strong incentives to build prepaid group practices of medicine, family health centers, etc.
- There must be a mechanism for consumer participation in planning, evaluation, and for "public accountability."
- Cost sharing provisions are to be opposed.
- Members of HMOs and Family Health Centers should not have to pay deductibles and coinsurance, or should have them paid on their behalf.
- Comprehensive health planning measures should be continued.

5. Colorado Health and Environmental Council

Dr. Charles H. Dowding, Jr., Chairman, stated that "very few of the bills introduced in Congress during 1973 and 1974 contain a community preventive medicine or a comprehensive home health care component," and that "most of the bills bypass the State and local governments and none establish the private physician's office as a basic health facility." Dr. Dowding described the basic components of a model national health care plan called the Community Cooperative Decentralized Plan, a plan which Dr. Dowding feels could be incorporated into one of the NHI bills already introduced into Congress:

1. Private Medical Practice

Physicians would refer patients directly to home health care as an alternative to physician care. Home health care should be a "supplemental service to visits to the physician's office."

2. Community Preventive Medicine Component

Services include health education, multiphasic screening, "twelve" basic personal health care services (not specified), environmental health services, health counselling, guidance and screening for the elderly.

3. Comprehensive Home Health Care

4. Management

"A cabinet-level separate Federal Department of Health which would consolidate all health programs, which would set policy and administer the National Health Care Program, is essential to managing the 100-plus billion dollar industry. Day to day operation would be handled at the State level, so that local and regional differences could be recognized. Federal guidelines would be channeled to each State Governor's appointed Board of Health and to the Governor's appointed Health Care Commission which would be a separate commission under the State Board of Health." The "fiscal control management, representing the same PSRO geographical area, would be the prime contractor for federal funding." Private insurance carriers would pay benefits but would be regulated "through a uniform benefit package mandated at the national level."

Under questioning from Congressman Brotzman, Dr. Dowding reiterated his claim that there is insufficient emphasis in any of the bills on home health care services.

6. *Patient's Aid Society*

James F. Donnelly, President, expressed the view that: "All tissue removed by surgery should be examined by one or more independent board-certified pathologists who are independent of the surgeon and the hospital. The pathologist could be the local medical examiner." Mr. Donnelly also recommended the following:

- All doctors should be required to keep complete and legible records according to JCAH standards, and records should be notarized by an accountable doctor.
- Patients should be provided with a statement that their records are available to them.
- The Federal Government should establish a national medical center in which patients could voluntarily put their medical records.

Mr. Donnelly also expressed his opposition to no-fault medical insurance. He further suggested that "there should be a law entitling patients to receive package inserts spelling out the side-effects [of drugs] and so on."

7. *National Association of Social Workers*

Speaking on behalf of the Association, Mr. Lawrence G. Shulman summarized his major points as follows:

- NHI program should provide broadly based funding through general tax revenues, an expanded Social Security system, or some combination thereof to ensure a dependable financial base.
- H.R. 12684 would introduce variable treatment of the poor and non-poor because of the differences in handling of the three categories of EHIP, AHIP, and Medicare.
- S. 2513 would also provide a "multi-track system".
- S. 3286/H.R. 13870 would have deductibles and coinsurance but would provide broad coverage.
- H.R. 22/S. 3 is acceptable because coverage is universal and under the same financing arrangements, and there are no deductibles and coinsurance.

Mr. Shulman cited studies which show the value of social workers in getting people out of hospitals faster. He noted that "no longer must any one group, one profession, or one industry be permitted to control the avenues, the bridges and the gates to that system, nor unilaterally determine the price and conditions for admission." He also pointed out that "despite the far-reaching and significant role of social workers in the mental health field, none of the bills as they now stand provide for direct payment to social workers for services rendered."

Mr. Shulman recommended that health manpower training in all areas be expanded and special emphasis be given to training minorities. He suggested that tax relief might be considered as an incentive to persons who would serve in underserved areas.

8. *American Association of Medical Clinics*

Dr. Loman Trover, President, accompanied by James Cobb, Executive Director, and Lawrence Hoffheimer, Legislative Counsel, made the following remarks:

- Control of the health delivery system should be retained by the private sector with appropriate input from providers, payors, and the public.
- NHI should be administered through a Cabinet level Department of Health and there should be a National Health Advisory Council in the White House.
- Day to day administration of the NHI program should be carried out at the State level.
- "We feel that both regulatory and policy-making bodies should consist of a majority of persons whose principal professional activity is in the health care field. Consumer representation is appropriate at all levels in an advisory capacity."

--There should be State and local control of private health insurance carriers using Federally mandated uniform benefit packages.

--The NHI plan should include the following benefits:

Full hospitalization coverage for physical illness and injury

All physician services, wherever rendered

Outpatient prescription drugs with moderate patient cost sharing

Mental Health Care with basic in-hospital treatment and some provision for post-institutional management

Extended non-acute institutional care upon order of physician without the requirement of prior hospital stay

Home health care on physician prescription

Preventive services including dental care for children up to age 12 with appropriate phasing in of other dental care for all ages

Well-child care up to age six and eye exams by physicians and optometrists

Family planning

Periodic health testing ordered by a physician

Necessary rehabilitation services

Patient education services ordered by a physician

--Catastrophic coverage should be included. Every person should have the opportunity to participate and there should be sliding scale subsidies based on income.

--Funding should come from mandatory employer-employee contributions and general revenues. Employer-employee contributions should be the primary means of purchasing private health insurance coverage. General tax revenues should be administered through a separate tax fund.

--Prospective rates should be established for institutions and UCR fees should be paid to physicians.

--Standards of care for use in peer review should be established and administered at the local level.

--All current governmental health programs should be included beginning with provisions for immediate National Health Insurance coverage for Medicaid, Medicare, and Maternal and Child Health programs. Supports the ultimate phasing in of CHAMPUS, Veteran's Administration, Federal Employees Health Benefits Program, and Indian Health Service into a uniform and comprehensive health insurance system.

--There should be appropriate incentives for using non-institutional services.

--Incentives should also be created for getting services to underserved areas and fostering alternative methods of delivering services.

Dr. Trover on rural areas: rural people are entitled to the same level and quality of benefits as are available in urban areas. "To produce this type of benefit package, I think the approach would have to be through a regionalization concept approach in which a certain prescribed region would be able to put together both primary and secondary centers with the secondary centers having the capability of producing a very broad range health care delivery picture."

9. *International Association of Rehabilitation Facilities*

Charles L. Roberts, Executive Vice President, stated that the purpose of his testimony was to point up the need for inclusions of comprehensive medical rehabilitation services in any national health insurance legislation reported by the Committee.

He recommended that any bill should cover the following four points:

1. Recognition of comprehensive inpatient rehabilitation services
2. Coverage of comprehensive rehabilitation services provided on an outpatient basis
3. Inclusion of definition of rehabilitation service which will eliminate confusion
4. Recognition of rehabilitation facilities as eligible providers of services

Mr. Roberts noted that similar definitions for rehabilitation services in hospitals and skilled nursing homes has caused confusion under Medicare and resulted in retroactive denials. No bills where benefits are modeled after the benefits in the Medicare program provide for outpatient rehabilitation services, although there is provision for physical therapy. There are no provisions for rehabilitation services after the patient no longer requires care in a skilled nursing facility or hospital.

Mr. Roberts cited confusion because of lack of definition of medical rehabilitation, particularly because of its "strong association with the vocational rehabilitation movement." He urged that there should be specific recognition of rehabilitation facilities as providers of service, and appropriate standards should be established.

He also recommended that the Commission of Accreditation of Rehabilitation facilities should enjoy the same status regarding rehabilitation facilities as JCAH does for hospitals regarding acceptance by Medicare of accreditation.

10. *Townsend Foundation*

Mr. John Doyle Elliott, Secretary, stated that the Townsend Foundation is opposed to H.R. 12684 because "the private sector of life, free enterprise, State and local public authorities, are not up to the job." Mr. Elliott added the following:

- All social security beneficiaries, as well as the aged and disabled, should be entitled to full Medicare benefits.
- Remove all limits for complete efforts against all illnesses, "from beginning to end."
- There should be no bills to patients.
- Cover everyone under the same system.
- Finance the program from general revenues as defined in H.R. 4018, the "Townsend Plan Bill."

11. *Community Council of Greater New York, Health Task Force*

David Banta, M.D., and Mrs. Sylvia Hunter, speaking on behalf of the Task Force, outlined the following positions:

- Supports universality of coverage
- Supports uniform benefits
- Payments to providers must be considered as payments in full
- Cost sharing which acts as a barrier to seeking care is unacceptable
- Supports the provision of Mills-Kennedy bill which waives coinsurance and deductibles for preventive services for children, prenatal care, and family planning
- NHI should be publicly accountable, and publicly administered, without fiscal intermediaries
- If fiscal intermediaries are included, there should be strict standards and careful monitoring
- Catastrophic insurance would distort the medical manpower priorities toward the super-specialties and away from primary care.
- "Ninety-eight percent of the population would be required to pay for services used by less than two percent."

Mr. Burke and the witnesses discussed the effect that the removal of health insurers from a national health insurance program would have on the people in the health insurance industry. Mr. Burke expressed concern that no provision has been made in any of those bills which propose to eliminate health insurers.

12. *Dr. Samuel J. Barr, Winter Park, Fla.*

Dr. Barr, Director, EPOC Clinic, expressed concern about the possible exclusion of abortions and sterilizations from any national health insurance proposal.

13. *The "Train More Doctors Society"*

Representing the Society, Mr. Morton Krouse, attorney-at-law, made the following comments on the Kennedy-Mills bill:

- In Title XX, Sec. 2051(w), titled "Physician Extender Services," the words "and responsibility" should be added after "control" on page 120, lines 4 and 5. The purpose is to make clear who is responsible for the services provided by the physician extenders.
- In Sec. 2011(d), titled "Catastrophic Coverage," under Title XX: The proposal is a financial disaster for persons with incomes between \$8,000 to \$10,000.
- Opposed to deductibles and coinsurance in Title XX.
- Opposed to the Health Resources Development Board as an unnecessary spending of tax money.

Mr. Krouse further state that the United States should double the number of medical students "right now". A goal of one doctor for 500 people should be stipulated in any proposed national health insurance bill.

14. *Samuel M. Fisher, Havertown, Pa.*

Mr. Fisher wants the authorization for the National Institutes of Health increased from 2 to 4 billion.

He also urged passage through letters to Congress of a voluntary contribution of one percent of an individual income tax to be set aside for cancer and health research. He also urged passage of the Brinkley bill H.R. 10746, to provide 15 billion dollars over the next five years and "impose a 2 percent surcharge to finance the project."

He supports H.R. 13870.

15. *American Association of Nurse Anesthetists*

Ms. Hanna Hudecek, CRNA, representing the Association, advocated direct payments to nurse anesthetists, particularly in rural areas where hospitals are smaller.

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1. *American Academy of Family Physicians*

Dr. James G. Price, President, accompanied by Dr. Carl B. Hall, Chairman of the Board of Directors, and Dr. H. L. Huffington, Director and Chairman of the Commission on Legislation and Public Policy, stipulated 13 basic principles which the Academy feels should be included in any national health insurance plan. Following a summary of his written statement, Dr. Price was asked by Mr. Burke whether the Academy's opposition to the payroll tax mechanism in the Mills/Kennedy bill, with its \$20,000 ceiling on taxable earnings for purposes of health insurance, also applied to the ceiling imposed under the present Social Security tax. Dr. Price answered that "people who are fortunate enough to have the capability to pay for services of any kind ordinarily might be expected to pay more for them than the individual who can't, and that the "individual who has the greatest need should perhaps derive more for the money that he puts in than does the individual whose need may not be as large."

Mr. Burke also asked Dr. Price whether the Academy felt the method of physician reimbursement under the Mills/Kennedy bill was fair and equitable. Dr. Huffington responded, saying that he thought so.

Mr. Brotzman asked Dr. Price to elaborate upon the Academy's position that a national health insurance plan should be phased in gradually. Dr. Price explained that the Academy envisions "as a total health bill being enacted and being implemented over a period of time, in order of the priorities...that perhaps a first portion of it to be implemented might be catastrophic insurance."

Mr. Brotzman questioned Dr. Huffington regarding possible advice on improving the distribution of existing medical manpower. Dr. Huffington suggested that it is important to have physicians who are trained to feel competent in rural areas and that Congressional support should be given to family practice residency training programs with special loan forgiveness provisions and to incentive payments to medical schools which graduate students who enter the field of family practice.

2. American Academy of Pediatrics

Dr. Donald W. Schiff, Chairman of the Committee on Third Party Payment Plans, accompanied by Mr. George Degnon, Director of the Academy's Washington office, and Mr. Al Stolper, Administrative Assistant to the Executive Director of the Academy, presented the Academy's belief that "national health insurance provides the opportunity for removing the financial barrier to achieving comprehensive health care for children." With regard to the Mills/Kennedy bill, Dr. Schiff stated that the Academy suggests the following modifications: 1) specific authorization for pediatricians to use physician-extender services as defined in Sec. 2051 (w); 2) creation of an entirely new drug formulary including biologicals, antibiotics, psychotropics, decongestants, sedatives, dietary supplements, and individual drugs such as pheno-barbital; 3) inclusion of a pediatrician on the formulary committee in recognition of the different drug requirements of children; 4) extension of coverage of mental health services to 100 inpatient days per year; and 5) removal of financial advantages of receiving care from a comprehensive community care center as compared to other mental facilities. Dr. Schiff further outlined the 8 basic principles which the Academy feels essential to a national health insurance bill:

- Catastrophic insurance coverage based on an income-related sliding scale with special consideration to families in the \$8,000 to \$12,000 income bracket;
- Coverage of comprehensive child health care, as defined by the Academy;
- Coverage of preventive health services from birth to age 21;
- No deductibles or coinsurance applied to preventive health care for children and pregnant women;
- Support for the credit card principle as a means to reduce physician overhead cost and possibly reduce administrative costs;
- Creation of a cabinet post of Secretary of Health;
- High priority to be given to increased funding of psychological services; and
- Adequate funding of health education.

Dr. Schiff also noted that the Academy feels the services provided through the special programs for Crippled Children, Maternal and Child Health, and Children and Youth should not be deleted by a new national health insurance program.

Mr. Brotzman asked Dr. Schiff to elaborate upon the role of the physician-extender in the pediatric situation. Dr. Schiff explained that in pediatrics such individuals are called pediatric nurse practitioners or pediatric associates and are often degree nurses with 4 years of nurse training, plus intensive training in the field of pediatrics. Mr. Schneebeli remarked about the concern of the Academy over the need for catastrophic coverage, particularly for newborns. Dr. Schiff noted that the Academy has been actively supporting State-level legislation on behalf of mandatory newborn coverage, now passed by twenty some states.

3. *National Association for Retarded Citizens*

Dr. Elizabeth M. Boggs, Member of the Governmental Affairs Committee, accompanied by Miss Susan Weiss of the Washington staff of the Association, emphasized in her statement on behalf of the Association the need for primary prevention of birth defects and secondary prevention after birth through early case finding. Dr. Boggs noted that attention to the issue of well child care could be "a little bit threatened by attempts to define the nature of care to be given so that [it] applies only to illnesses and injuries." Dr. Boggs also brought attention to the catastrophic consequences of long-term disability and the need for an ongoing long-term support system for children "not merely confined to a residential placement or institutional placement." She further stated that the Association believes the cumulative catastrophic costs of the mentally retarded "which are properly considered a liability of a family should be insurable."

Addressing the relationship of the Maternal and Child Health Program and the Crippled Children's Program under title V of the Social Security Act, Dr. Boggs stated the Association's position as follows:

We believe that the care of any individual child which is of a type that would be ordinarily reimbursed by a State under the Crippled Children's Program on a fee for service basis, whether it is hospital or physician care or anything else, should in fact be covered by national health insurance and that the resources that are now, the funding resources that are now available in title V, should be increasingly directed towards the establishment of universal services and making available the resources through which the NHI mechanism can function.

4. *National Association for Mental Health, Inc.*

Mrs. Hilda Robbins, Vice President of Region I of the National Association, focused her testimony on the following: 1) the cost of insuring mental illness; 2) the importance of providing outpatient and partial hospitalization coverage for mental illness in community mental health centers; 3) the extent of coverage for inpatient, outpatient, partial hospitalization and psychotherapeutic drugs in bills currently under consideration; 4) the effectiveness of community mental health centers; 5) the importance of structuring any program of national health insurance to facilitate development of community mental health centers; and 6) a model plan of coverage for the mentally ill under national health insurance.

Mrs. Robbins stated that her testimony was aimed in part at exploding "the myth that including coverage for mental illness in insurance plans causes rates to skyrocket." She cited a study by the American Psychiatric Association published in 1972 which "shows beyond question that over-utilization of out-of-hospital psychiatric services under private insurance plans has not occurred":

A comparison of the experience of eleven major health insurance plans shows a low of 1 percent and a high of only 6.4 percent of total benefits were paid for mental health care. Even more striking are the data relating to the annual cost of all mental illness benefits per person covered. The lowest amount was \$1.09 and the highest \$7.32 annually.

Mrs. Robbins drew attention to statistics citing the "dramatic reduction in the number of patients in state mental hospitals" since 1955 due to various factors such as community mental health centers, medications, and improved treatment methods. She itemized the following NAMH recommendations with regard to coverage of mental health services under national health insurance.

- Services should be unlimited when provided in an organized setting, as provided for in H.R. 22
- Change in terminology of H.R. 13870 and H.R. 12684 referring to "comprehensive community care centers" to read "comprehensive community mental health centers"
- Waiver of deductibles and coinsurance for outpatient mental health services
- Preference to be given coverage of services rendered in comprehensive community mental health center, so that unlimited service are covered in this setting

- Regarding partial hospitalization, unlimited coverage of this form of outpatient intensive care with preference to coverage of services rendered in a CCMHC
- Inpatient services in either general or psychiatric hospital should be limited to 45 days, but no limit for children
- Trade-offs between inpatient and partial hospitalization in H.R. 12684 should be dropped
- Psychotherapeutic drugs should be added to drug formulary in H.R. 13870.

Mr. Schneebeli asked Mrs. Robbins to present any actuarial data supporting her statement that coverage of mental health services under private insurance is not prohibitively expensive. Mrs. Robbins agreed to do so.

5. *Consumer Federation of America*

Elizabeth Langer, Legislative Director, accompanied by Shelby Southard and Ken Kovacks, members of the Board of Directors of the Federation, stated the view of the Federation that health care is a right and should be provided, like universal education, police and fire protection, by the Government. Among the concerns of the Consumer Federation are the following:

- Serious coverage gaps in H.R. 13870 and lack of universality under H.R. 12684
- Coinsurance, deductibles, and restrictions on covered services which work excessive burdens on consumers and limit range of preventive care, as under both H.R. 13870 and H.R. 12684
- Limitations under H.R. 22 on drugs, dental care for adults, long-term nursing care, and psychiatric care
- Abolishment of Medicaid under H.R. 13870 with the result that "most of the nation's poor who are eligible for Medicaid will be worse off under Mills/Kennedy than they are now"
- Regressive nature of financing under Administration and Mills/Kennedy bills; recommends increased use of general revenues and removing the income ceiling on the payroll tax
- Administration of health insurance must be public and not provide for administration by private insurers or use of insurers as intermediaries
- Consumer input should be significant; administration bill contains no provision for consumer representation and H.R. 13870 provides for consumer membership in advisory bodies which "are not significantly involved in the administration of the overall program"
- Comprehensive quality controls in H.R. 22 should be included in program
- Cost controls in Administration bill are "virtually no different from present day practices"
- Recent court decisions have exempted insurance companies such as Blue Cross from provisions of Sherman Anti-trust Act; "The effect of such anti-trust exemptions is to stifle the move toward reform of our medical institutions by lending legitimacy to the discriminatory trade practices of the powerful elements of the 'fee-for-service' system against innovative group practice plans."
- Present tactics to discourage group practice are more "subtle" than in the past, e.g. "Blue Shield's authority to discipline its members for participating in group practice by expelling them from the Medical Service Bureau."

6. *National Cancer Foundation*

Ms. Irene G. Buckley, Executive Director, accompanied by Ms. Mary Overton, Assistant Executive Director, explained that the official position of the Foundation at the present time was not to make specific comments in support of or in opposition to any of the current NHI proposals, but to point out the special problems, needs and catastrophic expenses of the cancer patient. Ms. Buckley referred to a study entitled "The Impact, Costs, and Consequences of Catastrophic Illness on Patients and Families," noting that the results of the study showed that self-maintaining middle income families, covered by medical insurance, could be reduced to poverty in less than two years when encountering a catastrophic illness in the family.

Ms. Buckley emphasized the Foundation's view that catastrophic illness insurance should be an integral part of a comprehensive plan for national health insurance, and should not be a separate program. She rejected any approach to catastrophic health insurance on a disease-by-disease categorical basis as "unsound, impractical, and uneconomical." Ms. Buckley further noted that none of the current NHI bills adequately meet the cost or cover the services required for long-term catastrophic illness.

With regard to deductibles and coinsurance under NHI, Ms. Buckley voiced the Foundation's opposition to such features, emphasizing that the cumulative effects of such cost-sharing, compounded by the potentially long duration of the illness and the reduced income of the patient, "may cause severe devastation and certainly financial hardship." One of the most serious concerns of the Foundation is the inadequacy of provisions in the current bills for care outside the hospital, since costs of post-hospital and home care for the long-term cancer patient frequently exceed combined costs of physician and hospital care and are generally not covered by insurance.

--Mills/Kennedy bill "relies heavily upon our present form of health monopoly -- the fee for service system," and contains no provision for alternative payment forms for physicians.

7. American Foundation for the Blind, American Association of Workers for the Blind, and the Blind Veterans Association

Irvin P. Schloss, Coordinator of Governmental Relations for the American Foundation for the Blind, stated that all three organizations which he was representing in his testimony before the Committee endorsed the enactment of H. R. 13870 with a series of amendments "designed to assure coverage of health services and all health aid services for individuals who are blind or severely visually impaired." Mr. Schloss pointed out that there are 480,000 blind people in the U.S., 75 percent of whom are 40 years of age or older. He also noted that there are 1,306,000 individuals who are severely visually impaired, most of whom are over age 45.

Among the recommended amendments of H. R. 13870 were the following:

- Coverage under both title XVIII and proposed title XX of vision services designed to enable an individual who has a residual vision to obtain maximum visual efficiency with this residual sight.
- Coverage of a range of optical aids as a part of low vision services, varying from inexpensive hand-held magnifiers to more complex optical lense systems like microscopic and telescopic lenses.
- Provisions for rehabilitation services as an allied health service to individuals who lose their sight; should be authorized under both title XVIII and proposed title XX as a covered extended care service.
- Coverage of the services of a mobility therapist and rehabilitative teacher of the blind to inpatients in hospitals, infant or nursing facilities, ECFs, homes for the aged, and private homes.
- Specific coverage of low vision services as part of developmental vision care for children under title XX.
- Coverage of periodic comprehensive audiological services for all blind and severely visually impaired individuals, provided either by an otologist or audiologist.
- Explicit language to be added to title XIV of Public Health Service Act, to assure establishment of training programs for low vision aid therapists, for mobility therapists and rehabilitation teachers for the blind.
- Explicit authorization for expansion of rehabilitation facilities for the blind and for establishment of new facilities where indicated, for expansion and establishment of low vision service centers or clinics.

8. *American Council of the Blind*

Durward K. McDaniel, National Representative of the Council, stated that "a large fraction of the blind and handicapped population is, if it can meet the means test, covered by Medicaid," but that conditions of eligibility and degree of covered services varied considerably from State to State. He emphasized that the Council would not favor the inclusion of any means test in any health bill enacted by Congress. He further noted that all three major bills the Committee was considering were defective in "the matter of consumer emphasis, consumer participation, and consumer representation." The Council also objected to "the inclusion in any legislation which Congress may pass of a delegation of administrative authority to a vested interest industry [the health insurance industry] which is not in sympathy with the establishment and operation of a comprehensive health care system." Mr. McDaniel made the following comments on other aspects of any proposed NHI program:

- In favor of a comprehensive health care system without deductibles or coinsurance, publicly administered by the Federal Government, without the involvement of State governments.
- In opposition to a gradual, first-step approach such as Mills/Kennedy -- "if that first step is taken with all of its limitations, defects, exclusions, coinsurance and deductibles, that the second step will be delayed for at least a generation."
- Health care should be established as a matter of right, just as public education is.
- H.R. 22 is the only bill which establishes the right to health care and would "start this country on the right path," and could let the government control costs.

9. *National Easter Seal Society for Crippled Children and Adults*

Dr. Maynard I. Shapiro appeared on behalf of the Society and was accompanied by Richard Verville, Washington Legal Counsel to the Society, and Dr. Thomas Coyle, Medical Director, Rehabilitation Center, Bridgeport, Connecticut. Dr. Shapiro devoted part of his testimony to a description of the human and economic significance of the preventive and rehabilitation programs of the Society. Dr. Shapiro emphasized that any health financing legislation dealing with rehabilitation must meet two objectives: 1) services necessary to improve the patient's mental and physical function; and 2) services necessary for the maintenance of an improved condition or the prevention of deterioration:

Clearly, the financing of a service should not withdrawn simply because a patient's progress has reached its optimum point, especially where withdrawal will result in deterioration. It will only cost the Government more if it has to finance the the re-habilitation of the patient after his condition has deteriorated.

Dr. Shapiro pointed out that neither Medicare nor any of the NHI bills before the Committee "clearly provide for comprehensive rehabilitation coverage on either an inpatient or outpatient basis." Dr. Shapiro also expressed the Society's concern that there is no definition of the term "rehabilitation services" in either the Medicare law or the NHI bills. He submitted for the record a suggested definition of the term, including a comprehensive list of services, stating that "without such a definition, the administering agency and the carriers will interpret the term strictly, as has been the Medicare experience regarding inpatient care."

Dr. Shapiro noted that in a non-hospital based outpatient rehabilitation facility, only "bits and pieces of comprehensive medical rehabilitation care are reimbursable under Medicare or the bills before [the Committee]," and that patients in a geographic area without a nearby hospital or one providing rehabilitation services are therefore at a disadvantage.

He further suggested that any health insurance bill should include a definition of "outpatient rehabilitation services" and "rehabilitation facility." The new definition of the term "rehabilitation services" would 1) apply to both inpatient and outpatient care; 2) would substitute for the present outpatient benefit (under Medicare) regarding physical therapy, speech therapy, and prosthetic and orthotic devices; and 3) would broaden the scope of reimbursable outpatient rehabilitation services to include occupational therapy, other medically necessary therapies, audiology and vision services, and medical social and psychological services.

While indicating the Society's support of the preventive care and child health aspects of the bills before the Committee, Dr. Shapiro questioned the definition of "well child care" in H.R. 13870 in its reference to screening programs for "intellectual development and specific diseases." He felt this was too limiting and suggested the addition of screening programs "for congenital and other defects or disabling conditions."

Dr. Shapiro also urged the Committee to develop a clear role for the title V well child care program in the context of national health insurance and to assure its continuity so that agencies could receive continued grant support to cover non-reimbursed costs such as planning, etc.

10. *National Cystic Fibrosis Research Foundation*

Dr. Paul R. Patterson testified on behalf of the Foundation and noted that one out of 1500 births are children afflicted with cystic fibrosis. He stated that through the services of title V and Medicaid, "these individuals have received financial assistance, but unfortunately when they reach the age of 21 in most all States with the exception of Texas and Pennsylvania, the children no longer can receive additional care, so that pretty much they are left with their own financial tragedies." Dr. Patterson emphasized that the nature of severe chronic pulmonary disease is such that it is not simply a catastrophic experience in one year, but for years to come.

With regard to the impact of cost-sharing on the victim of chronic illness Dr. Patterson stated that "deductibles for separate hospitalizations within one year or for limited drug prescriptions could well devastate the patient and the family and thus completely negate the principles of health insurance as a means of access to medical care." Dr. Patterson offered the following additional comments on the NHI bills before the Committee:

- Support for continuation and expansion of title V programs for mothers and children and provision of preventive health care for mothers and children without cost-sharing, as provided in Mills/Kennedy bill.
- Concern over lack of clarity relating to reimbursable outpatient expenses for rehabilitation services.
- Program should cover both social and medical services provided in the home by qualified persons, whether or not provided through a home health agency.
- Objection to Administration bill's modification of all services provided under title V, Medicare and Medicaid and its percentage levels for maximum personal liability for families in \$5,000 to \$9,000 income bracket.
- Applauds philosophy behind Long/Ribicoff catastrophic approach but does not feel private insurance would be adequate to meet deductible amounts plus other financial strains on families with catastrophic illness.

11. *National Hemophilia Foundation*

Dr. Margaret W. Hilgartner, Member of the Medical and Scientific Advisory Council of the Foundation, accompanied by Louis N. Friedland, Chairman of the Board, described for the Committee the long-term blood needs of hemophiliacs and others afflicted with chronic diseases, in particular the medical and financial problems: 1) replacement material is extremely costly, averaging about \$2,000 to \$5,000 per patient per year; 2) replacement therapy generally carried out in outpatient emergency rooms where third party coverage is often available; 3) reconstructive surgery for correcting crippled joints is extraordinarily expensive, and rarely covered by insurance; and 4) a marked increase in last ten years in blood product utilization by hemophiliacs.

Dr. Hilgartner described the financial and social advantages of home therapy, or self-infusion of necessary blood components and the necessity for covering such treatment in national legislation. Dr. Hilgartner voiced the following concerns with regard to bills before the Committee:

- Clarification of definition under Mills/Kennedy bill of "drugs" and "biologicals" to specifically include blood and blood products as prescription drugs (pg. 117 of the bill).
- Change in wording of Mills/Kennedy bill, pg. 118, line 9, to read "(Except for insulin in the case of diabetics, and blood products in the case of hemophiliacs and other chronic blood disease patients)."; this change would allow coverage of blood products not requiring prescriptions, as may in the future be the case in home treatment and self-treatment modes.
- Re Administration bill, questions advisability of allowing Secretary of HEW to set blood product deductible by regulation (Sec. 1832 (b) (2) (c), line 18, pg. 30 of the bill), as may lead to higher deductibles on blood than on drugs and does not differentiate between blood used by hemophiliacs and blood required for surgery, accidents or other events.
- Re Long/Ribicoff bill, would like clarification so that blood and blood products used by hemophiliacs would be treated as prescription drugs.

Dr. Friedland also made a statement before the Committee describing his experiences as a father of a hemophiliac, particularly the joint damage and resulting arthritis caused by the disease. Dr. Hilgartner, under questioning from Mr. Burleson, later indicated that the most recent statistics on hemophilia indicated that 100,000 persons in the U.S. are affected, of whom 25,000 have a severe disease requiring fairly frequent transfusions.

12. *National Kidney Foundation*

James C. Hunt, President, accompanied by Dr. George Scheiner, Past President, and other members of the Foundation, submitted his prepared testimony and devoted most of his oral testimony to personal observations on experiences under Public Law 92-605. He referred to a position paper developed by the Kidney Foundation entitled "The Guidelines for Implementation" for purposes of P.L. 92-605. Among Mr. Hunt's concerns were the following: 1) the fact that local, regional, or national level advisory review boards for the program have not yet been established, 2) the "extreme degree of superlegalism in presentation of the sharing arrangements with respect to amounts of services," and 3) lack of flexibility regarding the provision of programs and development and activation of new facilities.

Mr. Hunt emphasized the Foundation's sentiment that under NHI, it would be advantageous to retain private health insurance but with a minimum standard of coverage mandated and available to all citizens.

13. *Association of Kidney Patients*

Shep Glazer, President of the Association, presented comparative financial data indicating coinsurance costs under Part B of Medicare for patients on home dialysis without a technician, home dialysis with a technician, and in-center dialysis, noting that the first example of home dialysis without a technician is the least expensive mode but still presents other problems resulting from the home environment, strain on the family, etc. Mr. Glazer suggested the following:

- 1) 100 percent Government payment for treatments and medications, plus continuation of disability payments, for those chronic patients who return to work, thus providing a motivation for rehabilitation.
- 2) Payment of a flat rate for a technician or nurse to treat the patient at home.
- 3) Payment of a flat fee or minimum wage to spouses performing these duties, or as an option, allowing the spouse's time during dialysis treatment to be tax deductible.

Mr. Glazer also read a letter from the spouse of a patient on home dialysis, pointing out the strains caused on the family by lack of technical assistance in operating the machine.

14. *American Speech and Hearing Association*

Richard J. Dowling, Director of Governmental Affairs of the Association, stated his organization's position that "diagnostic and rehabilitative speech pathology and audiology services should be made available on referral by a treating physician to the beneficiaries of any new national health insurance system, in inpatient and outpatient settings, whether such settings are public nonprofit agencies or private, nonphysician-directed speech and hearing clinics." The Association opposes the "cumbersome prescription requirement" under current Medicare law regarding hearing and speech rehabilitation services. Mr. Dowling also stated that "no health practitioner should be encouraged to render [covered] hearing examinations and related services unless he or she is an audiologist, otologist, or otolaryngologist."

15. *Maternity Center Association*

Mrs. Ruth Watson Lubic testified as to the needs of child-bearing families and the major problems in maternity and infant care. She noted that maternity care has traditionally been neglected in health insurance policies, with the result that couples may pay from 2/3s to 3/4s of childbirth expenses directly. The Association is conducting studies of the total cost of prenatal and maternity care, with preliminary evidence for New York City indicating that the complete cost may be in the range of \$6,000. As a result of such escalating costs, Mrs. Lubic noted that many young families are turning to "unsupervised do-it-yourself home births," estimated for the State of California at a rate of 3,000 a year. Mrs. Lubic offered the following recommendations with regard to maternal and infant care under NHI:

- Coverage of comprehensive maternity care including antepartum, intrapartum, and postpartum periods, for normal and complicated pregnancies with no deductibles and no copayments required.
- Coverage of comprehensive infant care in a like manner up to at least age 5, and regardless of where such care is provided.
- Recognition of the maternity care team as well as of the individual physician.
- Definition of maternity and infant care should include health education, nutrition counselling and supplements when authorized by a physician or physician-extender.

Mrs. Lubic also noted that a purely catastrophic approach to NHI would "totally neglect the needs of most child-bearing families."

Mr. Conable questioned Mrs. Lubic regarding the need to provide adequate coverage for maternity care to be sure "that we aren't creating a bias in favor of abortion economically." Mrs. Lubic replied that there should be the opportunity for free choice to be made by families and "therefore, you would need to take the economic element out of it insofar as possible."

June 21, 1974

1. *National Legislative Conference, Hon. Richard Hodes, chairman, Health and Rehabilitation Services Committee, House of Representatives, State of Florida, Hon. Harry E. Simpson, minority leader, House of Representatives, State of Maine, Hon. Mike Parker, House of Representatives, State of Washington, and Hon. Mike Mitchell, Member of the Senate, State of Idaho*

The stated intention of the witnesses was "to try to demonstrate to you [the Committee] those actions that States can take which would, in fact, help resolve many of the issues which this committee has to consider in order to properly put together a National Health Insurance Program."

Mr. Mitchell stated that all of the NHI proposals were deficient regarding the coverage of preventive services.

Mr. Simpson of Maine stated that Maine had enacted legislation to cover catastrophic illness for working class families. 75,000 persons will be covered effective July 1, 1974 and a "pool" of \$6,800,000 has been set up to cover the catastrophic illness expenses of this group. In addition to catastrophic coverage, a medical care program is provided for persons not eligible for Title XIX whose incomes are 33 percent or less above the standard for Title XIX. Financing of the program will come from a two cent increase in the cigarette tax and from Federal funds.

After describing the program, Mr. Simpson expressed doubt that the State could afford it, saying, "we need Federally financed health insurance soon."

Mr. Parker of the State of Washington described the operation of the State's Hospital Commission. The Commission requires a uniform system of bookkeeping for all hospitals and set rates for individual hospitals. The Commission also requires a uniform bookkeeping system for public assistance patients in nursing homes, is considering including nursing homes "under this type of rating structure" and the possible modification of the hospital commission into an overall Health Commission for Rate Approvals.

Mr. Hodes of Florida stated that his State has passed legislation setting minimum standards for health insurance and legislation to pay for intensive care in nurseries for newborn children. Mr. Hodes stated that if care is financed by the State, it has the responsibility to fund access to it, i.e., transportation. His example was the need to transport newborn babies to neonatal centers, which have been established by the State. He emphasized that access to equal care will become an issue in any NHI program.

The State of Florida has also established a hospital authority which can issue revenue bonds. This was cited as a savings regarding construction, because the bonds would be tax exempt.

The State passed legislation to fund family practice training in community hospitals, a program for physicians' assistants, and an HMO law. Mr. Hodes expressed concern about the stringency of the Federal HMO law, and pointed out that since none of the prototype HMO's would qualify under the HMO law, there is some question whether this new type of HMO (under the terms of the Federal law) would achieve the savings attributed to the prototypes.

Mr. Hodes stated that an NHI program would have to "carefully examine the health resources in this country and the ability of States to provide and to assist in the development of those resources."

Congressman Mills again reiterated a point made earlier when the American Public Health Association testified that insufficient attention was directed to prevention.

Mr. Gibbons asked what the role of the States should be under an NHI program.

Mr. Hodes replied that the State could carry out most of the tasks referred to in the legislation, if the money were there. All the other witnesses agreed.

Mr. Brotzman asked Mr. Parker if he were familiar with the system of paying doctors in British Columbia.

Mr. Parker said yes and described the program in some detail, including the fact that the fees are negotiated between the doctors and the government. He stated that although the doctors were less well paid than U.S. doctors, they were generally satisfied with the health insurance scheme in British Columbia.

Mr. Mills asked the opinion of the panel regarding the Administration's proposals to collect all the deductible and copay for the providers.

Mr. Hodes said that it could be done. Mr. Parker agreed and urged that the States be allowed administrative flexibility in carrying out their responsibilities under any NHI program.

2. *National Association of Counties, Jack Walsh, chairman, National Health Insurance Subcommittee*

The stated intention of the testimony was to urge that Counties have a role to play in national health insurance.

The association urged the committee to report out a comprehensive bill as opposed to catastrophic coverage insurance only.

Mr. Walsh advocated that any NHI program have the following features:

1. Universal coverage.
2. Financial participation must be affordable.
3. Any NHI program should be at no cost to the Counties.
4. "Truly comprehensive"...covering not only all personal health care services but also specialty services."
5. Specialty services includes alcoholism, drug abuse, emergency care, mental health, preventive medicine, tuberculosis, legal custody cases, etc.
6. A national health insurance system should not have arbitrary benefit limits, but other means of controlling utilization should be devised, based on the individual's health care needs.
7. Counties cannot absorb additional health care costs and many counties are operating at maximum taxing levels permitted by State laws. There should not be a maintenance of effort requirement for Counties in any NHI program.
8. NHI should be federally funded.
9. Mr. Walsh expressed concern about the minimal involvement of Counties in developing an NHI program and the minimal roles contemplated in the various proposals regarding planning and regulation.
10. Any NHI program should include provisions to prevent inflation of costs.
11. "Planning for services and financial planning must be unified to avoid inequitable cost shift due to gaps in coverage and reimbursement." (It appears that Mr. Walsh is concerned about Counties having to pick up the tab for uncovered services for the indigent.)
12. Regulatory functions must be consolidated. States should have the option of developing planning, regulating, and cost control systems consistent with Federal guidelines. Licensure, regulating, and franchising laws must be modernized to relieve manpower shortages.

13. Local government should have an active role in standard setting and planning.

In response to a question from Congressman Brotzman, Mr. Walsh advocated that government officials from local and county governments be included on comprehensive health planning boards.

3. *Golden Ring Council of Senior Citizens Clubs, Moe Diamond, chairman*

The Council requested the following:

- a. A twenty percent increase in basic social security benefits;
- b. Combine Parts A and B under Medicare and eliminate the part B monthly premiums;
- c. Include outpatient drugs under Medicare; and
- d. Eliminate all coinsurance and deductibles under Medicare.

Mr. Diamond noted that good home care is essential to any NHI program: "a homemaker or a housekeeper to do house chores and shopping at the home of an elderly, frail person on an average of two or three days a week would cost about \$50 or \$60 a week in contrast to \$200 or \$300 in a nursing home.

4. *American Association of Retired Persons, National Retired Teachers Association, Cyril F. Brickfield, legislative counsel*

-- "A national health plan must address the issue of long term care. Skilled nursing care should be provided in a medical surrounding with qualified nursing staff. There should be no limitations on prior hospitalization as this prevents optimum utilization of health resources."

-- "There should be no limitation on the length of stay...."
Likewise, intermediate care is a reimburseable item."

-- "We suggest a system that mandates noninstitutional providers to accept established fee schedules as a condition of participation."

-- Consumers should have a voice in establishing fees.

-- The cost sharing mechanism should include a catastrophic protection feature.

-- Cost sharing should be tied to the individual's ability to pay.

-- Older Americans should receive health care as a right; not tied to employment or ability to pay.

-- Medicaid must be federalized and standardized regarding benefits and eligibility.

With respect to H. R. 14079, the Association views the bill as "progressive and desirable but it falls far short of the comprehensive protection needed by the aged and disabled." The federalization of Medicaid is a desirable feature but there should be included an automatic cost of living adjustment feature. The \$3 copayment for ambulatory physician services is acceptable but "we see no justification for the confiscatory special copayments for long term institutionalized residents." The witnesses also voiced the following views on H. R. 12684:

-- The Administration bill fails to address itself to the problems of the health care needy and the problems of rising health care costs.

-- "The whole 'certified State' approach is unwise since it will result in two separate health care systems for the aged--a new Medicare in certified States and old Medicare in non-certified States."

-- Durational limits on benefits and cost sharing are unacceptable.

-- "Our figures indicate that approximately \$1.2 billion will be added to the elderly's out of pocket charges under the Medicare bill."

-- The charge account method under the bill is endorsed by the Association.

The Association stated the following with regard to H. R. 13870:

-- There is a question as to what happens to the aged indigent once Medicaid is abolished.

-- It fails to provide adequate relief from cost-sharing, doesn't cover certain items now covered under Medicaid programs, and "makes the provision of intermediate nursing care contingent on an ill-defined and administratively questionable new program."

-- There is no provision for crediting deductible and coinsurance amounts under Medicare toward the catastrophic special waiver feature of the national health insurance program.

-- There are problems of coordinating benefits between Medicare and the national health insurance program.

-- Failure to add the special waiver provision will deny low-income Medicare beneficiaries the benefit of the special waiver provision.

-- Long term care program should be a Federal program modeled after the Medicare use of State resources.

-- Enrollment in the long term care program should be mandatory with an increase in retirement cash or benefit amounts sufficient to cover the premium cost and for transfer of such amounts directly to the long term care trust funds.

The Association endorses H.R. 13385--the Comprehensive Medicare Reform Act--100 percent. The bill would add dental services, outpatient drugs, and intermediate care services to Medicare benefits and would abolish limitations on the duration or amounts of inpatient care, skilled nursing and home health care.

The bill would also eliminate deductibles and coinsurance under present law and would substitute minimal copayments for the more expensive items of service. Copayments would be limited to \$750 a year for a family and this amount would be adjusted for levels of income.

Institutional providers would be paid on a prospective basis and physicians would be paid according to fees schedules. Providers would be required to accept the Medicare payment (plus any copayments) as payment in full.

Under questioning from Congressman Corman, Mr. Brickfield stated that the Kennedy-Griffiths bill would induce costs, and would be inflationary.

5. *National Association of Insurance Commissioners, Samuel Weese, chairman, Accident and Health Subcommittee and member, National Health Insurance Task Force*

Mr. Weese's stated intention was to make the case for State regulation of health insurance.

The NAIC "would be interested in reviewing the possibility of meeting Federal minimum standards" and looking at alternatives for inducing States to adopt these standards.

Mr. Corman questioned Mr. Weese regarding benefits and costs offered under individual and group policies. Mr. Corman asked what the "best" policy in West Virginia would cost an individual policy holder and what it would cost a group policy holder. Mr. Weese replied it would be about \$50 for the individual policy holder and \$36 to \$40

for the group policy holder. Mr. Weese further stated that, even with that dollar differential, the group policy coverage is likely to be more comprehensive. Individual policy holders are also subject to cancellation.

Mr. Corman then asked what the role of insurance companies should be in fixing hospital and physician charges. Mr. Weese responded that someone would have to carry out that function, and stated that it might be a State Commission.

6. American Association of Homes for the Aging, Rev. Richard Reichard and Dr. Robert Butler

Mr. Reichard was very supportive of the long term care program under Part D of Title II of the Kennedy-Mills bill.

Any NHI program should include:

1. Comprehensive services, both non-institutional as well as institutional; and
2. Elimination of the distinction between medical and health-related social needs.

The following specific comments were offered on H.R. 13870:

- Coverage for long term care should be mandatory.
- Copayments are endorsed but should be income-related, buy-in provisions should exist for SSI beneficiaries, and the present State buy-in responsibilities should be retained.
- The concept of non-profit, community-sponsored long term care centers is an acceptable provision.
- The "levels of care" concept should be abandoned.
- Dental, eye, and foot care should be covered.
- Medicaid should be retained until the long term care program is in place.
- The payment provisions in Section 249 of P.L. 92-603 should be incorporated into H.R. 13870.
- The language of any NHI legislation should be neutral regarding non-institutional versus institutional care, and present language in H.R. 13870 is biased towards non-institutional care.

Mr. Clancy asked Mr. Reichard what he meant by health-related social services.

Mr. Reichard used the services of social workers interviewing prospective and incoming patients as an example.

Mr. Corman asked whether there is a need to separate medical and social conditions.

Mr. Butler responded that such distinctions are arbitrary and not useful in dealing with the problems old people have. In response to a question from Congressman Corman about financing, Dr. Butler indicated that he favored the income tax. Mr. Reichard, responding to the same question, said he favored restrictions on the amount of profit that could be taken by owners of nursing homes.

Mr. Corman asked Mr. Butler for the Association's experience with SSI.

Mr. Butler said homes were having problems with SSI because endowments were being considered monthly income. Congressman Corman noted that California's nursing homes were also having problems with SSI.

7. Association of State and Territorial Health Officers, Dr. Maurice S. Reizen, president

Dr. Reizen directed his comments at one bill, H.R. 13870:

ASTHO favors compulsory coverage, and government supervision of the "insurance administration," controls and incentives, existing government programs to be phased out as indicated, financing through a combination of social security taxes and general tax revenues, promotion of improvements in the delivery system, and the incorporation of primary care benefits.

ASTHO stated that there was inadequate attention given to preventive health services and a preventive health "philosophy." The bill is almost silent on the role of health departments. Health departments should have a role in five major areas:

- 1) Surveillance of Providers;
- 2) Gap filling and resource development;
- 3) Continuation of unique public health services, e.g., family planning, communicable disease control, case finding, diagnostic and screening techniques, maternal and infant care programs, and environmental health programs;
- 4) Consumer Advocacy; and
- 5) Prevention and health maintenance through health education.

ASTHO stated that the Federal Government should set policies, goals, and standards, and provide the funding, and the States should carry out the program.

8. *National Federation of Independent Business, Frederick L. Williford, director of government affairs*

The Federation urged the adoption of a health insurance scheme similar to that in Japan, where participation is compulsory for companies with five or more employees in the mining, retail, and manufacturing industries, and insurance is voluntary for such companies with under five employees.

The Federation is most favorably disposed to the Burleson bill, H. R. 5200. The attractive features include:

- The program would be voluntary.
- The amount paid by the employer and the employee is left to those two parties to determine.
- Employees may elect individual coverage only and retain the cash income benefits, and the policyholder would pay the entire premium.
- The employer can take the entire premium as a normal business deduction for tax purposes.
- The program is administered, in large part, by the States and the insurance carriers.
- The bill would protect the individual insurance agent.
- Catastrophic coverage is provided.

Mr. Burke asked Mr. Williford if small business might be willing to reduce the social security taxes now being paid by small businesses and to finance health insurance benefits to their workers and families from the general treasury.

Mr. Williford said yes.

9. *National Retail Merchants Association, Helen Lefler on behalf of, and Martin Amdur, counsel*

The Association believes that:

- A NHI program would be inflationary.

-- Any NHI plan should be nation-wide in scope, "covering all employees who are not protected by a company plan that is at least actuarially equivalent to the Federal plan."

-- The unemployed should be protected through contributions by the Federal and State governments.

-- The national plan should be minimal in terms of coverage. To this end, the NRMA would be most disposed to the Long-Ribicoff bill.

-- The plan should be administered by private insurance companies.

-- The national plan should mandate that every employer provide a minimum health insurance program covering catastrophic illness under a policy with an approved carrier.

-- "We wholeheartedly endorse the implementation of standards to deal with the problems of loopholes, waivers, exclusions and internal policy limits which take away with one hand almost as much as it purports to be given with the other."

-- There should be standards of performance for insurance companies prepared, implemented, and monitored by the Federal Government.

Mr. Conable asked Ms. Lefler her opinion as to an approach whereby the deductible was gradually reduced over time, beginning with the Long-Ribicoff level of \$2000. Mr. Conable stated that this approach might be the quickest way to a total Federal program.

Mr. Amdur responded that NRMA was in favor of the Long-Ribicoff bill only if Congress decides to enact a program which is mandatory. If a bill is passed, they think it should have mandatory catastrophic protection and deal with the aged and the poor as a special problem.

10. *Opticians Association of America, Thomas F. Ostertag, president*

The Association recommends uniform availability of eyeglasses under Medicaid.

Regarding NHI, the Association offers the following recommendations:

- 1) There should be explicit recognition of opticians in the legislation.
- 2) There should be specific language and regulations in the legislation pertaining to freedom of choice of doctor or dispensing optician.

3) Providers of eyeglasses and related optical products should be reimbursed on the usual and customary principle.

4) There should be a dollar allowance for lenses and frames given to the beneficiary to be used toward the purchase of the eyeglasses of his or her choice.

5) There should be both national standards for optical products and for dispensing opticians.

6) Representatives of dispensing opticians should be included on governing and advisory committees established to plan, implement, and evaluate any national health insurance program which provides eyeglasses as a benefit.

11. *American Chiropractic Association, Dr. Stephen E. Owens, president, and International Chiropractors Association, Dr. William S. Day, president*

The provisions under section 273 of the 1972 Medicare amendments should be included in any national health insurance program, referring to the inclusion of chiropractic benefits with free choice for program beneficiaries.

Review of claims for chiropractic services should be made by chiropractors, not by medical or other health personnel.

X-rays should not be mandated to demonstrate a sub-luxation.

12. *American College of Nursing Home Administrators, Edward Brody, president*

The following eight provisions should be included in any national health insurance program:

1) Long term care should be available to everyone.

2) Quality assurance and appropriate utilization provisions should be included in the long term program under NHI.

3) NHI should support continuing education for the aged and gerontological research.

4) Quality management payments should be included along with quality and effectiveness guidelines.

5) Provision of adequate manpower for care to the aged is critical to any NHI program.

6) Reimbursement should recognize the patient's medical, spiritual, psychological, and social needs and should not have a negative impact on quality.

7) Long term care resources need to be linked together.

8) ACNHA supports the inclusion of the following non-institutional services:

- a. Home health services
- b. Homemaker services
- c. Nutrition services
- d. Day care and foster home services
- e. Community health center outpatient services

13. *New York City Health Officers Advisory Committee, Patricia Nolan, M.D., president, and Gary Eidsvold, M.D., member and assistant professor of community health and environmental medicine, Downstate Medical Center, Brooklyn, N.Y.*

The comments of Dr. Nolan were directed to H. R. 12684, H. R. 13870, and S. 2513.

There are lack of incentives for the use of preventive and ambulatory care in all three proposals, principally because of the deductibles and coinsurance. These payments also deter the chronically ill who must satisfy the payments each year.

The Committee supports the inclusion of the Health Resources Board in H. R. 13870 as a means of affecting the redistribution of health manpower.

There should be appropriate emphasis on quality assurance, improvements in early diagnosis techniques, and the applications of computer technology for both quality assurance and cost controls.

There should be no fiscal intermediaries.

Mr. Pettis asked Dr. Nolan if NHI would cause a deterioration in the quality of health services. Dr. Nolan replied that it possibly would for ambulatory care, where the greatest increases in care would occur. Congressman Pettis raised the question of how it will be possible to get health manpower to serve in underserved areas. Dr. Eidsvold replied it may be necessary for the government to take steps to cause the necessary redistribution. Dr. Nolan, in response to a similar line of questioning from Mr. Burke, stated it may be necessary to find ways to get patients to doctors where they now practice.

14. *Harvard Medical School, Dr. David D. Rutstein, Ridley Watts professor of preventive medicine*

Dr. Rutstein approves of the Congressional efforts to get an NHI program but stated. . . "I am very unhappy that the proposed legislation

will do relatively little to meet the needs of the Americans in the prevention and treatment of their diseases and in the improvement of their health."

There must be incentives for doctors to control costs and utilization. Dr. Rutstein suggested the following method:

-- Hospitals must be regionalized and services coordinated.

-- Every doctor should have his office at the hospital and outlying areas should have reception centers.

In response to a question from Mr. Pettis about what should be done "to solve the problems you (Rutstein) are talking about," Dr. Rutstein said the first step should be to set up a quality control system to measure the outcomes of the medical care system relating to unnecessary disease, disability, and death, and unnecessary surgery. "If I were a Congressman, and you asked me what I would do, I would encourage the National Center for Health Statistics to test out in a particular area with their surveys." He then referred to the excellent performance of the National Center for Disease Control in Atlanta, and suggested that they may have a role. The respective roles of the two Centers were not made clear in the testimony.

Dr. Rutstein recommended a Federal Health Board which would have the same powers in health that the Federal Reserve Board has over "the quality of credit." There would be regional boards and a central board.

If health insurance is limited to catastrophic illness, this will encourage more catastrophic illnesses as defined by the providers.

Ability to pay should be considered in designing the payment system under any NHI program.

Congress should have a central administrative structure, "a central office."

Mr. Pettis questioned Dr. Rutstein about physician extenders. Dr. Rutstein replied it is difficult to define the role of the extender until we have defined the role of the doctor, who does many things that could be done by others.

Mr. Pettis asked how the Federal government might deal with the multiplicity of State approaches to licensure of physicians. Dr. Rutstein said the aforementioned Federal Health Board could play a role in making recommendations in this regard.

15. *Federation of Chiropractic Licensing Boards, Dr. Richard E. Vincent*

Review of chiropractic care should be done by chiropractors.

X-rays for chiropractic conditions should not be mandated as in the case in the current Social Security legislation. "The current agency guideline which requires the elderly to pay out-of-pocket for services necessary to a case evaluation prior to administration of care is difficult for those of us who represent the consuming public to understand."

Any NHI program which contains chiropractic services should not be administered without chiropractic assistance nor should any program be developed without such input.

Mr. Burke asked about the experience in Massachusetts in implementing the Medicare chiropractic program. Dr. Vincent indicated that dealing with the physicians on the Boards of Blue Cross/Blue Shield had been difficult, that the administrative people in these agencies have been cooperative, and that to date 1700 claims had been processed, 40 of which had been held for peer review.

Mr. Pettis asked if the same variations in State licensure requirements existed for chiropractors as existed for physicians. Dr. Vincent said yes but also said the differences tended to be relatively minor.

Dr. Vincent asked that educational financing for chiropractors be made available from Congress.

June 28, 1974

1. *American Public Welfare Association, Hon. Wilbur J. Cohen*

Wilbur J. Cohen, Dean of the Graduate School of Education, University of Michigan, represented the American Public Welfare Association. Mr. Cohen urged the extension and improvement of health insurance and asserted that action by Congress on NHI legislation is possible this year by virtue of the widespread agreement which exists among the many sponsors of bills on a number of important issues in the debate. These areas of agreement he enumerated to include the following:

- 1) A broad scope of benefits should be offered in any program.
- 2) Low-income individuals and families should be covered in a national program.
- 3) General revenues will have to be used to finance a program.
- 4) Employers should be required to assume a major portion of the premium costs of a program.
- 5) Benefits must be phased-in.
- 6) Medicaid must be federalized, i.e., the Federal government should assume administrative and financial responsibility for this program.
- 7) A new basis for financing nursing home care must be found.

Mr. Cohen made the following additional points during his presentation:

-- The program should be financed through Social Security payroll taxes; "...when you take the whole system, the whole \$50, 60, 70 billion that is being spent under Social Security, it only costs 2.4 percent for the collection and administration of the entire program. That is the cheapest, most efficient, most effective system of collecting contributions in the United States. No other insurance company, private or public can compare with it.... I have no doubt in my mind that if efficiency and saving money is your objective, then you ought to use the Social Security system to collect the contributions and make the

actuarial calculations, because you would be saving one to two billion dollars a year in administrative costs alone."

-- It is possible to use State agencies and private insurance companies as intermediaries for reimbursement. The provision of H.R. 1 which proposes to use State agencies or corporations established especially for this purpose deserves special attention.

-- In the phasing-in of benefits, coverage of maternity care, comprehensive health care for children, and family planning services should receive priority in any basic plan. Deductibles and co-insurance should not be applied to comprehensive health care for children.

-- Basic malpractice insurance coverage should be provided by the Federal government to those physicians and hospitals accepting assignment under the NHI program.

-- The NHI bill which the Committee reports should combine a basic benefit package with a catastrophic benefit and a skilled nursing home benefit.

-- The Social Security Administration should be reestablished as an independent government agency.

-- The Committee should "reduce the employee payroll tax under Social Security, increase the employer tax, and thus meet head-on this point of attack on Social Security which is sweeping the country, that the 5.85 percent rate is very regressive." Mr. Cohen added subsequently in the question-and-answer session that the employer would not bear the entire burden of the higher rate: "...with the corporate tax rate at 48 percent, whatever you levy on the employer, the Government is paying half of that cost. For every additional dollar that the employer pays, 50 percent is a deduction."

In the question-and-answer session, Mr. Corman asked in what context Mr. Cohen would recommend that a national health insurance program be compulsory. Mr. Cohen replied that he would follow the model of H.R. 22 "in which everybody in the United States would be covered for medical care without regard to their insurability. Now, the reason I am for that is that you can save at least a billion dollars a year by not having to determine anybody's eligibility." He added that H.R. 22 would "save at least two billion dollars a year on another point, which is that everybody could walk into a doctor's office and merely use his Social Security card; the doctor would give him the service and collect without any evidence of insurability."

Mr. Corman inquired about the costs of administration involved in deductibles and copayments. Mr. Cohen replied, "if you eliminated the coinsurance and deductible (in Medicare), it would be the greatest relief to the bookkeeping system of doctors and hospital offices that you could possibly imagine." Regarding the effect of deductibles and coinsurance on over-utilization, Mr. Cohen stated that after one reviews the literature on the subject, "you are not quite sure what the answer is. There are various answers which say yes; it reduces unnecessary utilization and it also proved that it eliminates necessary utilization." A decision to include them in any national health insurance program will therefore have to be made "on the basis of what I call conventional wisdom rather than on research knowledge."

Mr. Corman asked if the physician or patient were more responsible for over-utilization. Mr. Cohen replied, "in my opinion, it is the physician who has the major responsibility, at least in connection with hospital care. But the physician is reacting to a set of difficult factors.... Twenty-five percent of the people who are in the hospital today would not need to be in the hospital. In other words, you could save at least a billion dollars a year in hospital care in the United States if you had alternative methods of institutionalization.... You are not going to solve that problem until the Congress of the United States decides to finance alternatives to in-hospital care."

2. American Institute of Certified Public Accountants, Willard H. Erwin, chairman, Task Force on Health Care Institutions

Willard H. Erwin, Chairman of the Task Force on Health Care Institutions, directed his comments on national health insurance to three subject areas which are of particular interest and concern to the American Institute:

a) Reports of a financial, statistical, or compliance nature which providers of health care services will be required to submit under the program.

-- A broad provision, such as appears in H.R. 1, which empowers the Secretary to promulgate regulations concerning information to be supplied by providers is preferable to provisions which specify such requirements within the legislation.

-- A broad provision which permits the Secretary to issue such regulations has two advantages. First, it would permit flexibility in developing appropriate reporting requirements based upon particular types of health care services. Second, it would facilitate amendments to requirements which will undoubtedly be necessary in a program as far-reaching as national health insurance.

-- Consideration should be given to establishing uniform data collection and reporting requirements among all the programs (Medicare, Medicaid, etc.) that will exist upon enactment of any national health legislation. Simplification of regulations could minimize the cost of administering health care programs.

b) Current problems relating to reimbursement procedures which should be considered in NHI legislation.

-- NHI legislation should include a mechanism for appealing reimbursement rates. Without such a mechanism, possible inequities in the interpretation of reimbursement provisions might arise.

-- Because of variations among third-party payors in definitions of allowable costs for purposes of reimbursement, institutions are not receiving either full reimbursement for their incurred costs or sufficient funds for maintaining the quality of health care in the future. Consideration should be given to the establishment of a uniform rate of payment by third-party reimbursers.

-- Historically, interpretative rulings regarding health services to be reimbursed have been applied retroactively. Such retroactive applications, especially in instances involving rebates, preclude effective fiscal management and planning by health care providers. The legislation should authorize the Secretary to prescribe the extent to which any rulings or regulations shall apply without retroactive effect.

-- The rates of payment to be established for the provider should be determined and communicated sufficiently in advance to enable effective program planning, and capital and operational budgeting by the institutions. If operating and/or capital budgeting of the providers are to be relied upon for rate determination, an appropriate body should be created for the purpose of monitoring and reviewing these budgets for compliance with the program.

-- Whether or not prospective rates of payment are utilized, consideration should be given to including in the reimbursement rate, a return on investment for the voluntary not-for-profit and investor-owned institutions, as well as for the placement and modernization of facilities.

-- Provision should be made for adjusting the reimbursement rate during the year, or in the following year, for inequitable overpayments or underpayments based upon unusual or significant variations from the institution's approved budgetary expectations.

c) The need for independent examination of certain data contained in financial, statistical, and compliance reports.

-- NHI legislation should require an independent examination of the financial statements of health care institutions and fiscal intermediaries. Without an independent audit, all interested parties can only assume that the financial statements submitted by those who manage an organization do, in fact, fairly and accurately represent management's performance.

-- The independent audit would allow the certified public accountant to offer suggestions to the health care institution for improvements in internal controls, operating methods, and accounting procedures.

-- In addition to requiring independent audits of health care providers, NHI legislation should also specify the qualifications deemed necessary for independent public accountants to conduct such audits.

3. *National Council of Senior Citizens, Nelson H. Cruikshank, president*

Nelson H. Cruikshank, President, stated that at its latest convention, the National Council applied for purposes of evaluation, six criteria to several NHI bills currently pending before the Committee. These include: 1) the universality of coverage and the uniformity of benefits offered by the bill; 2) provision for the reform of the health care delivery system; 3) provision for cost and quality controls; 4) provision for consumer representation; 5) adherence to social insurance principles in administration and financing; and 6) the comprehensiveness of benefits. Mr. Cruikshank indicated that, as measured by these standards, H. R. 22 was judged the proposal most worthy of endorsement by the National Council.

During his presentation, Mr. Cruikshank singled out for discussion H. R. 13870's provision for long-term care. He stated that the National Council "commends the authors of the Mills-Kennedy bill for undertaking and tackling this problem." He added that the National Council "generally approves the program content (of this provision) but we are critical of the voluntary premium or limited coverage approach. The voluntary program would require a fixed premium per month. It means that a couple would have to pay \$12 a month for long-term health care protection plus \$12.60 for Part B coverage under Medicare or a total of \$24.60 a month. This is a heavy burden on older people. The fact that the program is voluntary, as presently designed, also means that the per capita costs would be high since the election of coverage can be expected to be particularly great among people likely to experience the risk of insured gains...."

On the subject of the costs of the various NHI bills, Mr. Cruikshank submitted that "the issue is not how many dollars are to be added to the Federal budget by the inauguration of a comprehensive health program, the issue is how best to collect and channel the dollars necessary to provide a good program. In fact, it is not only conceivable but very likely that a \$70 billion Health Security program would actually cost the American people less than a \$10 billion bargain basement program designed to pay only a fraction of the total of all of the charges for health care, leaving the balance to be paid by high deductibles and co-insurance payments and through wasteful and inefficient commercial insurance carriers whose premiums would, of course, include the cost of advertising, sales commissions, profits, retentions, and all the other gimmicks known to the insurance industry.

Mr. Cruikshank urged the Committee to be deliberate in its consideration of national health insurance legislation "for the very practical reason that I am firmly convinced that any health insurance bill that would be a good bill passed now would face a veto."

4. National Urban League, Ronald H. Brown, director

On behalf of the NUL, Ronald H. Brown, Director, offered the following observations on H. R. 13870:

Although this bill contains several commendable features, such as simplified premium collection and administration by an existing government agency, the NUL opposes this proposal because of the several "provisions, limitations, and omissions which cast doubt on its adequacy as a solution for problems in health care delivery faced by the poor and near-poor in this country." Mr. Brown indicated the bill's weaknesses to include the following:

- 1) A system of deductibles and co-insurance, peer review of fee schedules, reliance on means tests for the poor, contributions by State governments in the financing of the program, retention of Medicare for the elderly as a separate plan, and a serious weakening of possible Federal commitment to health care reform.

- 2) Absence of mandated national standards of licensure and certification of health professionals. Mr. Brown stated, "This is an especially vital issue in the black community because we have such a critical shortage of health care personnel. Our communities must not be placed in the position of accepting poorly qualified professionals simply because more highly qualified physicians are unavailable.

Mr. Brown included in his testimony a discussion of those principles and priorities which the NUL believes should guide the development of national health insurance legislation:

-- The overriding goal of a national health program "must be to insure that each and every person, regardless of race or income or geographic location, has high quality, comprehensive, dignified medical, dental and mental health care."

-- A program of national health insurance should start from the premise that "the present system of health care financing has failed and that tinkering with it will probably prolong the failures at a higher cost." There exists a need "for a single national health system trust fund operated by the Federal Government with funds from general revenues, contributory taxes, or a special surtax. The Social Security system, with its proven efficiency and low administrative costs, should be the model for the financing."

-- The system should be "on a prepaid basis, stressing preventive and outpatient care to reduce hospitalization in an effort to counter rising hospital costs partially caused by private insurance programs."

-- The cost of an effective and equitable system should not preclude serious consideration of it by the Committee. "If an effective and equitable plan results in a higher aggregate cost than that experienced heretofore, the difference will represent health care which was previously denied to the poor and near-poor. It is important that the total cost be spread as widely as possible to minimize the impact on individuals."

-- The national health program should provide for "consumer participation in all of its functions and assure community control of facilities and programs that provide direct services."

-- "Poor people and minorities who have traditionally been denied decent health care... must be brought into the system through effective public health outreach programs that stress the dignity of the consumer of health services."

-- The numbers of primary health practitioners must be increased. "The problem is that the doctors we have are not practicing the general preventive health care for the poor of our nation. A rational national health program should provide incentives to increase the numbers of general practitioners and correct the imbalances of our present chaotic system."

-- The delivery of services is not "solely dependent upon the number of doctors. The doctor shortage can be alleviated by creating new career structures for paraprofessionals. Medical paraprofessionals can perform some of the routine tasks now reserved for highly trained professionals and perform a key role in community health centers and health outreach programs."

-- The keystone of a national medical education program should be "free professional training open to any applicant in return for a five-year service commitment upon professional certification. This would open the health professions, from doctors to social workers and nurses, to anyone capable of fulfilling the course of training, regardless of that individual's personal financial status. And it would create a large pool of health professionals committed to public health service and available for professional service in the areas now most in need of trained personnel. Such a health education program would go far toward increasing the numbers of black doctors, now less than two percent of all doctors in the United States.

-- A national health program should encourage "without income penalties, continuing training and formal education of health professionals."

-- "There should be a single class of health services for all. No plan enacted by this Congress should include one set of eligibility criteria and benefit levels for the poor and another for the affluent. No physician should be able to exact a higher price for his services than another physician other than what might be warranted by experience and measurable skill, and the cost of skill and experience should be spread through the insurance mechanism."

-- Any system of deductibles and co-insurance will "inevitably lead to barriers against use and a rich-poor dichotomy in the system. If individual misuse of health services is a problem, such misuse will be identifiable under a national health program. Individuals who misuse the system should be counseled, and flagrant misuse can be curtailed by penalty."

5. National Urban Coalition, Leda R. Judd, director, health program

Leda R. Judd, Director, Health Program, directed her comments to several issues in the debate on national health insurance which particularly concern the NUC.

-- "If we have to go to co-insurance and deductibles, we should take a serious look at the level at which they come into play, because \$4800 for a family is not a standard which assures anything. Certainly

not an adequate standard.... I am sure if statistics were available on overutilization we would find that it is not the poor or working poor, that perhaps it is the more affluent who use their doctors as a source of a sense of well-being and perhaps don't have a medical need."

-- "We are fond of putting consumers on advisory boards but leaving decision-making to the professionals. Why don't we just reverse that and have the consumers make the decisions and let the professionals form the advisory boards on matters of technical concern where consumers don't perhaps have the information they need.... Quality control would be assisted by opening up the whole system to some consumer input, in letting people find out just exactly what it is that is going on."

-- "Articles are coming out daily on the numbers of foreign medical graduates that we have who are by our standards unqualified for care. Those physicians are going into the large city hospitals. They are the persons to whom the poor in this country, the minority groups in this country, are going for care.... Whatever national health insurance bill we adopt, there are going to be significant increases in demand on health manpower and I think we must begin to give serious concern to how we are going to provide this manpower."

-- "The time for action is now, we do need a bill, but I strongly hope that we won't have a sort of piecemeal approach. If we adopt catastrophic insurance, I am sure in a year or two we will be back with the same kinds of problems. We need an overall redesigning of the system."

6. *Women's Lobby, Inc., Carol Burris, president*

Carol Burris, President, indicated that the Women's Lobby prefers, among those bills pending before the Congress, H.R. 22 and is concerned with the following aspects of NHI legislation.

-- Deductibles and co-insurance discourage preventive medicine, which is particularly important for women. Furthermore, because women utilize medical services at higher rates than men, coinsurance will have a particularly adverse impact on them.

-- NHI legislation should extend coverage of well-child care beyond the age of six.

-- NHI legislation should include as covered benefits family planning services, contraceptive services, and abortion services.

-- A prenatal care benefit should include coverage for all pregnancy-related diseases.

7. *National Women's Political Caucus, Marvella Bayh*

Speaking on behalf of the Caucus, Mrs. Marvella Bayh directed her remarks to the following:

-- For women, prevention and early detection of medical problems are especially important. Cancer is the leading cause of death in women ages 30 to 54. Most of these deaths are attributed to breast and cervical cancer, both of which require early detection to effect a cure.

-- Statistics indicate that for low-income women who do not generally visit a physician for regular check-ups because of the cost and inconvenience, the incidence of cervical cancer is four times greater than for higher income women; and for black women the rate is almost twice as high as it is for white women.

-- Any national health plan should include coverage for regular gynecological examinations.

-- A national health plan should include care for the chronic problems of the aged. Special attention should be paid to age-related illnesses, such as menopausal difficulties, chronic hypertension, and diabetes.

-- Since women "traditionally are among the lowest income earners, deductibles required for health insurance place an undue burden on already overburdened budgets. Preventive care becomes difficult."

-- Deductibles in the Administration's proposal would make it "difficult for low-income groups to seek preventive care. Even if deductibles were met, preventive care would not be covered under the Administration bill as it is now written."

-- The Kennedy-Mills bill, "though laudibly dropping deductibles for prenatal and family planning care, does not include routine gynecological examinations or health care for older people."

-- Co-insurance provisions will deter low-income persons from seeking the care they require.

-- Because of greater expenses for health care for women, particularly during child-bearing years, "plans which rely on payment by employers of a percentage of individual premiums, would create a disincentive for employers to hire and extend insurance benefits to women.... Clearly, if employers are required to provide national health insurance plans as in the Administration bill, they would be more likely to employ those persons that would not cost them additional premiums. That would not be women."

-- Single women with children, required to carry individual policies by insurance companies, would "suffer the greatest financial burden since they would be subject to the highest premium rate, while being the least able to pay them and probably in most need of medical care."

-- Insurance companies generally do not cover maternity benefits for single women. Specific provisions should be included in NHI legislation which would allow maternity care for all women, regardless of their marital status.

-- H. R. 22 comes "closest to meeting criteria for national health insurance.... We support this legislation because of its emphasis on preventive care and its universal coverage. It does not have the deductibles and co-insurance features found in other bills and it is not discriminatory in operation."

8. *National Council of Jewish Women, National Affairs Committee, Dorothy Lasday*

Ms. Dorothy Lasday, member and Vice Chairman of the National Council, stated that her organization has resolved to work for and support a comprehensive national health insurance program. She offered the following comments on bills now before the Committee:

-- Deductibles and coinsurance in the Administration bill would "actually increase the cost of care to the individual family and may deter others from seeking necessary care."

-- Real danger in adopting H. R. 14079 is that "impression would be created that this program will take care of all the needs of our population and many years may go by before a comprehensive health insurance program is actually established."

-- H. R. 13870 is improvement over two preceeding bills, but high deductibles and coinsurance would place serious hardships on many families, lack of cost control could be inflationary, and lack of universal entitlement and imposition of means test implicit in cost-sharing provisions are undesirable features.

-- Voluntary nature of Administration would perpetuate existing gaps in coverage.

The Council would support the following basic principles in an NHI program:

- a) Universal coverage;
- b) Broad and comprehensive benefits, including preventive services for all prenatal care, psychiatric care, and health maintenance;
- c) Stringent and realistic cost and quality controls; redistribution of physicians and other health resources;
- d) Reduction or elimination of deductibles, coinsurance, and Medicare premiums, and greater use of general revenue financing; and
- e) Unified government administration.

The only proposal which meets the Council's criteria is the Health Security Act. Ms. Lasday also drew attention to the particular needs of women in a health insurance program. She stated that the present system and all pending proposals discriminate against women in the following ways: 1) women are judged to be malingerers and are charged higher premiums because of their child-bearing role, 2) many employers are forced to practice subtle discrimination in hiring men instead of women because of higher group medical insurance premiums for women.

Ms. Lasday also related experiences she had had in rural areas of the South where the availability of health services was severely limited and malnutrition a common problem among low-income families.

9. Association of Trial Lawyers of America, Leonard M. Ring, president

Leonard M. Ring, President of the Association, recommended that coverage under an NHI program be universal and compulsory, and that benefits should cover all injury or illness. He also stated that the system should operate without subrogation:

It may be well to consider whether we should not make some change and limit the workmen's compensation medical expense to the \$1,000 deductible that you have here [in H.R. 13870]. Of course, as far as deductibles, I mentioned earlier that we believe that there should be no exclusion for national auto no-fault where the people are then charged a premium for auto insurance, where most of the cost is for medical which would be provided and could be provided cheaper under this bill.

Mr. Ring further noted that 35 percent of the auto insurance premium is for medical care, a separate expense item which could be eliminated, thus reducing auto insurance premiums, if such medical care were covered under the NHI program.

With regard to subrogation, Mr. Ring stated the following:

We are in favor of no subrogation, even in cases where there would be a right of recovery and even though it is contrary to the selfish interest of lawyers, because subrogation will only provide an incentive for litigation where the only ones who would get anything out of it would be the lawyers, if it is a nationally funded system.

Mr. Ring expressed the hope that if the NHI program includes a provision for medical malpractice insurance, there should be "at least a \$10,000 deductible where the doctor shares in the cost or in the risk, rather than give them complete and blanket immunity." Mr. Ring commented as follows on remarks by Wilbur Cohen on no-fault medical liability insurance:

When he got off on no-fault and medical malpractice, I must humbly suggest he was in an area that he didn't know a thing about. National health insurance that you are talking about is no-fault insurance, if you apply it to injuries, accidents as well as illnesses. When he [Cohen] parenthetically said that he is in favor of medical malpractice on a no-fault basis and yet at the same time he wants the injured victim of medical malpractice to recover, he did not realize that one excludes the other.

The Chairman noted that the relationship Mr. Ring had brought out in testimony between automobile no-fault and no-fault under NHI was pertinent. Mr. Ring further noted that "if you pass national health, as I believe you should, and if you at the same time pass an auto no-fault bill, benefits under the auto no-fault bill either have to be given by the national health bill, or else you are going to have to provide double medical coverage to the people."

10. *National Welfare Rights Organization, Johnnie Tillmon, director*

Mrs. Johnnie Tillmon, Director, stated that her organization feared Congress "is preparing to enact another new welfare system --not for the benefit of people being deprived of adequate health care--but instead, a welfare system for the rich, the ones who have always profited from the real welfare doles." She stated that

current NHI bills would subsidize the present health delivery system. She charged that the Administration bill would subsidize the medical insurance industry by 1) forcing employers to buy insurance at prices set by insurance carriers; 2) entrenching the insurance carriers as administrators of the Government program through contracts that "will be padded to give them tidy profits"; and 3) "blatantly exempting carriers from competitive bidding for contracts with the Federal Government." Mrs. Tillmon stated her organization's belief that adequate health care is a basic human right and that "it is time to run the profit-making institutions who created this crisis out of the health system."

The NWRO recommends the following with regard to NHI legislation:

- A federally-administered comprehensive health program that does not use insurance carriers as administrators;
- Effective cost and quality controls supervised by consumers as well as providers;
- Community control of all medical facilities, run by joint consumer-medical worker boards;
- Preventing doctors from individually seeking reimbursement from the program, with doctors instead becoming employees of the community-controlled facilities;
- Financing of the program totally from Federal general revenues;
- Automatic compulsory coverage of all U.S. residents; and
- Elimination of any deductible or coinsurance formulas.

The Chairman asked Mrs. Tillmon whether she was aware that under H. R. 13870, no deductibles or coinsurance would apply to a family of four with less than \$4,800 annual income. Mrs. Tillmon thanked the Chairman for clarifying this point. The Chairman further noted his dissatisfaction with the existing Medicaid program in that the poor in his State "get nothing like the medical benefits that the poor in many other States get."

11. National Health Law Program, Margaret Ewing

Mrs. Margaret Ewing of Los Angeles, appeared on behalf of the National Health Law Program and also represented the Los Angeles County Health Rights Organization. She devoted her comments to 3 bills and the way each would treat current Medicaid eligibles and the extent to which these bills could improve access of the poor to medical care.

H. R. 13870...

-- Provides income levels generally higher than Medicaid eligibility in most states;

-- Cost-sharing provisions bear more heavily upon persons with income above the minimum income eligibility standards than the highest premium payments now permitted under Medicaid;

-- 1 percent payroll tax levied on even AFDC and SSI recipients compounds cost to the poor;

-- Eliminates Federal matching with which to supplement Federal program and "fails to grandfather all current Medicaid eligibles into the program at their current levels of eligibility and out-of-pocket costs."

H. R. 12684...

-- Establishes income levels for AHIP higher than Medicaid eligibility levels in most States, but not so high as they might first appear, due to use of gross rather than net income figures.

-- Persons earning between \$3,500 and \$5,250 must pay substantial premiums higher than currently may be imposed by States under Medicaid;

-- Sizeable cost-sharing would adversely affect current recipients not now obligated to pay such costs; and

-- Fails to grandfather present Medicaid eligibles and fails to provide Federal matching for States desiring to include persons with higher incomes in State Medicaid programs supplementing AHIP.

H. R. 14079...

-- Provides higher income eligibility than Medicaid eligibility in most States;

-- Definition of income does not permit deductions or exclusions from gross income unlike Federal Medicaid definition of income;

-- Provides no Federal matching for States to supplement medical assistance program by including persons with higher income levels than the Federal standards; and

-- Good features include its grandfathering of current Medicaid eligibles and its "spend-down" provision.

Mrs. Ewing noted the following with regard to benefit structures under the above named bills: 1) H.R. 13780 is deficient in limiting preventive services to persons under age 13, limiting drugs to 19 categories of chronic medications, and limiting nursing home services to "post hospital extended care services," except for voluntary program for the elderly, 2) Administration bill also limits preventive services to children under 13 and limits residual Medicaid program to provide only nursing home care, home health care, intermediate care, mental and TB hospital care, and psychiatric hospital care, and 3) H.R. 14079 fails to cover outpatient drugs, eye care and glasses, hearing tests and aids, or dental care, but allows Federal matching for State supplementation in these areas.

The Chairman asked Mrs. Ewing whether she felt that States would not be willing to finance a supplemental program, since the Federal government would be picking up most of the cost of the current Medicaid program. Mrs. Ewing stated that "whether they [the States] would opt to put their money into peripheral benefits, instead of State welfare, is something I couldn't forecast." Mr. Duncan asked if Mrs. Ewing could provide the Committee with a copy of a study prepared by the National Health Law Program showing the individual States and the problems they have had with Medicaid. Mrs. Ewing agreed to do so and noted that her formal written statement included a summary of this study.

12. Medical Committee for Human Rights, Arthur Mazer, chairman

National Chairperson, Mr. Mazer did not appear, but submitted a written statement.

13. Planned Parenthood Federation of America, Frederick S. Jaffe, vice president

Frederick S. Jaffe, Vice President, Center for Family Planning Program Development, indicated that Planned Parenthood believes that any program of national health insurance should: 1) provide universal, mandatory coverage for all U.S. residents, thereby avoiding the pitfalls of discontinuous, fragmented coverage and restrictive eligibility which characterize Medicaid and most private insurance plans; 2) require, as mandated services, coverage of family planning and other preventive health services; 3) exempt from cost-sharing requirements family planning and other preventive services, in order to encourage utilization and avoid more costly expenditures for curative services.

Mr. Jaffe asserted that coverage of family planning services in a program of national health insurance is particularly important for the reason that they produce "enormous health and social benefits, reflected in reduced rates of unwanted pregnancy, infant mortality, prematurity, congenital abnormalities, mental retardation, illegitimacy, and other adverse outcomes of pregnancy. These important benefits to individuals and to society need to be stressed because, in a very basic sense, family planning services are not really a cost to

the health system; they free up for other uses more resources than they require. Studies have shown that each dollar of Federal investment in family planning services returns more than two dollars in savings during the next year alone in governmental expenditures for medical care and assistance.... More resources devoted to family planning means that fewer resources will be needed for the more expensive services for delivery, termination of pregnancy and the care of fetal losses, premature infants and those born in congenital abnormalities."

Planned Parenthood is pleased by the fact "that each of three new proposals before the Committee--the Mills-Kennedy bill, the Long-Ribicoff bill, and the Administration bill--gives some formal recognition to family planning and other preventive services. However, none of them as presently drafted is adequate and some would, in fact, lead to fewer persons receiving subsidized services than is presently the case in the programs pioneered by this Committee." Planned Parenthood recommends the following changes in the above-mentioned legislation:

- They should exempt family planning and other preventive services from all deductible and cost-sharing requirements.

- They should state explicitly that "public and private family planning clinics and maternal health clinics that currently qualify as providers under existing Federal programs are considered to be eligible providers under the NHI program. In the family planning field, organized clinics now provide family planning services to more than half of all low and marginal income persons receiving family planning services. If this vital component of the delivery system is to continue to function, its full participation must be specifically mandated... and mechanisms must be established in the legislation for Federal certification of these clinics, if necessary, similar to the certification procedure for neighborhood health centers under Medicare.

- Specific authority should be included to enable clinic providers to "directly dispense contraceptive drugs and devices, so as to enable providers to pass on the sizeable savings that accrue from bulk purchase."

- Neither the Mills-Kennedy nor the Administration proposals provide for "reimbursement to clinic providers of the full cost of providing comprehensive care, including the cost of necessary related social and educational services. In this respect, the Long-Ribicoff provision for coverage of voluntary 'family planning counseling, services, and supplies' is an improvement and should be adopted or adapted."

- Legislation should specifically state that family planning clinics will be reimbursed on the basis of prospective payment systems.

-- Neither the Mills-Kennedy nor the Administration bills "confronts the very difficult issue of preserving patients' privacy, particularly acute in regard to such highly personal services as venereal disease detection and treatment, mental health services, pregnancy, drug abuse, and family planning. Although the health card system is an important and desirable concept, the billing procedures associated with it would conflict with the confidentiality of the provider-patient relationship because, in the case of many young persons, the bills for cost-sharing would be sent to their parents. This creates a situation in which many young persons will decide to forego needed care rather than risk embarrassment or parental disapproval.... We believe that a step toward a solution of the problem of confidentiality would be to require that the billing statement of any patient, regardless of age or marital status, contain no reference to indicate the receipt of family planning services, V.D. treatment or other sensitive services.... This provision would be strengthened if cost-sharing is eliminated for these services. This is a technical point which, if adopted, will protect the privacy of patients from over-efficient computers and encourage the utilization of highly personal, but also highly important services. We also recommend that individual health cards be issued to all family members above age 13."

-- The Committee and the Congress must be particularly deliberate and unambiguous in its treatment of family planning services in the law. The administering agencies and fiscal intermediaries proposed by the three above-mentioned bills have had "little or no experience with preventive services. They have been dealing with curative services, hospitalization and that kind of service. We believe it cannot be assumed that they will automatically understand the problems and the opportunities associated with the delivery of comprehensive family planning services under an insurance program. In fact, based on our experience with Medicaid, it is reasonable to assume that they will continue to fail to draw the important distinctions between curative and preventive care unless the Congress is precise and direct in the basic legislation."

14. *National Family Planning Forum, Russell H. Richardson, president*

Russell H. Richardson, President of the Forum, explained that the Forum represents organized family planning programs providing services to low and marginal-income women and families. He stated that "if NHI is to eventually supplant categorical project grants for the continuing support of existing family planning services, it must offer patient coverage and financial support which are at least as broad as those available under the present project grant authorities [title v]." He urged the following with regard to an NHI program in order "to ensure the full provisions of voluntary family planning services under that system:"

-- Establish identical curative and preventive benefits for everyone under a mandatory enrollment system assuring continuous benefit coverage regardless of age, income, employment status, or state of residence;

-- Federal administration;

-- Mandate, not merely authorize, the provision of family planning, medical and ancillary social services, drugs and supplies, for all persons without cost-sharing requirements and with guarantees of confidentiality;

-- Specify that certified family planning providers, including public and private clinic facilities, are eligible for reimbursement;

-- Require that such providers be reimbursed at actual cost for services, drugs, and supplies;

-- Designate a Federal agency to oversee certification of family planning clinic services, such as Division of Direct Reimbursement, created by Bureau of Health Insurance to certify providers of ambulatory services under Medicare;

-- Require a Health Resources Board or similar body to assess and revise annually the adequacy, availability, and quality of family planning services; and

-- Establish a development fund to assure the capacity for expansion of family planning services in underserved areas.

Mr. Richardson further noted that "the purpose of an NHI system is to secure the nation's health and, at the same time, to contain costs. We know that family planning services are singularly cost effective. It is, therefore, logical that all financial barriers to utilization of relatively low cost, preventive services, such as family planning, be removed."

In indicating his support for Federal administration of the NHI program, Mr. Richardson described some of the problems encountered by providers of family planning services under current State administration of the Medicaid program and Title IV-A contracts:

These [State Medicaid] programs operate with ineffective and uneven policies regarding certification of providers, have limited payment levels, and maintain inefficient fee-for-service billing methods which require programs to maintain operating reserves from other sources. The opportunity to contract directly with family planning providers under Title IV-A and to cover a broader range of low-income persons has brought mixed results at best. A Planned Parenthood survey revealed that by 1973, only 16 States had signed contracts with family planning providers and

nearly identical findings were produced by a separate survey financed by DHEW. Many Title IV-A contracts contain only vague definitions of services and standards of quality and frequently employ cumbersome patient certification procedures.

15. *David A. Williams, M.D., Laurinburg, N.C.*

Dr. Williams expressed the following objections to national health insurance legislation:

-- "Medical care that is efficient, productive, and effective must be a personal, direct relationship between the doctor and the patient.... The doctor must be free to use his judgment solely in his patient's behalf, and the patient must be confident that he will do so. The responsibility of the patient's well-being must rest entirely between these two people, and they must have the authority to meet the patient's needs. Interposition of any other factor into this equation must be bad medicine. The reason is that responsibility and authority must go together. Government has a bad track record of interfering more than helping, of dictating and controlling."

-- "Nothing in the Federal health programs we now use is encouraging to the contrary, and they are child's play compared to Mills-Kennedy. I should not be expected to support any course which puts me and my patient in such a position. I will be reduced to an automaton if my work is dictated by a cost-accountant, a clerk-typist, an MD administrator who hasn't been a doctor in 25 years, a lay field representative, and a computer terminal.... If I am to be ultimately responsible, both morally and legally, to get the medical job done for my patient, I must have the ultimate authority to do it."

-- "The only way to prevent the deadly intervention of Big Brother between doctor and patient is to have no Federal money involved in the individual relationship. What I mean is that each individual patient call or transaction should not be subjected to administrative scrutiny.... If each transaction must have bureaucratic observation and approval, the system will surely become monolithic and oppressive. Medical resources will be so overloaded at both ends that care will be less available, and at tremendously higher cost."

16. *Steven Jonas, M.D., State University of New York at Stony Brook, N.Y.*

According to Dr. Jonas, the major issues to be faced in fashioning a program of national health insurance in the United States include the following: "will American medical and dental practice be corporatized and, if so, how will that be accomplished, and will the profit-making capability of the private health insurance industry and its degree of administrative control be vastly expanded or will the U.S. follow the example of other capitalist countries and convert its health care industry into a regulated, semi-public utility?"

Dr. Jonas elaborated on these points: In most capitalistic countries, health care industry profits are made only around the fringes, in drugs, hospital supplies, and the operation of proprietary institutions. Private medical and dental practice is permitted, but the industry as a whole is not a source of corporate profits and the whole system is operated like a semi-public utility. In the U.S., on the other hand, corporate profits are made "from the center of the health care industry, the financing system," i.e., the commercial insurance industry. Several NHI bills before the Committee, including the Administration's proposal would "vastly expand the influence, and the profitability of the private health insurance industry" and as a consequence "would probably vastly accelerate the corporation of American medical and dental practice, because of the central role which the private insurance industry, with its huge investment capability and interlocking directorships, plays in the U.S. corporate structure as a whole."

July 1, 1974

1. American Baptist Churches in the USA

Reverend Richard E. Ice stated that the criteria for a national health insurance plan should include:

- Equal access to care for all citizens;
- Freedom of choice of patients to choose their doctors and for physicians to choose the type of practice they wish to engage in;
- "Comprehensive health care, including physical, dental, mental, emotional, and preventive care...."
- A planning system at Federal, State, and local levels to monitor the health system and to recommend needed changes.

Reverend Ice supports the one percent payroll tax on employees under H.R. 22 as reasonable and suggested that the attempt to provide all the premium revenue through payroll and self-employment taxes would be regressive and would hurt small business. He contended that people with moderate incomes and self-employed persons would be hit the hardest.

Reverend Ice noted that none of the proposals "have faced the problem of insuring long-term care for the elderly." Reverend Ice suggested an expansion of the benefits under Medicare with cost sharing by the elderly as a solution.

Mr. Conable questioned Reverend Ice as to the long-term care provisions in the Kennedy/Mills bill, noting that the Reverend's testimony made it appear that he was not aware of those provisions. Reverend Ice said he was informed that the Kennedy/Mills provision had a four-month limitation on long-term care. Mr. Conable referred him to Part D in the Medicare proposal of the bill.

2. American Legion National Veterans Affairs Rehabilitation Commission

Mr. Robert E. Lyngh, Deputy Director, expressed the American Legion's concern that the Veterans' Administration hospital system be protected. Mr. Lyngh suggested that the national health insurance legislation contain two specific provisions:

- that the VA hospital system be recognized as a provider of care exclusively to veterans;
- that veterans be allowed to seek care at VA hospitals without submitting to a means test.

If those two provisions were contained in the Act, the American Legion would concur in allowing reimbursement to the VA from other Federal agencies for non-service connected care rendered by the VA hospital system to veterans. Mr. Lyngh described an example whereby the VA might bill the health insurance trust fund or a carrier for the services to veterans provided under the national health insurance legislation by VA hospitals for non-service connected conditions.

In response to a question from Mr. Ullman, Mr. Lyngh stated that the American Legion supported the administration of national health insurance through private insurance carriers. Mr. Corman pointed out the difficulties of determining whether a disability is service connected, particularly if there has been a long time lapse. This problem tends to create difficulties for the patient in securing access to care, when he has no other potential resource except the VA.

3. Church of the Brethren

Dr. Larry K. Ulrich, Chairman of the Annual Conference Committee on Health and Welfare, accompanied by Ralph Smeltzer, Washington Representative, made the following general statements:

- H. R. 22 comes the closest to being "genuinely comprehensive" and universal.
- The Church is opposed to H. R. 1, H. R. 12684, H. R. 13870, and H. R. 14079.

Dr. Ulrich suggested inclusion of the following changes in the current bills:

- A program to deal with problems of redistribution of personnel and facilities.
- A program for the education of health personnel; recommends H. R. 14357 introduced by Congressman Roy to the Committee.
- Assurance of confidentiality of patients' records.

- A program to educate people on using health resources, including how to use the delivery system when the NHI program is first introduced.
- "Assurances that proposed plans rectify current inequities and bureaucratic injustices and that continuing evaluation occurs to provide a better system than we now have."
- Support and assistance to health professionals in making the necessary modification required by a national health insurance program.

4. Friends Committee on National Legislation

Dr. Malcolm Lee Peterson, accompanied by Harold B. Confer, Legislative Secretary for Human Rights, stated that the Friends Committee "recognizes that the concept of health in a positive sense, as opposed to the concept of disease in a negative sense, should lead the health care system to seek the achievement of the well-being of the whole person, emphasizing the development and maintenance of good health through consumer education, preventive care, and community health action programs." There should be optimum participation of consumers and providers in planning a comprehensive health care system .

Dr. Peterson presented the Committee's comments on the following specific items:

- Advocates the exclusion of copayments.
- Advocates that preferential payments and other incentives be given to prepaid comprehensive health care programs.
- The health system should be pluralistic, but standards should be established pertaining to quality of services, cost containment mechanisms, and equitable distribution of services.
- Direct payments should be made to designated non-physician providers of services.
- Consumers should have a voice in directing the national health insurance system at all levels of the system.
- Financing of the education of future providers should be coordinated with the financing of the provision of services and should equitably distribute the cost of education throughout the delivery system, rather than at the point where education and delivery co-mingle.

5. *National Council of Churches of Christ in the U.S.A.*

Dr. Grover Bagby, accompanied by David M. Ackerman, Associate Director, Washington Office, stated the national health care goals, in the view of the Council, should be:

- Universal coverage;
- Accessibility of health care to everyone;
- Comprehensive benefits, including maintenance and prevention as well as diagnosis and treatment, and including dental and mental services;
- A system organized to provide continuity of care;
- Financing provisions which will assure (a) equal access to services, (b) reasonable costs to providers and adequate compensation to health professionals, and (c) appropriate emphasis on preventive care;
- Attention to quality and cost controls;
- Consumer representation in planning and administration.

Dr. Bagby indicated that of all the current NHI bills, H.R. 22 comes closest to meeting those goals.

Mr. Conable questioned Dr. Bagby on the issue of freedom of choice for consumers in selecting their medical practitioners. Mr. Conable implied that the need to impose professional standards on the system might restrict absolute freedom of choice, e.g., with regard to naturopaths or other practitioners which the Government might not feel "scientifically commendable." Dr. Bagby acknowledged that there should be professional standards to "protect the public from charlatans, from forms of so-called medical services that could be shown to be by our best medical leadership to have a negative effect on the health of the people."

Mr. Waggoner questioned Dr. Bagby regarding his stated testimony on the superior health resource capacities of the U.S. and the accompanying irony that the U.S. is the only western industrialized country without an NHI plan. He asked Dr. Bagby whether the absence of a national health plan might have actually contributed to the development of such resources. Dr. Bagby replied that "one of the reasons we have such a high quality of medical education and medical research establishments that are superior to anyone in the world and the best trained physicians as a whole, is because for a period of time, we have had a very heavy investment of Federal funds in this activity, tremendous investments, so we have in a sense, a national establishment in these areas."

In response to a question from Mr. Waggoner as to how the Council of Churches would advocate financing a health system, Dr. Bagby said the approach set forth in H.R. 22 would appear acceptable. Dr. Bagby later acknowledged that the country probably could not afford a plan along the lines of H.R. 22 at this time, but that such a program would have to be phased in over time.

6. *Network (an organization of Sisters, Priests, and laypeople concerned with social justice in legislation)*

Sister Carol Coston, O.P., Executive Director of NETWORK, accompanied by Sister Mary Rae Waller, O.P., stated that there has been a growing consciousness among NETWORK members that:

- Access to health care should be a right for all;
- Program should include prevention as part of comprehensive care;
- Deductibles and copayments at the time care is needed should be eliminated;
- Consumer participation is necessary.

Sister Carol stated that NETWORK supports H.R. 22.

7. *United Church of Christ, United Church Board for Homeland Ministries*

Leroy H. Jones, Chairman of the Health Advisory Committee of the United Church Board, accompanied by Frederick Hoffman, Washington associate, stated that of the following four bills--H.R. 1, H.R. 12684, H.R. 14079, and H.R. 13870, only the last-named represents a serious step in the right direction. Mr. Jones made the following suggested improvements in H.R. 13870:

- Inclusion of preventive services for persons of all ages, not just children to age 13;
- Elimination of deductibles;
- More comprehensive coverage;
- Unification and coordination of health system and elimination of separate systems for the military and their families, veterans, older persons, etc.;
- Lack of universality (due to requirement of contributions) should be corrected;

- Need for consumer input at all levels and particularly in quality of care reviews.
- Inclusion of a National Quality Control Commission, similar to the one proposed in H.R. 22.
- Increased funding of the Health Resources Board.

Mr. Jones also directed part of his testimony to reasons why H.R. 14079 should not be passed and the pitfalls associated with a purely catastrophic approach to health insurance.

8. Public Citizen Health Research Group

Ralph Nader, accompanied by Dr. Sidney Wolfe, Director, and Robert McGarrah, Attorney, made the following observations about the health bills being considered:

- None of the bills, with the possible exception of H.R. 22, sufficiently emphasizes preventive services.
- All of the bills perpetuate the existing inefficiencies and distortions in the present system of health care.
- The bills do not deal with the problem of physician redistribution or means to produce more "preventive family practice" physicians.
- Quality controls should include national standards and public disclosure of performance of all hospitals and doctors.
- Private health insurers should be excluded from participation in a national health insurance program.
- Mr. Nader stated, in his opinion, Congress should not pass a bill this year but should wait until next year to pass a more extensive bill.
- The financing system should be progressive.
- Consumers must have a majority role through local, State, and regional governing agencies whose activities and data are open to the public.
- The development of cooperative prepaid health institutions "must be given first priority."

Mr. Brotzman asked what kind of progressive taxation Mr. Nader recommended. Mr. Nader said it would be a progressive payroll tax, structured in such a way as to increase the maximum income limits, increase percentages taxed as income increases, and tax unearned income.

Mr. Pettis asked how licensure should be handled and what the role of the States should be. Dr. Wolfe responded that the Federal government should establish licensing standards which the States would use, or improve upon.

Mr. Duncan asked how more doctors of family medicine can be produced and how doctors can be encouraged to practice in rural communities. Mr. Nader replied that doctors should be required to serve two to three years in underserved areas in return for taxpayer support.

Dr. Wolfe also added that physicians should receive more exposure outside the hospital during their training.

July 2, 1974

1. *First Church of Christ, Scientist, Christian Science Committee on Publication*

H. Dickinson Rathbun, Manager of the Washington, D.C. office, accompanied by David Williams, presented the belief of Christian Scientists that "any national health insurance program should allow nursing and institutional services for Christian Scientists as parallel as possible to those offered to citizens who rely on medical treatment when they are ill." Mr. Rathbun indicated that Christian Science sanatorium benefits and visiting nurse services should be offered on a parallel basis with hospital, skilled nursing facility, and home health service benefits. He noted that direct payments to Christian Science practitioners would not be desirable under an NHI program administered by the government but that such services could be included under an employer-employee plan administered by private carriers. He also expressed the hope that criteria for handling Christian Science benefits would, as under Medicare, be designed through HEW, whose regulations pertaining to such benefits under Medicare have been satisfactory.

2. *Lutheran Council in the United States of America*

Dr. Robert E. Van Deusen, Director of the Office of Public Affairs and Government Relations, accompanied by Dr. Byron L. Schmid, Director of Social Security and Planning, and Dr. Norman R. Kurtz, of Brandeis University, explained that the Council represents the American Lutheran Church, the Lutheran Church in America, and the Lutheran Church--Missouri Synod. Dr. Schmid summarized for the Committee the written testimony of the Council as follows:

- Basic health care must be recognized as a right of all citizens rather than a privilege.
- Support for a program of universal, legally mandated, continuous coverage not subject to interruptions from changing employment or other causes.
- Deductibles, coinsurance, health insurance premiums limit accessibility of health care, and thus should be avoided.
- NHI program should promote integrated system of health services, including HMO's, ambulatory centers, neighborhood health centers, etc.

- Benefits should be comprehensive and include health education, full range of preventive diagnostic treatment, and rehabilitative services.
- Program should be accountable to the public with consumer representation at all levels, and built in standards for licensure and monitoring of cost and quality of services.
- General revenue and payroll tax sources for financing do help distribute the financial burden over the entire population; private insurance alone is not adequate for this task.
- National, regional, state and sub-state level planning bodies should study health care needs on a continuing basis and recommend policy and legislative action.
- H. R. 22 comes closest to embodying Council's policy goals, with H. R. 13870 second best; Mills/Kennedy bill weak, however, in its cost control provisions.
- Administration, Ullman, and Medicrodit bills inadequate because of voluntary nature of plans, extensive reliance on private health insurance, sizeable cost-sharing features, weak cost control mechanisms.
- Re Long/Ribicoff bill-- "greatest problem is the limitation to catastrophic insurance."

Mr. Conable asked the witnesses whether they had considered the element of cost involved in the potential loss of freedom of choice for both consumers and doctors under a massive Federal program with health delivery dictated by the Government. Mr. Kurtz responded saying that "under the current system we certainly are not operating under a system which gives us freedom of choice." Dr. Schmid added that "this is a balancing question," and that Congress should design a system which makes choice a viable option.

Mr. Duncan questioned the witnesses concerning the future of the Lutheran hospitals "if the Government takes over all the medical care of all the people." Mr. Kurtz felt that the Council's concern was primarily with legislation good for the national health in spite of its possible infringement on the viability of Lutheran hospitals.

3. Panel Presentation by United States Catholic Conference, Catholic Hospital Association, and National Conference of Catholic Charities

Separate statements were presented by a panel consisting of: Sister Virginia Schwager, S. P., Director, Division of Health Affairs, United States Catholic Conference; Sister Mary Maurita Sengelaub, R. S. M., President, Catholic Hospital Association; and Rt. Rev. Monsignor Lawrence J. Corcoran, Executive Director, National Conference of Catholic Charities.

Sister Virginia stressed that "the right to life clearly implies the right to health care." She stated that the NHI program should provide universal coverage for all U.S. citizens, resident aliens, and aliens admitted for employment, and that the mandated benefits package should include the following: preventive services; all physician services; all inpatient, outpatient and medical services; all catastrophic illnesses; all prescription drugs; post-hospital extended care, nursing home care, medical home health services; rehabilitation services; care for the developmentally disabled; dental care including orthodontia; therapeutic devices, prosthetic devices, including hearing aids and eyeglasses; health-oriented social services; mental health services; and necessary medical transportation. Sister Virginia further noted that automatic cutoff limits on mental health services, such as a 30-day limit, "should be discouraged in favor of an emphasis on quality control and peer review," and that services of certified mental health professionals in addition to psychiatrists should be included.

Sister Mary Maurita advocated on behalf of the Catholic Hospital Association financing of the NHI program from the broadest base possible, using a mix of payroll tax, tax on self-employed income, and general revenues, with no tax assessment made on income from public assistance, SSI, social security, unemployment or workmen's compensation. She also urged the elimination of any deductible or coinsurance provisions or means tests. Sister Mary Maurita also recommended State and local government administration of the program under Federal guidelines, with State-administered rate setting commissions and comprehensive health planning. A State Health Commission within each State should coordinate the planning, rate setting, and reimbursement functions. The role for insurance carriers would be that of fiscal intermediaries, supplemental insurance carriers, and developers and administrators of HMO's, with these functions performed on a prospectively determined, reasonable cost basis. Sister Mary Maurita also noted that the CHA endorses individual professional audit reviews as a supplement to institutional quality review programs.

Monsignor Corcoran expressed support for the basic concept of long-term care in the Mills/Kennedy bill but suggested certain modifications, as follows:

- Long term care provisions should be covered for everyone under the NHI program, on a non-contributory basis, and mandatory nationwide.
- Medicaid should be phased out only as new long-term care provisions are phased-in.
- Prospective reimbursement for providers of institutional care on cost-related basis for actual care rendered rather than reimbursement based on the levels of care.

Monsignor Corcoran also stressed the role of health consumers and need for mandated consumer participation in determination and review of policy, in planning agencies, on boards of carriers and intermediaries, and in Federal agencies responsible for administering the program. He also urged provision for appropriate appeal mechanisms and procedures for consumers, endorsed the concept of consumer participation on governing boards of long-term care centers, as provided in H.R. 13870, and suggested a specific definition of the term "consumer."

Sister Virginia devoted part of the remainder of the testimony to a statement of the Church's opposition to any program that includes abortion as a method of family planning.

Following the testimony, Mr. Karth asked Sister Virginia which of the bills now before the Committee comes closest to what was proposed in the Panel's testimony. Sister Virginia replied that "no one bill provides a total or practical solution to the inadequacies we see in our present health system and we were attempting to take what we consider the best out of the four or five major bills to present to you today."

4. *United Presbyterian Church*

James McDaniel, Coordinator of the Unit on Health and Human Development, Program Agency, United Presbyterian Church in the U.S.A., enunciated several main principles which the Church feels should be embodied in any NHI program and noted that of the 3 bills under Committee consideration, "it would appear that H.R. 13870 most embodies the concerns expressed by the 183rd General Assembly of the United Presbyterian Church." However, Mr. McDaniel criticized H.R. 13870 for several features which work against "a basic commitment to make health care available to all people in this country without regard to their ability to pay:"

- Lack of universality;
- Limitations on access to care resulting from deductibles and coinsurance;

- Limitation of preventive services, dental, eye, and ear care to only those under 13;
- Limited tools and resources available to Health Resources Board to correct maldistribution and personnel shortages.

With regard to the abortion issue, Mr. McDaniel stated that "we believe individuals and society itself will be best served by safeguarding the legal option of abortion according to the judicial decision of the Supreme Court."

5. American Dietetic Association

Annie Galbraith, R.D., Member of the Executive Board of the Association, stated that "nutrition services under the supervision of qualified nutrition personnel should be a component of all health and health-related programs and should be designed to reach the total population with priority to such nutritionally vulnerable groups as infants, children and youth in the growing years, women in the child-bearing years, and the older age population." Ms. Galbraith pointed out that Medicare currently does not pay for dietitian services provided as part of home health visits, and that neither the Administration nor Mills/Kennedy bills would correct this, since both adopt the medicare definition of home health services. She estimated that extension of home health benefits to include nutritional care would cost less than \$5 million and would be partially offset in terms of cost by decreased hospital utilization.

Ms. Galbraith endorsed Section 1883 of the title XVIII amendments under H.R. 13870 pertaining to coverage of nutrition services in the home, when certified by a physician. She also recommended that nutritional care be integrated into covered preventive, diagnostic, restorative services, etc. Later, responding to a question from Mr. Ullman, Ms. Galbraith explained that there was a need for "individualized nutritional care planning and dietetic counseling in particular cases where patients may be at high risk." Mr. Ullman pointed out that "one of the problems is that generally nutritional services have been in the field of public health, rather than in health insurance."

6. Hon. Robert J. Lagomarsino, Representative in Congress from the State of California, and Peter Fisher, Santa Barbara, California

Congressman Lagomarsino introduced Mr. Fisher, who is a resident in the Congressman's district. Mr. Fisher presented to the Committee a proposal for paying for health care modelled after a proposal recommended by the British Columbia (Canada) Medical

Association in 1967 in response to a request by the provincial government. Mr. Fisher noted that the British Columbia Medical Plan "is unique in Canada, and possibly in the world, because enrollment by the residents is entirely voluntary while the fee-for-service doctors are solely responsible for controlling utilization and limiting the cost, within the premiums and subsidy set by the government." Mr. Fisher described at some length his proposal for an NHI program based on the B.C. model and noted that Congressmen Lagomarsino and Ketchum have a bill in the office of the Legislative Counsel containing the provisions of the plan he outlined for the Committee. Mr. Fisher explained that the basic assumption underlying his plan was that "all medical care, per se, is delivered by or under the direction of medical doctors. Therefore, it is the doctors' expenses and desired net income that constitute the actual cost of medical care."

July 9, 1974

1. Hon. Charles E. Bennett, a Representative in Congress from the State of Florida

Mr. Bennett offered testimony in support of H.R. 307, a health insurance proposal introduced by Mr. Bennett and similar to the tax credit approach embodied in H.R. 2222 ("Medicredit"). Mr. Bennett pointed out that under the terms of H.R. 307, "low-income Americans under age 65 would receive "full Federally-paid health benefits." Persons with higher incomes would pay "an increasingly larger share of their own routine medical expenses until an outside limit is reached."

2. Hon. Bill Brock, a U.S. Senator from the State of Tennessee

Senator Brock stated that the proper role of Government in a national health insurance program should be "to protect people against those situations with which they cannot deal." He described for the Committee an alternative NHI proposal which he intends to introduce at some future date. The proposal, as outlined, is intended to meet the following criteria: 1) simplicity, so that it is understandable to every citizen, 2) equitable--"all too often, our taxpayers are asked to shoulder a new burden without receiving equal protection," 3) "easily administerable"--to minimize administrative costs, and 4) efficiency. Senator Brock's proposal would amend the Internal Revenue Code in order to allow each citizen a tax credit, or direct refund, to cover 85% of those health care costs which exceed 15% of "modified adjusted gross income."

Mr. Burke asked Senator Brock whether he would recommend reducing the Social Security tax on employers and employees in order to finance the health plan he proposed. Senator Brock acknowledged that the Social Security tax was "burdensome" and "regressive," but he felt that a reduction in Social Security taxes to finance his plan would jeopardize the Social Security system itself.

Mr. Duncan asked whether Senator Brock had any idea of the cost of the proposal. Senator Brock explained that it was difficult at this point to accurately estimate what any one of the current bills might cost, particularly because of the increased utilization that might result from a program. He indicated that his best estimates of cost for his proposal ranged anywhere from a billion dollars to \$8.5 billion and that he sincerely believes it to be "the least expensive bill of any presented, for one reason: it deals only with the problem."

Mr. Duncan asked Senator Brock what would happen to people now receiving Medicaid. Senator Brock stated as follows: "I am not suggesting that we eliminate Medicare and Medicaid. I am suggesting they be continued and that the effect of this program on them be studied to see if the two can be modified so as to pull [them] into this ultimately." Mr. Duncan also wondered whether under the terms of Senator Brock's proposal, people on welfare would also be subject to the 15 percent copayment on medical expenses. Senator Brock noted that these people would be covered for 85 percent of the cost under his proposal and Medicaid would probably cover the remaining 15 percent. He added that "I would like to see the family pay something in every instance.... But if you leave the law as it is, my interpretation of it would be that Medicaid in desperate circumstances could even pick up the 15 percent. But, remember, under my bill all that welfare income, Social Security income, in other words, Government support program is exempted from the categorization of income."

Mr. Corman asked whether there might be a tendency under the Senator's proposal "for the doctor to jack up the bill so that if they lose the 15 percent they will still get their full amount of the fees." Senator Brock denied that there was any incentive for the physician to jack up his fee in that situation. Mr. Corman repeated that he saw nothing in the bill that would discourage such practices. He added that the doctor might have to wait up to a year for the patient to be financially able to pay him. Senator Brock clarified for Mr. Corman that the taxpayer could seek a refund immediately when he incurs catastrophic expenses and that payment would take 30 days.

Mr. Karth queried Senator Brock regarding the apparent lack of incentives in his bill for persons to purchase basic health insurance coverage. Senator Brock stated that he did not believe there to be any impediments in the bill to purchase of such insurance:

As a matter of fact, I think there is more inducement because we allow the family to deduct the purchase of medical insurance as part of their deductible. It is allowed on their tax return. Secondly, most of your medical insurance plans are so-called group plans. They are paid for, in part, in most cases, by employers. It is a good buy for the employee. It is a good labor-management bargaining point.

Mr. Karth also asked Senator Brock to explain how the proposal dove-tails with the negative income tax features. He asked whether the Senator was proposing that the Government refund a poor family spending \$3,000 on medical costs \$2,550 of that \$3,000. Senator Brock responded affirmatively.

3. *Hon. Edward I. Koch, a Representative in Congress from the State of New York*

Mr. Koch stated that as a co-sponsor of H. R. 22, he supports a program of universal comprehensive health insurance for all Americans. He commended H. R. 13870 as the only bill which provides for continuing and expanding the Title V Maternal and Child Health Programs. He cautioned against any potential change in the language on page 14 of the bill which might result in the imposition of a 25 percent coinsurance on preventive health services for mothers and children.

He urged the Committee to consider safeguards in NHI legislation which would protect the right of privacy. He pointed to the lack of protection "which would make certain that the material maintained by the medical data bank into which 700 [insurance] companies today plug is available to the individual on whom the data is collected," and the absence of a procedure "which requires that that data be updated, that that data be expunged when the material is found to be incorrect, no way of controlling that data." He suggested that any NHI legislation contain the following "ten commandments on privacy":

- 1) Permit any person to inspect his own file and have copies made at a reasonable cost to him;
- 2) Permit any person to supplement the information contained in his file;
- 3) Permit the removal of erroneous or irrelevant material and provide that agencies and persons to whom the erroneous or irrelevant material has been transferred, be notified of its removal;
- 4) Prohibit disclosure of information in the file to individuals in the agency or organization other than those who need to examine the file in connection with the performance of their duties;
- 5) Require the maintenance of a record of all persons inspecting such files, their identity and purpose;
- 6) Ensure that information be maintained completely and competently with adequate security safeguards;
- 7) Require that when information is collected from him, the individual must be told if the request is mandatory or voluntary and what penalty or loss of benefit will result for non-compliance;

- 8) Require that those involved with the collection, maintenance, use, or dissemination of medical information operate with clearly defined data access policies, and with adequate data security measures to provide medical confidentiality;
- 9) Prohibit agencies or organizations from requiring individuals to give their social security number for any purpose not related to their social security account or not mandated by Federal statute, and further prohibit the development of any other universal numerical identifier.

Mr. Brotzman asked Mr. Koch if there was some way, in accordance with his commandments for privacy, to assure that the individual's right of access to his file might not result in the individual removing "something that really should be in the file and is truthful, but is something that perhaps he did not want to disclose." Mr. Koch noted that in privacy legislation introduced into the House by himself and Rep. Barry Goldwater, Jr., there is a provision which specifies that "an individual may see his file and then may take exception to matters that appear in that file; but the agency or the private company is not required to accept his definition of what is accurate or not, and there would have to be a mechanism whereby if there were a refusal on the part of the agency or company to delete the information, a mechanism whereby you could appeal that decision."

Mr. Koch also noted that privacy provisions in NHI legislation should distinguish the medical area from every other area, so that in cases where it might not be advisable for the patient to see his own medical record (due to its potentially adverse psychological effect), the patient's doctor would have absolute right to see such medical records if requested by the patient.

4. *Hon. Edward M. Kennedy, a U.S. Senator from the State of Massachusetts*

Senator Kennedy criticized proposals for purely catastrophic health insurance, noting that such approaches offered only "a hollow promise," were inflationary by definition, and did little with regard to the question of quality control.

Senator Kennedy devoted most of his testimony to comparing the Administration bill with that sponsored by the Senator and Chairman Mills. He also noted certain concessions he had made in sponsoring the Senate counterpart of H.R. 13870. Senator Kennedy also elaborated upon the cost control features of H.R. 13870, saying that these features could not be found in the Administration bill.

Following his statement, Senator Kennedy answered numerous questions from Committee members summarized into the following categories:

A. Disadvantages to a purely catastrophic approach

Mr. Pettis asked Senator Kennedy to comment on Senator Ribicoff's previously stated testimony that passage of any comprehensive NHI legislation would be misleading the American people as to the availability of health resources and that it would be dangerous to go beyond the level of benefits embodied in his catastrophic proposal. Senator Kennedy acknowledged that there were some legitimate questions in terms of phasing in the program, but that a purely catastrophic approach "is really an absolute disaster." Referring to the 60-day inpatient deductible and \$2,000 medical deductible under the Long-Ribicoff bill, Senator Kennedy stated the following:

I don't understand, quite frankly, how that is going to really meet what is genuinely recognized as an issue guaranteeing the right...of decent health care for the American people. I am concerned about those people who are being bankrupted because of expenses, but I think that is only a small part of what we are trying to do.

Mr. Karth asked Senator Kennedy if he would be more amenable to a catastrophic program with much lower deductible amounts than those proposed in the Long/Ribicoff bill. Senator Kennedy noted that the deficiencies of the Long/Ribicoff bill were not merely in its high deductible amounts but also in its lack of quality controls, its potentially inflationary effect, and its allocation of health dollars to expensive treatment and facilities, rather than a kind of balanced approach in which preventive care is also provided.

Mr. Burleson asked the Senator whether Congress should enact a catastrophic bill this session if it were not possible to pass the comprehensive bill the Senator favors. Senator Kennedy stated that he would oppose such action, saying he thought that would be "a step backward, in terms of getting the kind of guarantees which I think are terribly important." He later commented that the catastrophic approach fails to meet the economic needs of the people and that "it has taken care of them, so to speak, at the end of the line, rather than looking after people during the earlier parts of their lifetime."

B. Role of private health insurers under the NHI program

Mr. Brotzman asked Senator Kennedy to elaborate upon the role envisioned for the private insurance industry under the terms of H. R. 13870. Senator Kennedy explained that private insurers could serve as intermediaries performing largely administrative tasks as they currently do under the Medicare program. He noted that the bill limits the number of companies to those doing a certain percentage (3 percent) of the health insurance business, "probably 10 or 12 different companies," in contrast to the Administration bill which "would permit competition between...the 1400 different companies that are now providing the health insurance."

Mr. Corman later referred to some problems with the Blue Cross intermediaries in Minnesota. Senator Kennedy noted that the Senate Finance Committee had conducted a detailed study on the role of private insurance companies and their effectiveness in dealing "both from a quality and from a cost saving, and also for the provision of health care standards."

C. Deductibles and coinsurance

Mr. Brotzman asked Senator Kennedy whether he felt deductibles and coinsurance had any effect on overutilization of our hospitals. Senator Kennedy answered that he thought such features do prevent overutilization but for the wrong reasons, since "it keeps people out of the system that may very well be in need of it." He later added that "probably you have to have some minor figure on coinsurance, perhaps, or some deductible, but certainly not enough to keep them away. There has to be a reasonable amount....I do suggest that the kinds of figures that we are talking about even included in our bill [H. R. 13870] go probably too hard to keep people away."

Mr. Corman noted that former HEW Secretary Wilbur Cohen had estimated it would cost about \$3 billion first to monitor the deductible and copayment portion of any NHI program that required them and also to monitor those people who were in the gray borderline areas who might have to pay some but not the full amount because of their income. He asked Senator Kennedy whether he felt that limiting copayments and deductibles would go a long way toward simplifying and minimizing the administrative costs of an NHI program. Senator Kennedy agreed "wholeheartedly."

D. Foreign Medical Graduates

Mr. Pettis noted that the health system currently relies very heavily on foreign medical graduates and that the increased demand under an NHI program might tend to heighten this problem. Senator Kennedy agreed that this was a problem and elaborated upon some of the recommended solutions to this problem now before the Health Subcommittee in the Senate. He stated that 25,000 otherwise qualified Americans are turned down by medical schools each year. He suggested the following with regard to an NHI program:

If it is the judgment of this committee that until we know what we are going to do about foreign medical school graduates, we want to take some time to phase in, then I think it is not an unreasonable compromise. It is not one I advocate, but I think that is vastly preferable to the program of just doing catastrophic.

Senator Kennedy also mentioned that H.R. 13870 contains a health resources provision "to support and expand and elaborate on imaginative and creative ways of delivering health care."

E. Augmenting the Federal Bureaucracy and NHI Administration

Mr. Karth questioned Senator Kennedy regarding a statement made by Senator Ribicoff earlier in the hearings that the "Kennedy/Mills type health care system... would literally shatter the health care system in this country. It would be so overburdensome that it would literally fall by its own sheer weight." Senator Kennedy refuted this statement, adding that "we have another Secretary of HEW that has also considered the bureaucracies on this and feels that with regard to just plain administration that the job can be done." He noted that much time is currently spent by hospitals and physicians "to muddle through various insurance forms," and that the program in H.R. 13870 would "save a lot of administration on that kind of thing and free up medical personnel to do the kinds of things they were trained for."

F. Costs of the program

Mr. Vanik asked Senator Kennedy for an estimate of the total cost of his proposal. Senator Kennedy replied that it would be \$40 billion, with \$8 billion of that figure considered additional Federal revenues and the rest considered money now being spent either in premiums or through private insurance. He further noted that there would be a change in terms of the collection and expenditure system of health monies. He also pointed to the "difference in the premium payments

between the Administration program which I think is really quite, 1) rigid, and 2) regressive, and 3) variable, depending on whether you are a high risk, low risk, whether you are self-employed or not self-employed." He expressed the feeling that the total amount of money and new revenues under both H. R. 13870 and the Administration proposal "would be the same," and that "the actuaries are very, very close with this, both the Administration actuaries and those that drafted ours, within a couple hundred million dollars."

Mr. Vanik also expressed concern with cost control features and "allowing the total cost up to the present time, plus inflationary burdens that have been added":

Doesn't that have the effect of freezing in, in effect, the high cost of health services before the program begins? Because they are off controls now and they are escalating very rapidly. Wouldn't that have the effect of freezing in abnormally high cost and adding to that inflationary trend?

Senator Kennedy yielded on this "to the expertise of this Committee," and that he would accept and welcome the judgment of the Committee "to reduce that total figure or develop another formula."

Mr. Brotzman asked what percentage of total national health expenditures would be private versus public if the Mills/Kennedy approach were adopted. Senator Kennedy indicated it would be roughly 30 percent private and 70 percent public. Mr. Brotzman also asked about the \$8 billion in new Federal revenues. Senator Kennedy explained that the figure for the Administration bill was \$7.5 billion in new Federal money and that the attempt in drafting H. R. 13870 was to arrive at a benefit package with cost identical to the Administration's proposal:

What we have tried to do is model our package in terms of cost identical with the Administration, but to take the essential aspects of S. 3 which are the guarantees of various rights, the elimination of experience rating, for example, the elimination completely of coinsurance and deductibles so far as well-baby care, the reduction of coinsurance and deductibles which we have cut by about 35 percent from the Administration program, from \$450 to \$300, the more progressive features of payment, as was patterned after the S. 3 proposal, paying the premiums rather than the regressive features of the Administration program. We tried to take the budget figure of the Administration and then take the essential aspects of S. 3 and put them together.

5. *Hon. Claude Pepper, a Representative in Congress from the State of Florida*

Mr. Pepper's testimony was directed toward support for H. R. 22. He stated that, "it is better to wait, if we have to wait five years or whatever the number of years, to get a bill like H. R. 22, a comprehensive health insurance program, than it is to start with a program that would take a while to put into effect, a while to experiment with, but which will lead inevitably to the experience of the American people that we are not reaching the goal that we would achieve by having a national health insurance program." He noted that many features associated with the Health Security Act could also be found in the Mills/Kennedy bill but that the latter bill was deficient in its coverage loopholes which would leave certain groups out of the program. He applied similar criticism to the Administration bill, which by its voluntary nature, would stop short of universal coverage, the Ullman bill, which excludes government employees and certain other groups, and the Waggoner bill, which would not help anyone with less than catastrophic expenses.

Mr. Pepper emphasized the importance of disease prevention and health maintenance particularly for children and expectant mothers. He noted that only the Health Security Act provides the kind of comprehensive benefit coverage "essential to the health of any individual." He criticized the Mills/Kennedy, Administration, and other bills which require payment from the beneficiaries in the form of deductibles, coinsurance, etc. He stated that "by incorporating deductible payments of medi-gap insurance schemes into a comprehensive health plan, the system necessarily snowballs into a complex mass of administrative overhead." He noted that the cost-sharing features offered thus far are regressive, "fixed sum deductibles that are relieved only for the most indigent families." He termed deductibles "an entrance fee--the initial payment that secures availability of a health service," but a feature which does nothing to "encourage responsible utilization of services by those who can afford payment."

He stated that H. R. 22 "creates a climate most conducive to effective and consistent cost control because it encourages preventive health care measures." He also praised the bill as the only one which provides for nutrition services for all Americans without requiring a certification of need by a physician, thus encouraging people to obtain such services before "symptoms of malnutrition are present in the patients that require more costly treatment."

6. Hon. Bella S. Abzug, a Representative in Congress from the State of New York

Ms. Abzug emphasized the need for a "fundamental restructuring and reorganization of our health care system." She expressed her support for the Health Security Act as a "necessary minimum," and a "significant first step." Ms. Abzug feels the country "must eventually develop a national system of health care, going well beyond even the most ambitious bills which have yet been submitted to the Congress." She commended the comprehensive, cost-free services which are central features of social policy in Canada and many European nations. She rejected the argument that people are not ready to support and welcome a comprehensive approach such as that embodied in H.R. 22. She presented a list of reasons why she supports this bill and devoted the remainder of her testimony to a description of certain improvements which she feels should be made in the proposal as it currently stands:

- a) Quality control--"PSRO's are a step in the right direction, but they entrust the formation and application of standards of quality to professional groups." Quality control mechanisms in H.R. 22 should be strengthened by 1) including an active role for State and city health departments, utilizing experience in the New York City Department of Health, 2) strengthening the sanctions imposed for failure to adhere to standards, and 3) mandating inclusion of consumer representatives in PSRO's.
- b) Prevention and Health Education--amend H.R. 22, or any bill, to require HMO's to include major preventive and educational components in their programs of work, as a condition of eligibility, in order to relate such factors as housing, environmental conditions, nutrition, schools and drugs to the health needs of their patients.
- c) Non-medical Personnel--strengthen provisions of the bill dealing with paraprofessionals in order to correct the imbalance which now prevails in the health system.
- d) Consumer and Community Role--recommends greater role for consumers in governance and scrutiny of the program and would require full financial disclosure as a condition of reimbursement for all eligible provider organizations.
- e) Family Planning--must specifically allow coverage of all safe, medically acceptable and legal methods of family planning, including contraceptives, voluntary sterilization, vasectomy, and "safe and legal abortion must be available to any woman who finds herself pregnant and for any one of a multitude of reasons does not want to have a child then."

- f) Financing--amend bill to provide that 75 percent of all costs be met from general revenues within 5 years, and 100 percent within 10 years of enactment in order to move away from regressive nature of payroll tax financing.

Mr. Burke asked Ms. Abzug whether she thought it would be possible to get through the Kennedy/Mills bill, as a compromise bill with provisions of the Long/Ribicoff bill, if it were not possible to act on H.R. 22. Ms. Abzug stated that "the catastrophic illness bill is really quite limited. I don't see any reason to get excited about it.... I think that is a waste of good legislative effort, and really it is quite a minimal approach to a problem which might block any meaningful health legislation." With regard to a choice between the Administration and Mills/Kennedy bills, Ms. Abzug felt there was not that much difference, "that the Mills/Kennedy bill attempts to move somewhat further although its impact, I think, is in its continuation of the very significant exploitation by the private health industry, and its demand for coinsurance and deductibles is not that far away from the Administration bill."

7. *Hon. William R. Roy, a Representative in Congress from the State of Kansas*

In his testimony, Dr. Roy stated that "it is unlikely that we can provide all the health care services that [are] scientifically and technologically possible to deliver" and that Government will, therefore, have to make some difficult choices "as to what services we deliver for whom and where we deliver those services." He emphasized that "we are going to have to talk in terms of cost benefits as far as expenditures of health care dollars, something we have never done as physicians, something that I don't think hospitals have ever done, something I don't think any branch of our society has ever done, and something which I don't hear Government doing right at the present time."

In addition to the total cost factor as a barrier to providing all health care services, Dr. Roy noted that a second barrier results from a "gross, overwhelming maldistribution of physicians," both in terms of geography and specialties. He referred to the current health manpower bill being considered in the Interstate and Foreign Commerce Committees as a means to improve this situation. He noted that, with regard to speciality distribution, one of the most critical problems was the declining number of primary care physicians, at present somewhere between 35 and 40 percent of active physicians. Dr. Roy pointed out that "the health maintenance organizations, the British system, almost any organized system of health care, indicate by their placement of physicians that somewhere around 60 percent of physicians should be in the area of primary care."

Dr. Roy also expressed concern that "the very single greatest threat right now to the quality of health care services in this country is [that] inferiorly trained, culturally foreign physicians from medical schools [outside] the United States are being depended upon to deliver a great proportion of health care services." He added that 33 percent of all hospital-based physicians in the U.S. are FMG's and 19 percent of all physicians in the U.S. are FMG's, a number which is increasing at a very rapid rate.

Mr. Burke asked Dr. Roy for his opinion on the need for hospitals to pool their resources and facilities. Dr. Roy indicated that not only is there a need for certification of new health facilities, but also for recertification of existing facilities "in order that duplicating facilities, many of which are under-utilized to the point of being inefficient, can be combined not only to save dollars but to provide better health care."

Mr. Corman asked Dr. Roy for his assessment of the necessity for copayments for covered services under an NHI plan. Dr. Roy stated that "deductibles and coinsurance at least are necessary in order to hold the total price of the program down." He refuted the contention of some, however, that such copayments are effective means of curtailing overutilization. Mr. Corman implied ~~from~~ Dr. Roy's statement that copayments aren't "going to affect the total number of dollars we have to put into health care," but would just affect "which pocket they come out of." Dr. Roy agreed but noted that "which pocket these dollars come out of is of extreme importance." He further noted his own personal bias in favor of spending "10 percent, 12 percent, maybe even 15 percent of the gross national product for health care services, because I happen to think it is that important."

Mr. Corman also expressed his concern with earlier testimony from former HEW Secretary Wilbur Cohen that administration of the copayment features of any NHI program would cost \$3 billion, and that seemed like a waste of money. Dr. Roy offered his conclusion that "copayments probably don't work," but that deductibles and coinsurance can work:

Again, there will be some administrative cost, but I don't think the administrative costs are prohibitive because I feel that perhaps the health card as suggested by the Administration or the present sophistication of computer science makes it possible for deductibles and coinsurance to be handled.

Mr. Conable asked Dr. Roy why there is such a low percentage of physicians in the area of primary care. Dr. Roy stated that "our medical schools have encouraged physicians to go into specialties." Mr. Conable then asked whether Government should force "people to go into other areas of practice than what they want to do." Dr. Roy answered affirmatively, adding that he saw "no reason why they should not go into [a] speciality on a competitive basis," as has happened in the past.

Mr. Conable inquired about Dr. Roy's feeling with regard to financing of an NHI program. Dr. Roy replied that he favored third-party payment and that he was not "anxious at this time to go on record as favoring Governmental payment for all or nearly all health care services."

Mr. Duncan asked Dr. Roy whether he considered foreign countries to have a system of medicine superior to that in the U.S. Dr. Roy indicated that "there are a number of countries, at least one country that I can think of, that is probably getting more services for more people for the dollars spent than we are getting here in the United States":

I do believe that for all of its faults, that the English system is providing more health care to more people at lesser cost than most systems in the world. The problem of the English system is the problem I have been pointing to, that is, there are not enough pounds in the English system.

Mr. Brotzman asked Dr. Roy whether he had any feeling with regard to compromise legislation along the lines of the Long/Ribicoff bill if a comprehensive measure could not be passed in this Congress. Dr. Roy replied that he felt it would be "unwise to go the Long/Ribicoff route at this time" for the following reasons: 1) it would draw all the monies for health care services to the wrong end of the spectrum, i.e. exotic and expensive procedures rather than primary care, and 2) it would delay a comprehensive program which is in the best interests of the people.

SUMMARIES OF MATERIAL SUBMITTED FOR THE RECORD

[Page references are to pages in the printed hearings]

1. Statement of Hon. Marvin Mandel, Governor, State of Maryland ... pg.3537

Cautions against possible administrative overload of the Federal Government resulting from difficulties in implementing massive national health insurance program at the present time.

Cautions against passage of such legislation without appropriate provisions to encourage development and equitable distribution of health manpower.

Warns against possibility of errors in cost data on various bills.

Recommends that proposal include, as a bare minimum, catastrophic insurance for all Americans.

Supports long-term care provisions in H.R. 13870.

2. Analysis of H.R. 13870, the Comprehensive National Health Insurance Act of 1974, by Matthew Tayback, Sc. D, State Director on Aging, State of Maryland pg.3540

Presents analysis of long-term care provisions of H.R. 13870 and financial implications of this program for government of State of Maryland:

Supports provisions for State-level agencies and requirement for integration of medical and social services.

Endorses prospective reimbursement mechanisms but points to ambiguity of sec. 1890 (c) (1) and its potentially inflationary effect.

Commends such features as centralized medical records, role for consumers in policy-setting, accessibility as criterion for location of centers, matching formula for support of centers, requirement that centers publicize their existence and functions.

Commends the range of benefits provided in bill but also recommends inclusion of transportation in certain circumstances..

Expresses regret that coverage under long-term care program is not mandatory.

Suggests joint Federal/State sharing in premium payments for low-income persons eligible for long-term care program, and proposes that one-time enrollment be continued.

3. Statement of Hon. Malcolm Wilson, Governor, State of New York .. pg. 3543.

Expresses support for a national health insurance program with a federal role in the financing of health care.

Urges Congress to adopt a realistic program which recognizes the following:

- that national health insurance will cause health care expenditures to rise;
- that national health insurance financing will have an impact on the economic viability of employees across the nation;
- that recent changes in the birthrate make it precarious to develop a financing framework based solely upon a payroll tax system;
- that States and localities should be given a substantial role in the planning, development and regulation of the nation's health care system.

Discusses specific policy issues which are of concern to New York State:

- Uniform nation-wide eligibility based on a tax or tax-related system with options to obtain private coverage;
- Comprehensive benefit package, if not initially, then as an ultimate goal, with income-related deductibles and cost-sharing;
- Special provisions for financing long-term care;
- Controls and incentives on the delivery system, with prospective reimbursement systems developed on a state-by-state basis with a major role for States in the development and administration of such systems;
- A progressive financing mechanism which does not "arbitrarily require a reallocation of expenditures between employers and employees,";
- A role for States in the development of rate and regulations and incentives for development of more efficient medical care systems, but not in the administration of the collection or distribution system for NHI financing;
- Program should be designed to provide for needed manpower and facilities and improved organization of services.

4. Communication from Hon. Philip W. Noel, Governor, State of Rhode Island and Providence Plantations pg. 3547.

Expresses the following reservations about the Mills/Kennedy bill:

- Makes no provision for federal matching for certain residual services under Medicaid;
- May impose serious financial hardships if limitations are placed on long-term care services to the present Medicaid population now in the State's chronic disease hospitals;
- May result in serious budgetary consequences for states with liberal Medicaid programs if limits are imposed on stays in nursing and intermediate care facilities;
- May no longer provide federal matching funds for care of certain patients presently financed under Medicaid in intermediate care facilities and public hospitals, due to change in eligibility requirements.

5. Statement of Hon. Benjamin S. Rosenthal, a Representative in Congress from the State of New York pg. 3547.

Expresses support for H.R. 22, the Health Security Act, and describes shortcomings of Administration Plan and Mills/Kennedy bill.

6. Statement of Hon. James T. Broyhill, a Representative in Congress from the State of North Carolina pg. 3549.

Expresses support for the Administration plan, as embodied in H.R. 13968.

7. Statement of Hon. Edward J. Patten, a Representative in Congress from the State of New Jersey pg. 3551.

Urges support for the Mills/Kennedy proposal.

8. Communication from the Hon. Patsy T. Mink, a Representative in Congress from the State of Hawaii pg. 3552.

Urges the Committee to include psychologists as primary providers of care under any national health insurance legislation.

9. Statement of Hon. Wilmer (Vinegar Bend) Mizell, a Representative from the State of North Carolina pg. 3553.

Expresses support for H.R. 2226, the "medicredit" proposal.

10. Statement of Hon. William S. Cohen, a Representative in Congress from the State of Maine pg. 3554.

Voices concern over the protection of the rights of patients, especially those in long-term care facilities.

Describes for the Committee a bill, H.R. 11759, which would provide a Nursing Home Patients' Bill of Rights designed to guarantee the patients' civil and religious liberties and to offer protection against inferior medical care.

Urges the Committee to incorporate the provisions of H.R. 11759 in any national health insurance bill reported to the House or to act separately on it in order to make its provisions applicable to Medicare and Medicaid patients.

11. Copy of H.R. 11759, introduced 12/4/73, by Representative William S. Cohen, pertaining to the development of standards relating to rights of patients in certain medical facilities pg. 3557.

12. Letter submitted by the Hon. Leo J. Ryan, a Representative in Congress from the State of California, from a constituent, Stanley Berkowitz, MD, San Mateo, California pg. 3561.

Makes several suggestions regarding controls over the cost and quality of medical care as follows: 1) establishment of Cost

Control Councils, 2) requirements for preoperative consultations for surgical procedures, 3) setting finite levels on money allocated to elective surgery, 4) performance of peer review by a rotating group of specialists, 5) negotiating state-wide fee schedules with allowances for specialty and practice in specific underserved areas, 6) forced arbitration of malpractice claims up to certain plea levels, and 7) providing strict regulations for removal of licensure of physicians who abuse the system or are guilty of malpractice or fraud.

13. Material submitted by Hon. Ed Jones, a Representative in Congress from the State of Tennessee, including a reprint of a five-part series on health care written for the Dyersburg, Tennessee, State Gazette, by a constituent Mary O. Boyd pg. 3567.

Describes many of the problems affecting the health system in this country and the experiences of specific individuals in Dyer County, Tennessee, who have encountered difficulty in obtaining and financing adequate medical services.

14. Letter submitted by Stuart Symington, a Senator in Congress from the State of Missouri, from a constituent, James H. Garner, Jr., MD, Shawnee Mission, Kansas pg. 3575.

Notes that, unlike hospitals, many physicians continue to provide medical care at no cost to patients who are unable to pay.

15. Letter submitted by Hon. John A. Blatnik, a Representative in Congress from the State of Minnesota, from Harold B. Leppink, MD, Executive Officer, St. Louis County Health Department, Duluth, Minnesota pg. 3576.

Offers the following comments on the home care coverage provisions of H.R. 13870:

- 100 visit limit is too low;
- Bill should clearly spell out intent of Congress to provide a broad spectrum of home care, including preventive and supportive services, so as to avoid possibility of overly conservative administrative interpretation as is case under Medicare;
- Deductible and coinsurance amounts are much too high;
- Questions provisions for utilizing insurers as fiscal intermediaries.

16. Letter submitted by Hon. John A. Blatnik, a Representative in Congress from the State of Minnesota, from Evelyn L. Jernberg, Nursing Director, St. Louis County Health Department, Duluth, Minnesotapg. 3577.

Voices certain reservations regarding home health care under H.R. 13870 and questions meaning of "long-term care center" and "payment for minimum period of home confinement".

17. Letter submitted by Hon. Charles A. Vanik, a Representative in Congress from the State of Ohio, from Sarah M. Wilder, Coordinator and Assistant Professor of Dietetic Technology, Cuyahoga Community College, Cleveland, Ohio pg. 3578.

Recommends coverage of direct nutrition services provided by registered Dietetic Technicians reimbursed on a direct payment of fee-for-service basis.

18. Letter submitted by Hon. Charles A. Vanik, a Representative in Congress from the State of Ohio, from Mrs. Frank M. Barry, Director, Health Planning and Development Commission, Federation for Community Planning, Cleveland, Ohio pg. 3580.

Believes that there is no significant aspect of H.R. 13870 which would be inconsistent with the position on national health insurance endorsed by the Federation. Expresses personal sentiment in support of the bill.

19. Letter submitted by Hon. Charles A. Vanik, a Representative in Congress from the State of Ohio, from Irvin J. Gitlin, Vice President, Public and Government Relations, Greater Cleveland Hospital Association, Cleveland, Ohio pg. 3581.

Expresses certain apprehensions felt by hospital administrators with regard to potential impact of NHI.

20. Material submitted by Hon. Charles A. Vanik, a Representative in Congress from the State of Ohio, including copies of testimony presented at a hearing in Cleveland, Ohio, May 10, 1974, before the Northeast Ohio Congressional Council, by the following individuals pg. 3582.

- A) Statement of David A. Rodgers, Ph.D, Psychologist and Staff Member, Cleveland Clinic pg. 3582.

Feels that any national health insurance bill which fails to recognize psychologists as independent providers is inadequate.

Cites statistical and other data in support of inclusion of psychologists on an equal basis with psychiatrists in providing mental health services.

- B) Statement of Howard Bram, Director, Menorah Park Home, Cleveland, Ohio pg. 3584.

Generally supports long-term care provisions in Kennedy/Mills bill, but opposes \$6 monthly premium for such program and recommends financing of long-term care program through payroll tax method established for general program.

Questions suitability of establishing area centers to administer long-term care under the Mills/Kennedy bill and recommends that eligibility determinations be made by existing non-profit social services agencies.

- C) Reaction of Howard Bram to book entitled "Tender Loving Greed" as authored by Mary Adelaide Mendelson pg. 3585.

Takes issue with many of the points raised by Mrs. Mendelson in her book.

- D) Statement of Marjorie Herring, Legislation Chairman, Cleveland District of Ohio Occupational Therapy Association, Inc. pg. 3586.

Offers personal feeling that none of the national health insurance bills have built in adequate mechanisms to protect the rights of patients, professionals, institutions, or the third party payor.

Points to confusion in interpretation of term "rehabilitation" under Medicare.

Advises against tying eligibility for NHI benefits to paid employment.

- E) Statement of Amasa B. Ford, MD, Case Western Reserve University, School of Medicine pg. 3588.

Supports provisions of Mills/Kennedy bill, in particular its proposed creation of a Health Resources Development Board.

Suggests the following changes in the bill:

--At least one member of the Resources Board should be chosen from the field of medical and health science education;

--At least one member of the National Health Insurance Resources Advisory Council should also be from this field.

Also urges continuation of general Federal institutional support of medical schools (by capitation) and medical students (loans, scholarships, etc.) with such support to be tied to a national set of priorities developed by the Resources Board.

- F) Statement of Philip Chelnick, Chairman of the Senior Adult House Council of the Jewish Community Center of Cleveland pg. 3589.

Cautions against use of private insurers as intermediaries under the Mills/Kennedy bill and questions adequacy of cost and quality controls in that bill.

- G) Statement of the Social Policy and Action Division of the Cleveland Chapter of the National Association of Social Workers, prepared by Ruth Ellen Lindenberg and presented by Belle Likover pg. 3590.

Reaffirms the basic thrust of the Mills/Kennedy approach with the following reservations:

--Inadequacy of coverage of the working poor and lower middle class;

--Absence of provisions for stringent cost controls, water tight regulations, and severe penalties for violations;

- Possibility of physicians and providers (rather than consumers) dominating Health Insurance Benefits Advisory Council and the Formulary Committee;
- Premiums for long-term care program is unrealistic;
- Medical social services should be included by name in the various benefit packages and defined separately;
- Payment should be provided for medical social services rendered either through an agency or independent practice;
- Bill should be amended to provide for training of social work manpower.

- H) Position Statement on a National Health Insurance Plan, by the Cleveland Area Chapter NASW Division of Social Policy and Action pg. 3593.

Sets forth guidelines for a national health insurance program as endorsed by the organization.

- I) Statement of Rev. Paul A. Woelf, S.J., of the Cuyahoga County Health Consumers Coalition and the Committee of 100 of the National Health Security Action Council pg. 3593.

Expresses personal support for Kennedy/Griffiths Health Security bill.

21. Statement of Augustus H. Hewlett, Executive Director, Alcohol and Drug Problems Association of North America pg. 3595.

Recommends that alcohol and drug dependency problems be specifically included in national health insurance legislation.

22. Communication from Bernice O. Baum, Executive Director, American Association of Nurse Anesthetists, and copy of Standards for Nurse Anesthesia Practice, as developed by the AANA pg. 3598.

Notes that unlike the services performed by a physician-anesthesiologist, the services of the nurse anesthetist are not included among those services specifically covered under Medicare as "medical and other health services"; urges that the existing wording under Medicare not be used in national health insurance legislation and that existing inequities facing nurse anesthetists under Medicare be removed.

23. Statement of Arlie Schardt, Associate Director, American Civil Liberties Union pg. 3609.

Urges Committee to make explicitly clear that abortions are included among the surgical procedures covered by any national health insurance legislation.

24. Statement of the American Academy of Child Psychiatry pg. 3609.

Supports the concepts of equal coverage for mental illness, particularly for children, with a range of appropriate medical treatment consistent with psychiatric needs. Specifies the direct services, family services, consultative services, and other therapeutic services which should be provided.

25. Letter from Elizabeth S. Sharp, C.N.M., PhD, President of the American College of Nurse-Midwives pg. 3610.

Notes that neither H.R. 13870 nor H.R. 12684 make specific provision for the services of certified nurse-midwives and urges Committee to make specific inclusion of such services as a separate reimbursable category.

26. Communication from Frederick J. Hofmeister, MD, President of the American College of Obstetricians and Gynecologists pg. 3611.

Presents the views of the ACOG that the national health insurance program should...

- Cover complete maternity and periodic health maintenance exams for women, care for the indigent, crisis care, catastrophic obstetric-gynecologic health care;
- Provide appropriate medical care services regardless of the location where provided, or whether they be diagnostic or therapeutic;
- Provide free choice of provider and equal opportunity to competitive delivery systems;
- Provide a method for evaluating benefit structures through a medical services advisory board consisting of practicing physicians;
- Be phased-in, if necessary, because of inadequate funds, facilities, or personnel;
- Include provision for individual participation in payment for health care, including deductibles and coinsurance, but not for maternity care or care for the indigent;
- Allow pluralistic methods of providing health care, with reimbursement for medical services on a fee-for-service basis (within competitive limits) and with no preferential reimbursement to subsidize a specific mechanism of health delivery;
- Provide adequate reimbursement for educational and research programs.

Includes appendix describing in detail the position and interpretations of the College with regard to NHI.

27. Statement of Robert E. Wise, MD, Chairman, Board of Chancellors, and John W. Travis, MD, Chairman, Commission on Medical Services and Insurance, of the American College of Radiology pg. 3616.

Urges the Committee to treat radiologists under any federal health insurance legislation in exactly the same manner as all other physicians, with the same advantages and obligations.

Refers to specific sections of major bills (H.R. 13870, H.R. 12684) wherein the legislative language is acceptable or unacceptable to the ACR and requests that under H.R. 13870, section 2051 (g) (1) specifically designate as covered services the services of radiologists in the several settings as physician consultative services.

Singles out section 228 (e) of H.R. 1 as one which has caused radiologists much difficulty under Medicare and urges substitution of language in Sec. 2051 (a) (3)(4) of H.R. 13870.

28. Statement of John C. Datt, Director, Congressional Relations, American Farm Bureau Federation pg. 3617.

Recommends that a tax credit system be used as the financing mechanism for a national health insurance program, that participation be voluntary, that the private health insurance industry be retained, and that provisions be made for assistance to the indigent and near poor.

29. Letter from Richard S. Ross, MD, President, American Heart Association pg. 3618

Expresses the hope that any national plan for health insurance close those gaps in existing third party payment mechanisms which affect cardiovascular and cerebrovascular disease.

Believes that NHI financing should not interfere with continued, and expanded, funding for biomedical research programs and training of medical personnel.

Recommends that any NHI program include among covered services the following:

- Reimbursement for risk factor screening for high blood pressure and for serum lipid measurement;
- Reimbursement for screening for rheumatic fever and rheumatic heart disease and payment for appropriate antibiotic therapy;
- Reimbursement for physician-ordered patient education services performed by other medical professionals or paraprofessionals;
- Payment for semi-skilled assistance "around the home," and for a wide range of rehabilitative services.

30. Statement of Theodore R. Mann, Chairman, and Joseph B. Robinson, Director, Commission on Law, Social Action and Urban Affairs, American Jewish Congress pg. 3619.

Supports the concept of a national health insurance program which includes in its fundamental provisions:

- Universal coverage with a single benefit standard;
- Elimination of cost sharing provisions;
- Effective cost and quality control;
- Effective consumer participation;
- Equitable financing.

Believes that none of the current NHI bills fully meet the above-mentioned standards, although H.R. 22 comes the closest except with regard to the principle of equitable financing.

31. Statement of Leslie Cheek III, Vice President, Federal Affairs, Government Affairs Department, American Insurance Association pg. 3624.

Urges the Committee to include in NHI legislation specific language making Workmen's Compensation benefits primary to NHI benefits and embodying the concept that mandatory first-party automobile accident insurance be the primary source of indemnity for auto accident injuries.

Further urges that with the exception of social security and Workmen's Compensation, all other benefits, including national health insurance and statutory disability protection, be eliminated as to auto accident-incurred injury or disability or made excess of mandatory first-party no-fault automobile insurance.

Supports recommendations of the Health Insurance Association of America with regard to the substantive aspects of the pending NHI legislation.

32. Letter from Robert J. Anderson, MD, Managing Director, American Lung Association and copy of ALA's Position Regarding a National Health Program pg. 3628.

Emphasizes that coverage of outpatient drugs and home health services are essential if the respiratory disease patient is to be served adequately under a national health insurance program.

Believes that preventive health care is extremely important, especially for children, and that such services should be available in such a way that poor families will not be discouraged from seeking them.

Urges that health education program be incorporated into a national health insurance program wherever this is feasible and productive.

Outlines the specific types of services needed by lung disease patients.

33. Statement of the American Society of Hospital Pharmacists .. pg. 3631.

Reviews selected national health insurance issues which relate to pharmacy practice and prescription drugs.

Recommends that appropriate reference to "pharmaceutical services" should replace, or at least be used in connection with, the term "drugs and biologicals."

Discusses various aspects of the professional services provided by hospital pharmacists.

Proposes certain changes in section 2047 (pertaining to a national health insurance formulary) of H.R. 13870 deemed to be

"consistent with recognized principles of hospital formulary management and modern institutional practice."

Suggests revisions in the area of provider reimbursement to allow a flexible means of compensating pharmacists for their professional services, with consideration given to location, extent of services received by the patient, etc.

34. Statement of Guiding Principles on the Operation of the Hospital Formulary System, approved by the American Hospital Association, American Medical Association, American Pharmaceutical Association, and American Society of Hospital Pharmacists, 1964 pg. 3639.

Defines a hospital formulary (drug) system, and sets forth 12 guiding principles for utilizing such a system; recommends adoption of such a system by hospital medical staffs; presents the American Hospital Formulary Service Classification System.

35. Letter from Alfred W. Bauer, MD, Kirkland, Washington, along with a copy of a pamphlet prepared by Dr. Bauer entitled "National Health Insurance, the Doctor and His Patients." pg. 3642.

Offers 12 guidelines for evaluating national health insurance proposals.

Proposes an alternative to existing bills in the form of a two-tiered national health plan consisting of the National Illness Care Insurance Plan and the Medical Savings Account, based on a design developed in West Germany as an alternative to the existing German medical scheme.

36. Statement of Lester Breslow, MD, on behalf of the Association of Schools of Public Health and the Association of Teachers of Preventive Medicine pg. 3652.

Focuses on the potential value of preventive medical services.

Feels that preventive medical services could be incorporated into national health insurance by establishing "packages" of services to be provided at certain ages for each sex; outlines the kinds of services that would be appropriate in such a package.

37. Statement of Rachel Floersheim Boaz, New York University ... pg. 3654.

Examines the financing provisions of H.R. 12684 and H.R. 13870.
 Concludes that both bills would result in a diversion of
 benefits to economically fortunate persons and away from their
 less well-off counterparts by encouraging an income-induced
 unequal consumption of medical services and therefore, an
 income-induced unequal entitlement to benefits from the program.
 Notes that the policy of direct patient participation in payment
 of medical bills as a means to instill consumer cost-conscious-
 ness is clearly obviated by the tendency to purchase supple-
 mentary insurance to fill the gaps.

38. Communication from the Citizens' Committee for Children of
 New York, Inc. pg. 3662.

States that the following principles are essential for children
 in a national health insurance plan:

- Incentives towards a more rational health delivery system;
- Universal eligibility;
- Full-service benefits for pre-natal care and for all
 children from birth;
- Progressive sources of financing and cost containment;
- Administration by a public agency with strong account-
 ability provisions;
- Provisions for consumer participation at all levels.

Believes that none of the four major bills under consideration
 by Congress meet all of these principles, catastrophic health
 insurance least of all.
 Opposes mandating private health insurance and use of fiscal
 intermediaries.

39. Letter from James D. Everett, Executive Director, Cleveland Hearing
 and Speech Center, Case Western Reserve University, Cleveland,
 Ohio pg. 3665.

Stresses the importance of speech and hearing services as part of
 the totality of health care.
 Urges consideration of including such services under those
 "supportive services" which would be covered under any national
 health insurance plan.

40. Letter from a constituent, Ollie Cobb, of Knoxville, Tennessee, to
 the Hon. John Duncan, a Representative in Congress from the
 State of Tennessee pg. 3666.

Believes regulatory mechanisms should be at Federal level and not
 delegated to the States.
 Suggests that medical students in Tennessee be required to sign
 an indemnity bond, guaranteeing practice within the state for
 at least 6 to 8 years;

Feels doctors should be required to accept assignments under Medicare.

Feels that H.R. 22 is most adequate of those measures thus far proposed.

Encloses copy of article reporting views of State Insurance commissioners with regard to NHI.

41. Statement of the College of American Pathologists pg. 3669.

Supports H.R. 2222 as the most practical approach.

Urges that compensation mechanisms treat all physicians in the same manner without distinctions introduced by regulation relating to P.L. 89-97, the original Medicare law.

Supports the position that all physicians, including hospital-based physicians not on a salary basis, should be reimbursed on a fee-for-service basis.

Recommends that no program payment be made for blood, as would decrease incentives for blood replacement;

Opposes creation of a Health Resource Development Board, as provided in H.R. 13870.

Opposes creation of a Health Resource Development Board, as provided in H.R. 13870

Opposes conversion of Social Security Administration to independent agency status, as provided in H.R. 13870.

42. Statement of Morton Davis, OD, President, College of Optometrists in Vision Development pg. 3671.

Feels that developmental vision care services should be included among covered services under any NHI plan.

Describes the nature of developmental vision problems and the corrective therapy needed.

Details the extent of vision problems among the population.

43. Statement of the Commission on Social Action of Reform Judaism pg. 3678.

Supports the following with regard to an NHI plan:

- Equal access of all citizens to comprehensive health care, including preventive services, physical, dental, mental and emotional fields of practice;
- Professionally established national standards of health service, including national licensure, continuous review, etc.;
- Consumer representation at every level, except for professional licensure boards;
- Increased State and Federal government financial support for enlarging supply of medical manpower and for training and use of paramedical personnel;
- Freedom of choice for both patient and physician;
- Costs to be shared by employers, individuals, and general revenue funds, with public administration, and a variety of reimbursement formulas including incentives to practice in shortage areas.

44. Statement of Alfred Baker Lewis, Chairman, Connecticut Council on Health Security pg. 3679.

Expresses support for the Health Security Act.

Describes problems affecting the existing health care system.

Believes government health insurance would reduce costs of health care.

Presents outline of costs of the Health Security Proposal.

45. Letter from Charles L. Huber, National Director of Legislation, Disabled American Veterans, Washington, D.C. pg. 3683.

Expresses concern as to effect any national health insurance plan might have on the existing Veterans Administration system of hospitals and clinics.

46. Communication from Robert Coulson, Chairman, Public Social Policy Committee, Federation of Protestant Welfare Agencies, Inc., New York pg. 3684.

Presents the Federation's viewpoint that all U.S. residents have a right to good medical care through a program providing the following:

- Coverage of all forms of health care of the same quality and in the same degree for all segments of the population;
- No limitations in the form of deductibles and coinsurance;
- Strict controls on quality and cost accountability;
- Publicly-available fee schedules for all providers;
- Financing through general revenues and an income-related payroll tax;
- Methods for improving availability and delivery of services and adequate funds earmarked for medical research;
- Advisory committees of objective citizens to promote local concern.

47. Statement of Lynn J. Hildebrandt, Durham, North Carolina ... pg. 3685.

Sets forth 8 criteria believed essential to evaluate any NHI proposal.

Believes H.R. 22 comes closest to meeting all those criteria.

Feels Congress may not be able to assure all health needs of all people and should perhaps concentrate on a program of basic benefits, emphasizing primary care, preventive service, health education, nutrition, diagnostic, and health maintenance services.

Strongly opposes the Long-Ribicoff approach.

48. Letter from C. Lowell Harriss, Professor of Economics, Columbia University, New York pg. 3689.

Recommends that all costs of financing an NHI program be clearly visible.

Suggests that any costs required from the employer on behalf of each employee not be hidden but be specifically and clearly itemized as an additional item paid by the company so that workers would get a clearer picture of total employment costs and the expenses of government programs.

49. Statement of Samuel Ingwersen, AIA, Architects and Planners, and the HAPPS Collaborative, Columbus, Ohio pg. 3691.

Feels there has not been sufficient planning or demonstration of plans at all levels of the system, especially at the local institutional level.

Warns that none of the current proposals will provide the necessary sanctions or incentives to improve the planning process at the local institutional level.

Urges that interim activities are needed to encourage local leadership before an NHI program is actually passed.

50. Communication from Frank L. Gentry, Executive Director, Kansas Hospital Association, Topeka, Kansas pg. 3697.

Does not endorse any of the current proposals, but would prefer the concept of H.R. 1, with certain reservations.

Supports an approach embodying gradual implementation.

Favors concept of State controls, with generalized federal guidelines, but opposes total control within a single state agency.

Presents the following principles for consideration in developing an NHI program:

- Process of developing legislation should involve continuous input of both consumers and providers;
- Institutional providers must be reimbursed at a level to meet their financial requirements;
- Joint employer-employee financing with Federal guidelines establishing minimum scope and benefits of insurance coverage;
- Federally-financed catastrophic benefits for all persons;
- Federally-financed premiums for the medically indigent of all ages;
- Federal guidelines for voluntary and governmental certificate of need and rate review mechanisms;
- Avoidance of a single universal system;
- Changes in health delivery and financing should be made in an evolutionary manner;
- Realistic and scientific evaluation of the scope of available resources;
- Federal financial support to innovations and experimentation in health delivery and financing;
- A meaningful partnership between the voluntary and governmental sectors, between providers and consumers, etc.

51. Communication from Ralph M. Atchison, DDS, President, Kansas State Dental Association, Topeka, Kansas pg. 3702.

Believes that any NHI program should cover under its dental benefits only those persons who are medically indigent. Strongly opposes any government program providing comprehensive dental care for all persons, regardless of income.

52. Letter from Sidney Koretz, Bailey's Crossroads, Virginia, and a series of communications between Mr. Koretz and the Hartford Courant, Continental Casualty Company, the New York Times, the Wall Street Journal, and the Honorable George Romney, then-Governor of Michigan pg. 3702.

Feels that "doubtful actuarial projections serve in place of social economics" in determining cost projections for any future NHI program.

Points out the frequent misinterpretation of the Consumer Price Index as a cost-of-living index.

53. Statement of Charles J. Kelley, Immediate Past President, Massachusetts Federation of Nursing Homes pg. 3711.

Commends the Mills/Kennedy approach for its attention to the problems of long term care.

Warns against adoption of the Medicare disability standards since this provision has the same effect of destituting a person as does old age under Medicaid."

Fears that if Medicaid is disbanded after passage of an NHI program, there will be no residual program to assist the mentally retarded or mentally incompetent.

Feels that the Medicare reimbursement approach imposes expensive and time-consuming auditing and cost finding requirements, resulting in retrospective denial of payments with little incentive for institutions to hold costs down.

Recommends the Public Utility concept for reimbursement as one which recognizes approved capital costs and a fair return on total investment.

54. Statement of Marilyn J. Mehringer, Laura R. Mehringer, Dorothy E. Miller, and Paula M. Hyde, Evansville, Indiana pg. 3712.

Supports the Health Security Act with certain exceptions:

--Financing should be based on a graduated scale of income, rather than a flat one percent tax on all employees' income;

--Should provide for massive dissemination of information to the public about the new program.

55. Letter from Verne R. Kelley, ACSW, Executive Director, and Hanna B. Wston, M.A., Mid-Eastern Iowa Community Mental Health Center pg. 3713.

Expresses concern with protecting privacy and confidentiality of mental health services covered by national health insurance.

Suggests that for mental health services, a special coding system is needed in which the person's identity and his code number could be matched only at the facility where he is being served.

56. Statement on behalf of the National Association of Life Companies, Atlanta, Georgia pg. 3714.

Cites financial experience of member companies in group and individual health insurance business.

States that the Association is the only trade association in the field to support strongly the enactment of catastrophic health insurance, along the lines of the Long-Ribicoff proposal.

Criticizes creation of "administering carriers" under H.R. 5200. Dismisses the Administration bill as over-complicated, over-expensive, and inadequate; feels Mills/Kennedy approach would destroy most of the values of the present system; is particularly critical of H.R. 13870's limitation on number of administering carriers.

Expresses support for Long-Ribicoff bill but would like amended to be financed entirely through general revenues and to eliminate title 3--the voluntary certification program for private insurers.

57. Statement of the National Association of Patients on Hemodialysis and Transplantation, Inc., Great Neck, New York pg. 3716.

Endorses H.R. 13870.

Feels coverage is still needed, however, for paid dialysis aides in the home.

Voices concern regarding possible termination of Medicaid with its residual benefits for transportation to dialysis units.

58. Statement of Gail Rosenberg and Karen Mulhauser, Codirectors, Washington Office, National Abortion Rights Action League pg. 3718.

Recommends that family planning services covered under any NHI program be specifically defined to include abortion procedures and medical follow-ups.

59. Statement of James S. Kemper, Jr., on behalf of the National Council on Alcoholism, Inc. pg. 3719.

Recommends that any national health insurance program contain as minimal coverage the following benefits specifically designed for alcoholics:

- Emergency services--6 days in a medical, para-medical or other specialized treatment setting;
- Inpatient care--14 days in a medical, para-medical or other specialized treatment setting primarily concerned with intensive treatment of physical and mental complications of alcoholism;
- Intermediate care, short term--30 days in a social residential facility designed for intensive treatment of alcoholism as the primary illness;
- Intermediate care, long term--90 days in a residential facility which provides a program of service to assist in social and economic rehabilitation.

60. Letter from Joseph F. Nee, President, the National Foundation-March of Dimes, White Plains, New York pg. 3721.

Feels that any requirement for copayments under any NHI bill will act as a deterrent to the utilization of prenatal and well-baby care, particularly for the poor.

61. Letter from Patricia Butler, Staff Attorney, National Health Law Program, Los Angeles, California..... pg.3723.

Submits copies of analysis of Long-Ribicoff proposal for national health insurance prepared by Patricia Butler of the National Health Law Program and Andreas Schneider of the Health Law Project. Analysis emphasizes the effect of implementation of Long-Ribicoff proposal on poor, including those already receiving some services under Medicaid.

Offers several comments on S. 3286 (Kennedy-Mills) concerning poor people:

- Title XX does not cover part-time employees or persons who do not have Social Security taxes deducted from their wages.
- Individual deductible of \$150 per year is high and discourages early detection and treatment. Same holds for co-payment features.
- Income as defined in section 2033(d) does not include AFDC or SSI payments. Discriminates against low-income persons depending on their source of income.
- Drug benefits are very limited, as are mental health services. Coverage of family planning services should be explicit. Requirement that nursing home services are covered as "extended care services" only after a hospital stay is severe restriction and only partially remedied by supplemental Medicare plan. Title XX does not cover many services currently available under state Medicaid programs. Repeals Medicaid completely, but does not offer states the option of a federally-funded means to supplement covered services for poor.
- Provides only minimal consumer participation.
- Does not preempt restrictive state laws which limit formation of comprehensive health care organizations.

62. National Nutrition Consortium, D.M. Hegsted, President..... pg.3811.

Recommends that nutrition services be specified as a covered service under national health insurance.

Recommends that each subscriber and his family have available nutrition services which encompass primary, preventive, diagnostic, acute inpatient care, inpatient and outpatient care and rehabilitation for chronic and disabling conditions.

Supports premise that future health care legislation should stipulate dietary counseling services as an eligible service for third party payment.

63. National Para-Transit Association, Vincent A. Wolfington, President, Vincent L. Usera, Executive Director..... pg.3814.

Strongly urges that S. 3286 (Kennedy-Mills) provide for the inclusion of non-emergency transportation services under eligible covered services.

64. National Wholesale Druggists' Association, William L. Ford,
Executive Vice-president.....pg.3814.

Deeply disturbed by Secretary Weinberger's proposal for reimbursement of drugs based on "lowest cost generally available," or "Maximum Allowable Cost" (MAC).

Urges reimbursement of drugs based on the landed Product Cost, or retail pharmacy's acquisition cost delivered, plus fair, flexible, and variable dispensing charge.

Strongly opposes reimbursement based on such criteria as "manufacturers' suggested resale price" or "average wholesale price."

Believes that insurance coverage for drugs, as a part of institutional care, is appropriate.

Agrees that program to cover costs of drugs for those to whom the cost would be burdensome and otherwise deprived is appropriate.

Agrees that outpatient drug benefit program for Medicare enrollees is appropriate.

Aside from the circumstances just cited, is fundamentally opposed to public, particularly federally-administered, drug benefit programs.

65. Statement of Mahlon Z. Eubank, Director, Social Insurance Department,
New York Chamber of Commerce and Industry.....pg.3816.

Does not endorse any major health care proposal pending before the Committee on Ways and Means.

Supports a compulsory system which would:

--Provide quality health care to all Americans, regardless of income.

--Restructure the health system.

--Make maximum use of the private sector.

--Make comprehensive national health insurance available at the earliest date.

--Take simultaneous action to improve the organization, delivery, and financing of health care.

Summarizes and presents a detailed policy statement developed by the Chamber containing proposed provisions for a national health insurance act.

66. Statement of James R. Dumpson, Administrator-Commissioner, Human Resources Administration, City of New York.....pg.3828.

Recommends drafting a new national health insurance proposal which would:

- Create universal coverage without premiums.
- Provide a comprehensive uniform range of services including:
 - (i) preventive care specified as a covered service without copayments, (ii) comprehensive mental health services specifically, unlimited hospitalization and outpatient care, (iii) home health services, (iv) nursing homes and intermediate care facilities, (v) at a minimum, dental care for children, (vi) prescription drugs, (vii) transportation.
- Be financed by separate general revenue fund derived from income taxes.
- Be administered by an independent health services administration.
- Recommends payment to physicians' assistants, nurses, and allied health professionals.

Strongly opposes use of additional regressive payroll taxes to finance a national health insurance program.

Opposes cost sharing as a method of raising revenues or limiting access.

Believes H.R. 22 (Griffiths-Corman) comes closest to objectives, but believes the bill does not strongly state that Federal government must assume full responsibility for the establishment of a national health service financed by general revenues and providing universal coverage.

Opposes a health care system based on insurance.

67. Optical Wholesalers Association, Edward A. Dietz, Jr., President..pg.3834.

Lists positions adopted by Association with regard to public and private third party prepaid vision care plans, as follows:

- Believes that a Full Service Laboratory independently owned and operated is best qualified to provide ophthalmic materials to vision care plans.
- Believes that all types of plans covering vision care should be tested under public and private sponsorship.
- Will support and encourage programs that broaden number of people receiving professional vision care. Lists criteria for such programs.
- Will establish and maintain a Standards Review procedure to assure that ANSI Z-80 requirements are adhered to by Association members.
- Will cooperate with sponsors of plans by providing all pertinent information regarding ophthalmic materials and services, and by making Association members and staff available for assistance.
- Will safeguard public interest by seeking to include in all third party prepaid programs a provision that payment for ophthalmic materials be verified by a laboratory invoice.

68. Letter from Larry M. Belmont, Director, Panhandle Health District I, Coeur d'Alene, Idaho..... pg.3835.

Supportive of concept of "in lieu of hospital" and other types of institutional care, being part of any national health insurance proposal.

Would like to see number of home health visits provided as medically necessary, not with specific numerical limitation.

Opposes deductibles and co-insurance for home care.

Agrees that there should be provider guidelines for home health care.

Believes these guidelines should be strong and uniform, nationwide.

Believes that payments for home care should be based on usual and customary charges.

69. Statement of the Penn Mutual Life Insurance Co., Philadelphia, Pennsylvania.....pg.3835.

Believes that a national health insurance program should be primarily funded by premium payments from policies developed, written and serviced by private health insurers.

Believes role of the Federal government in national health insurance should be to:

--Establish policy-making body for developing and implementing national health policy and goals.

--Develop new programs and strengthen existing ones which decrease number of people without effective coverage.

--Mandate only two requirements: (i) high limits of major medical coverage for catastrophic illnesses and (ii) yearly limit on out-of-pocket medical expenses for the insured.

--Phase in mandated national health program benefits over a period of years.

--Encourage alternative approaches to provision of health care.

--Include coverage for drugs, dental and custodial care under Medicare and Medicaid.

--Pay full costs of legislated benefits under Medicare and Medicaid.

--Require development of quality control measures.

--Require legislation to minimize medical cost escalation.

--Increase the supply of health manpower.

--Permit private insurers reasonable returns on investments, to stimulate competition in order to contain insurance costs.

--Avoid indirect methods, such as community rating, in order to prevent discrimination in employment practices.

70. Letter from Matthew Marshall, Jr., M.D., President, Pennsylvania Medical Care Foundation..... pg.3838

Submits for Committee on Ways and Means consideration a statement and supporting materials presented at the Senate Finance Committee hearings on PSRO Program Implementation, May 9, 1974.

Material submitted includes: Dr. Marshall's statement to the Finance Committee and a Blue Cross of Western Pennsylvania report on Utilization Control Activities.

71. Letter from Edward J. Pfeffer, Arcadia, California..... pg.3885

Submits reference from the February 4, 1974, Congressional Record, concerning the health insurance efforts of President Truman.

72. Letter from Sandra J. Regenie, C.N.M., Director of Nurse-Midwifery, Assistant Professor, School of Nursing, Instructor, School of Medicine, the University of North Carolina, Chapel Hill, North Carolina..... pg.3888

Urges that definition of the term "physician extender services," in H.R. 12684 (Administration) and H.R. 13870 (Kennedy-Mills) be amended to read as follows:

"The term, 'physician extender services' means services performed under the supervision of a physician by a physician's assistant, Certified Nurse-Midwife, nurse practitioner...."

73. Letter from Mrs. Ray M.S. Tucker, Chairperson, Religious Coalition for Abortion Rights..... pg.3889

Believes that abortion and full range of fertility control services should be covered under national health insurance.

Urges Committee to reject any prohibition on coverage of abortion services in national health insurance legislation.

74. Statement of Frank Rodio, Jr., Camden County (N.J.) Planning Department..... pg.3890

Recommends enactment of H.R. 12684/S. 2970 (Administration).

75. Letter from Sister Monica Heeran, Administrator, Sacred Heart General Hospital Medical Center, Eugene, Oregon.....;..... pg.3891

Offers following comments relative to H.R. 13461, The Health Care Management Act of 1974:

- Section 105 recognizes need for sharing in full financial requirements of the hospital, which is a significant improvement over the present regulations.
- Section 106 protects the hospital risk related to unanticipated catastrophes or significant changes in patient mix or volume and is a vital provision.
- Section 109 forces providers to convert to the prospective incentive system.
- Section 206 is essential for viable incentive program.
- Section 104 cannot be supported. All purchasers of health care should be required to pay equal amounts for equal service.

76. Statement of the South Carolina Hospital Association..... pg.3892

Sets forth following criteria which should be met by any form of national health insurance enacted:

- Should support existing institutions and individual health care providers and should build on present health care resources.
- Must include method of payment to providers that assures quality of care, adequate growth and sufficient range of services.
- Should contain standardized minimum benefit package, mandatory for all persons. Cost of such coverage for employees earning above minimum income levels should be shared by employers and employee. Costs for those earning below should be provided through governmental assistance program.
- Should utilize existing health insurance carriers. State insurance commissions should determine adequacy of coverage standards and should ensure reasonable ratio of benefits paid to premiums earned. Existing health insurance companies should be permitted to write and offer supplemental insurance coverage.
- Should operate with minimal government controls. Federal government should establish minimal standards for health insurance coverage. Minimal regulation of health providers and insurers should be delegated to states.

77. Letter from E. Clarke Ross, Federal Programs Consultant, United Cerebral Palsy Associations, Inc., New York, N.Y. pg. 3892

Endorses comprehensive maternity and infant care for all Americans with no deductibles and no copayments. All such care should be covered by national health insurance.

Believes comprehensive preventive and treatment services for all infants, children, and adolescents necessary to establish and maintain optimal health.

Believes genetic counseling for families at risk, family planning, prenatal and postnatal care, and comprehensive early childhood diagnosis and intervention must be covered under any national health insurance program.

Well child care and sick child care, including periodic pediatrics and dental services, should be covered. These services should be rendered when necessary on a 24 hour basis.

Believes co-insurance and all deductibles for preventive services to children should be removed.

Firmly believes that national health insurance must cover early identification, intervention, and individual management of handicapped children.

Believes national health insurance must cover the specialized health needs of handicapped adults.

Long-term care must be covered under national health insurance.

Catastrophic insurance covering medical, rehabilitative, and health-related expenses should be universally required with government financing the cost of total premiums for low-income persons and families.

Hold harmless provisions must be required for all covered individuals and all services they presently receive under Medicaid.

Comprehensive list of appliances and assistive devices must be covered under any national health insurance program. Submits recommended list.

Concerned over phraseology of Part A, Section 2011(a) (2)(A) of H.R. 13870 (Kennedy-Mills). Believes language could be interpreted to exclude severely physically involved handicapped individuals from coverage.

78. Letter from Bishop James Armstrong, President, and Bishop Wilbur W.Y. Choy, Vice-President, Board of Church and Society of the United Methodist Church, Washington, D.C. pg.3895

Submits official "Health Care" statement of United Methodist Church, adopted by 1972 General Conference of the denomination. Believes that principles set forth in statement represent some part of standards necessary to establishment of effective and efficient health care system.

Also submits special staff study of seven major national health insurance proposals currently before the Ways and Means Committee.

79. Statement of S.X. Kaplan, President, U.S. Administrators..... pg.3910

Urges inclusion of effective quality assurance mechanism in final legislation. Believes such mechanism must be mandated and implemented.

Believes PSRO lacks strong quality assurance features.

Feels it is basically a cost containment system.

Believes PSRO capability for dealing with quality assurance issues is unknown at this time. However, if objective standards and criteria are issued and effectively implemented, PSRO could be used as a quality assurance mechanism in a national health insurance program.

80. Letter from Ellis A. Wallenberg, Audiologist/Speech Pathologist, Executive Director, Washington Hearing and Speech Society... pg.3913

Hopes national health insurance will cover hearing and speech handicapped individuals.

Believes any comprehensive health insurance act must include provisions for covering purchase and fitting of hearing aids, earmolds, and batteries

Submits written statement of Washington Research Project Action Council. Major points of the statement are as follows:

- Children should be provided with a broad range of preventive services including well and sick care.
- Financial barriers preventing children and expectant mothers from receiving care should be removed.
- In order to be universally accessible, any national health insurance system should include (i) financing of services for individuals facing non-financial obstacles to obtaining health services, (ii) funds for development of health resources, and (iii) a reimbursement system which promotes rational growth and distribution of health resources.

- Financing of a national health insurance program should be borne fairly by beneficiaries, based on income levels.
- National health insurance legislation should include procedural safeguards to protect individual rights.
- Government administrators and consumers should be involved in developing and applying quality care standards.

81. Statement of Barbara A. Weiner, Chicago, Illinois..... pg.3928

Offers following comments on provisions which should be included in a national health insurance bill:

- Supports creation of separate department of Health responsible for all Federal health programs.
- Should contain incentives for physicians and nurses to practice in shortage areas. States that H.R. 22 (Griffiths-Corman) and H.R. 5200 (Burleson-McIntyre) contain best incentive provisions. Points out that H.R. 13870 (Kennedy-Mills) has a disadvantage, because it provides assistance to individuals who practice in a shortage area for five years, which is too long-term a commitment.
- Essential for government to provide program of low-cost student loans. H.R. 5200 (Burleson-McIntyre) provides most comprehensive provisions for student loans and should be adopted in any final legislation.
- H.R. 22 (Griffiths-Corman) contains best provisions for consumer participation and should be adopted in whole.
- Must eliminate Part B Medicare Premium and requirement of three day hospital stay to be eligible for skilled nursing care. Must allow easy access to the skilled nursing facility and provide for longer coverage than 100 to 120 days presently proposed in most pending bills. Coverage in skilled nursing facility should be longer than hospitalization coverage. Ideally, should be no limits on the number of days of hospital or skilled nursing coverage. Provisions of H.R. 13870 (Kennedy-Mills) relating to establishing long-term care centers should be adopted without \$6 monthly premium requirement.
- Should eliminate out-of-pocket expenses.
- Should make participation compulsory.
- Should include an enforceable patient's bill of rights. Submits criteria for a patient's bill of rights.

- Should contain fully comprehensive anti-discrimination clause.
- Should limit FMG's from developing countries and increase positions available in U.S. medical schools.
- Should finance health insurance through income tax system.

82. Letter from Willis Worley, Jr., Willis C. Worley and Sons, Waurika, Oklahoma..... pg.3932

Urges Committee to consider legislation providing equal access to health care for those living in rural America.

Urges Committee to consider broadening scope of health care to include: "the patient will be provided transportation to the nearest appropriate facility with the physician or required specialty available."

83. Letter from Charles Zerfas, M.D., and Phyllis K. Zerfas, M.D., Beech Grove, Indiana..... pg.3932

Defines and discusses the term "health" and role of the Federal government in health. Submits article from the May 3, 1974, Indianapolis Star, entitled, "Congress' Hands Tied on 72 Percent of U.S. Spending, Stennis Says."

