APPENDIX A. REPORT OF THE DOMESTIC COUNCIL
HEALTH POLICY REVIEW GROUP

The Review Group, in the three weeks allotted for its work, has attempted to develop a coherent framework for policy decisions in the field of health. Our report is intended to serve as the basis for a discussion of alternative health policies and program initiatives.

If agreement can be reached by Administration officials on the purposes of a National health policy and the appropriate Federal role, the choice among individual program proposals can proceed in a logical and consistent manner.

December 8, 1970 Final Copy

Part I: The State of American Health Care

Statements about a "crisis" in the provision of health services have reached almost epidemic proportions over the last decade. Fortune Magazine said in a recent feature article "American medicine, the pride of the Nation for many years, stands now on the brink of chaos."

What are the facts?

A. What's Right with American Health Care?

Indices of physical health show an improvement in the general health status:

- The average American life span has increased from 49.2 years in 1900 to 70.2 years in 1968.
- The number of disability days (per person, per year) has decreased from 16.3 days in 1961 to 15.3 days in 1968.

According to a variety of measures, the National effort to improve health has been increasing:

- National expenditures for health care have been growing faster than GNP.
While GNP has grown 72% since 1950, health care spending has increased 164%.

- The number of physicians has increased from 289,000 in 1963 to 338,000 in 1969, up 17%.
- Health insurance coverage has been extended from 72% of persons under 65 in 1962 to 78% in 1970.

These facts indicate that health status is improving and that the Nation has not been grossly negligent in resource development or financing. But there are serious problems.

B. What’s Wrong with American Health Care?

Major problems fall into three categories:

1. Rising Medical Costs
   - While the consumer price index rose from 103.1 in 1960 to 127.7 in 1969, the price index for medical care rose from 108.0 to 155.0—twice as fast.

2. Disparities in Health Status
   - Gross statistics mask important subpopulation differentials.
     - Race. - Infant mortality in 1968 for whites was 19.2 deaths per thousand live births; for all others, 34.5 deaths per thousand live births.
     - Income. - Average disability days for families with $3,000 annual income is 22.8 per person, per year, compared to 13.8 days per person, per year, for families with $10,000 or more annual income.
     - Occupation. - Average disability days among those employed in the mining industry is 14 days per person, per year, compared to 11.4 days per person, per year, for all employed.
     - Geography. - Average disability days for farm families is 17.1 disability days per person, per year, compared to 15.0 for the metropolitan dweller.
     - Sex. - Women have an expected life span several years longer than men.

3. Maldistribution and Improper Utilization of Health Care Resources
   - 37% of the Nation’s counties have two-thirds fewer doctors on a per capita basis than the National average.
   - Recent research indicates that large numbers of unnecessary surgical procedures are performed each year.
   - Chances of successful recovery from the same surgical procedure performed in a teaching hospital are significantly greater than in a non-teaching hospital.

Part II: The Federal Role Today

Repeated statements of concern about the Nation’s health care system have been met with more Federal programs, more Federal spending.

Unfortunately, the process has gone forward without benefit of a guiding policy framework.

A. Types of Federal Intervention
The Federal Government has attempted to intervene at virtually every point in the Nation's health care system. It has sought to influence both the demand and supply of health services. *Demand* has been stimulated by major new financing programs (Medicare and Medicaid). Attempts have been made to stimulate *supply* through manpower training, construction, and research programs.

**B. Scope of the Current Federal Role**

Since 1960, Federal spending for health has risen from $3.5 billion to an estimated $21 billion in 1971!

In 1960, Federal spending for health comprised 13% of National health expenditures. In 1970, an estimated 27% of the total will be from Federal sources, a doubling in ten years.

The shift in responsibility away from the private sector to the Federal Government has been accompanied by a dramatic change in the *composition* of Federal spending.

**TABLE I**

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<th>1960</th>
<th>1971</th>
<th>Change</th>
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<tr>
<td>Federal spending</td>
<td>$3.5 billion</td>
<td>$21 billion</td>
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<tr>
<td>Biomedical research</td>
<td>14%</td>
<td>8%</td>
<td>-6%</td>
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<tr>
<td>Military and VA care</td>
<td>48%</td>
<td>15%</td>
<td>-33%</td>
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<tr>
<td>Health payments for Poor/Aged</td>
<td>13%</td>
<td>63%</td>
<td>+50%</td>
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<tr>
<td>All other</td>
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<td>Total</td>
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**Part III: A National Health Policy for the 70's**

The *Health Review Group* believes that the Administration should adopt a coherent set of principles as the basis for *National health policy* in 1971.

Recognizing the complexity of the subject, the limitations of agreed-upon measures of benefits, and the short time of our assignment, we do not intend this paper to be a definitive or necessarily final product.

But it is a beginning. And it builds on what the Administration has, by many of its actions, identified as the primary purpose and principles of Federal policy in the field of health.

**A. National Goals in Health**

The Review Group recommends the following principles to define the Nation's major goals in health:

*One*, that our first preference should be *prevention*, that is, avoiding the need for medical care. Most Federal programs over the last decade have assumed that health deficiencies are unavoidable. Massive investments have been made to provide more health care. To the extent possible, we should focus
more energy on avoiding health problems and thereby lessen the demand for expensive health services.

Two, that when medical care is required, the Nation should be able to provide it on a basis which assures:

- **Equity**: that all citizens, regardless of their economic position, have available to them a reasonable and basic standard of medical care; and

- **Efficiency**: that we use our health care resources more efficiently in order to stem the recent and unacceptable rate of price inflation for health care services, including using new scientific and technological developments to increase the productivity of the health care industry.

**B. The Federal Role**

The Federal Government should play a leadership and catalytic role in health. It should take the lead in developing a framework for assigning responsibility (Federal, State, local, and private) and in developing and disseminating new ideas.

As far as direct action is concerned, the Federal Government's role should be to undertake those programs and activities which no other institution in our society can perform, or which we can perform so much better that Federal action is warranted.

In developing and carrying out health policies which meet this test, the Federal Government must make maximum use of its existing leverage, derived from the fact that we already expend one dollar for every three that is currently spent in the Nation's health care industry.

The Federal role can be implemented through four principal devices—taxing, spending, regulation, and moral suasion. When an activity has been determined to be totally or partially Federal, it should be evaluated to determine which of these devices will accomplish best the defined program purpose.

Our political challenge in 1971 will be to redirect the growing debate on National health insurance into a proper debate on the entire subject of National health and to demonstrate that those who are concerned only with financing are not dealing with the fundamental problem.

**C. Seven Major Decision Areas**

The sections which follow are based on the health policy principles and concepts of the Federal role outlined above. Although by no means a complete survey of available options, they include the key alternatives presently available for major decisions.

The seven areas are interrelated. The first six relate to improving the supply and efficiency of health care. The seventh is Family Health Insurance. (Our ability to start FHIP in fiscal 1973 or 1974 without grave price inflation will depend in large measure on our success in reforming the supply side of the equation in the next few years).

In reading all seven sections, it is important to keep in mind that they do not represent finished programs; they are discussions of basic strategic and policy alternatives. Once the general directions are determined, each will require careful development, cost-estimating and legislative specifications.
1. New Approaches for Training Medical Manpower

(a) The Problem.—The costs of medical education have soared in recent years. Many medical schools are running into big deficits. Increasingly, they are turning to the Federal Government for short-term emergency “bail out” grants that do not solve the basic problem or stabilize the base of support for medical education.

There is general agreement that some increase in the output of medical manpower is needed, although the rate of increase is in dispute. This applies to physicians and allied health professionals alike.

The present pattern of Federal assistance for medical education is erratic—relying on a mix of formula grants, student scholarships, and special purpose project grants—and shows no clear policy.

Medical education needs reform—in its curriculum, its duration, its attentiveness to research and patient care, and its fiscal base.

(b) The Federal Role.—The Federal responsibility for medical manpower has several bases:

(1) The Nation “values” health and doctors, and the public perceives the support of medical education as a Federal task.

(2) Federal financing plans (e.g., Medicaid, Medicare) have sharply increased the demand for health care; there is some Federal obligation to respond to attendant pressures on supply, particularly of medical manpower.

(3) Health care personnel move across State lines and are a National resource.

(4) To the extent that medical schools are (or should be) engaged in health care and in reform of the delivery system, the Government has an interest in their activities.

At the same time, it must be noted that because physicians generally earn high incomes, the Federal Government should be able to recoup part of its investment in their education.

(c) Options.—The Review Group offers three alternative strategies to govern Federal support of medical education. (Any two or all three approaches could be combined.) The emphasis here is on physicians; but the same fundamental options would guide our approach to other health personnel as well.

(1) Capitation Funding: Under this approach medical schools would receive equal amounts per student enrolled. This is fundamentally a form of “first dollar funding” where schools would know in advance how much they would get from Washington. They would be responsible for finding the rest of their funds—their “last dollar” costs—they themselves.

Under this approach, various types of incentive bonuses should be added that would encourage curriculum reform, new types of teaching methods and institutions, and additional functions (e.g., sponsorship of HMO’s) for the medical schools.

The advantages of this capitation-bonus funding approach are:

—This is the most popular approach in the medical community and
and is advocated by the Carnegie Commission and Association of American Medical Colleges, among others.

- It rewards "output" (number of students) and, if the amount per student is high enough, would encourage expansion.
- It is even handed, treats all schools equally, and would seem to be a rational, long-term basis for Federal assistance.

The disadvantages of the capitation-bonus approach are:
- It takes no account of different costs in various institutions: a major research center, for example, costs more than a "degree mill".
- It assumes no responsibility for the viability of the institutions themselves; some medical schools, for which the amount per student is insufficient, might close.
- The minimum per student rates ($2,000–4,000, per year) at which this plan would be politically viable make it an expensive program.

(2) **Student Aid**: This approach would channel the funds through individual students rather than institutions. It would be possible to use student loans as well as grants and thus recoup a larger share of the Federal investment; repayment might be based on actual earnings (e.g., pay back a percentage of income, rather than a fixed amount).

The advantages of the student aid approach are:
- It is consistent with the Administration's basic higher education policy.
- It could be set up in a way that takes account of student financial need and assigns to the taxpayer a smaller share of the cost of educating wealthy students.
- Although "forgiveness loans" to medical students have worked poorly in the past, with changes, this approach might provide leverage to distribute doctors to places where they are needed (e.g., forgive the loan to a doctor who practices in a low-income area or in a Health Maintenance Organization).

The disadvantages of the student aid approach are:
- It is unstable and unpredictable from the viewpoint of medical schools.
- It creates a tremendous burden of indebtedness for young doctors and might thereby encourage them to go into rich areas or lucrative specialties instead of where they are needed.
- It is politically not very attractive.
- It might discourage low-income students from entering medicine.
- Insofar as it depends on loans rather than grants, it is not a realistic way to finance allied health professionals.

(3) **Negotiated Contracts**: Under this approach, the Government would continue, as under current law, to provide backup funding to medical schools in financial distress. This is a form of "last dollar" funding, but, unlike the present approach, it would require the development of a total institutional plan by each medical school and the negotiation of a contract with the Federal Government to cover the deficit. Included in the contract would be considerations
of enrollment expansion, research, patient care, curriculum reform, etc.

The advantages of the negotiated contract approach are:
- It requires minimum dislocation of current laws and practices.
- It commits the Government to institutional stability.
- It provides incentives for reform, improved management and planning and careful cost accounting.
- It recognizes heterogeneity by forcing separate treatment of each institution.

The disadvantages of the negotiated contract approach are:
- It is extremely complex to administer.
- It involves the Federal Government deeply in the internal affairs of every medical school.
- It implies the redefinition of medical education as a “public utility” subject to Federal regulation and subsidy.
- It might reduce fiscal responsibility for medical education on the part of States, private sources and the students themselves.
- The actual dollar cost of ensuring the viability of every institution might become quite high: it is an “open-ended” Federal program.
- This approach may not result in increased output.

(4) Next Steps: Needed for decision in this area are: (1) an analysis of the relative costs of any one or a combination of the reforms discussed above; specifically, the cost analysis should assess the offsets under existing programs (e.g., research, traineeships) that could result from a new approach, along with a detailed tabulation of the total costs of the new approaches at different levels of expenditure, enrollment and with varied objectives; and (2) a political and programmatic evaluation of how any given reform would affect the structure of medical education (particularly its high dependence on research) and thus how fast it could actually be put into place and with what consequences.

2. Reform of the Medical Care Delivery System—Stimulating the Development of Health Maintenance Organizations (HMO’s)

(a) The Problem.—In addition to the production of medical manpower, there is an urgent need for organizational reform to use the Nation’s medical manpower and other resources more efficiently.

The medical care system is poorly organized to deliver services at reasonable costs. Insurance pays for just about anything that is charged. Neither doctors nor patients have effective incentives to economize.

Beyond the method of payment, the medical system is not oriented to maintain health, but only to provide care once a health crisis has occurred. There are no financial incentives for providers to undertake health maintenance or preventive measures.

(b) The Federal Role.—In March of this year, the Administration proposed amendments to Medicaid and Medicare establishing “Health Maintenance”
as a major basis of our strategy for improving the organization of the Nation's health care system.

Under these amendments, which have passed the House, we would foster the growth of "Health Maintenance Organizations" (HMO's) designed to guarantee their members the provision (not merely the financing) of a wide range of hospital and physician services in exchange for a fixed prepayment fee.

HMO care employs different incentives than the present system. The Health Maintenance Organization agrees upon a fixed per capita payment in advance and then takes responsibility for deciding what services the patient should receive and furnishing those services. By benefitting from "patient well days," not patient sickness, HMO's are motivated to prevent illness, and failing that, to promote prompt and thorough recovery through efficient delivery of services.

The HMO approach is well suited to the concept of trying to limit direct Federal intervention and using our leverage devices to the maximum. Basically, what is involved is a redirection of existing Medicaid and Medicare funds so that there is an incentive to purchase medical services on a prepaid contract basis, rather than piecemeal and after the fact.

(c) Options.—The Administration could propose a financial assistance program to stimulate the development of new HMO's. Organizations which could become HMO's would include existing medical clinics, public general hospitals, medical centers and their teaching hospitals, neighborhood health centers, and a variety of other organizations. The program could include the following major components:

(1) A loan guarantee program.—The risks involved in HMO development and the fact that this is a new venture in health suggests that a major loan guarantee program, for construction initial operating costs, would be appropriate. (Existing loan guarantee programs cover construction costs only). Loan guarantees use substantially less Federal funds than direct Federal loans or grants for a given investment level, and the discipline of having to go to the private capital market would help screen out programs which are unlikely to become financially viable within a reasonable period.

(2) A direct loan program could also be used to provide funds to public HMO's. These loans, intended to provide a substitute for the risk capital of private, profit-making organizations, would cover initial HMO costs during the two-three year period before an HMO becomes self-sustaining. These loans could be limited to HMO's in what are defined as health service scarcity or poverty areas.

(3) A grant program could be provided as well, to subsidize start-up costs and initial operating deficits of HMO's in selected underserved areas.

(d) Next Steps: The encouragement of HMO's could become a major objective of the Department of HEW. The Department should be asked to cost out in detail the various alternative approaches available. This
analysis should include a projection of costs and numbers of new HMO's added over 10 years for each alternative—loan guarantees, direct loans and grants.

3. Overcoming Legal Obstacles to Reform

(a) The Problem.—There are two broad categories of legal obstacles to reforms that the Review Group (and most others concerned with this field) agree cause serious delivery system problems.

(1) Restrictions on group practice exist in many States. These vary in kind, but their usual effect is to make it illegal or difficult for physicians to engage in group practice, or for insurance or medical institutions to sponsor Health Maintenance Organizations (HMO's).

(2) Restrictive health manpower licensing practices. Laws which limit the practice of medicine via licensing or which define the functions that licensed personnel may perform also prevent the efficient use of health manpower in many States.

(b) The Federal Role.—Several considerations should be kept in mind in deciding upon the appropriate Federal approach to minimizing these problems:

—The organization of health care and the use of health manpower are in a state of flux. Variety and experimentation are needed. The Administration should avoid freezing in a single approach.

—Any action in these areas is an intrusion upon a traditional State function. The Constitutional, legislative, and judicial waters are uncharted as to where new types of Federal actions are warranted. And the political prospects of major action are uncertain.

—the medical profession, however, including the American Medical Associations and the American Hospital Association, are agreed that reforms are needed.

The Department of HEW, OEO, VA, and the Review Group are nevertheless agreed that any strategy should attempt to:

—Remove barriers to group practice and other new forms of health organization and delivery, but without limiting the range of experimentation.

—Reduce restrictive licensing practices and provide maximum flexibility for physicians, HMO’s, hospitals and others to use physicians’ assistants and other health sub-professionals.

—Encourage the training, recruitment and deployment of physicians’ assistants and other allied health personnel.

(c) Options.—There are three major alternative strategies which HEW could be asked to develop in more specific terms for inclusion in a 1971 health strategy.

(1) Rely principally on “moral suasion” and other forms of leadership to urge States and private organizations to amend restrictive laws and effect other reforms. The principal hazard with such an approach, of course, is that it may have no effect.

(2) Develop an array of “carrots and sticks” to push the States toward
changes. For example, make major health programs (e.g., Medi­
caid, Hill-Burton) available only to States that adopt specified kinds
of reforms, such as eliminating prohibitions to group practice or
the use of physicians’ assistants under defined types of conditions.
A similar approach would make new grants available to support
experimental programs in these areas. This strategy would probably
be more effective than Option (1), but it could make programs
complicated to administer, and might seem to attach “irrelevant”
conditions to basic health care programs.

(3) Arrogate to the Federal Government a substantially larger share
of the basic law-making and licensing authority in this area, in
effect, “preempting” the field. This might include Federal licen­
sure of medical sub-professionals and of HMO’s. This is likely to
be the most direct and potentially effective route, but it would have
many political and Constitutional risks.

4. Geographic Distribution of Medical Care—Manpower and Facilities
(a) The Problem.—Merely increasing the supply of doctors will not solve
the problem of geographic maldistribution of medical resources. Cur­
rently, 37% of all U.S. counties have less than a third as many doctors
per capita as the National average.

(b) The Federal Role.—The Federal Government has tried to influence the
geographic distribution of medical care through a smorgasbord of pro­
grams. We provide direct Federal services to 415,000 American Indians;
support 250 OEO and HEW health centers, mostly located in scarcity
areas; and fund 131 health programs for migrant workers. The Hill­
Burton program includes special incentives for the location of hospitals
in rural areas, but construction of facilities in these areas has often
failed to attract physicians. There is also statutory authority for for­
giveness of loans for nurses and physicians who practice in shortage
areas. (The program for medical students has not been successful, but
it has been limited by the fact that the forgiveness is available only for
practice in a rural poverty area. The program for nurses has been much
more successful).

(c) Options.—If the Federal Government wants to go further in providing
health care resources in scarcity and poverty areas, the Review Group
would put forward two options, both of which would involve addi­
tional direct Federal spending.
(1) The first option is to establish “Health Education Centers” in
scarcity areas which would be satellites of university-based medi­
cal schools. These centers would provide a base for patient care,
clinical training for medical students and residents, and continuing
education programs for health personnel. Specifically, the proposal
would involve construction grants to assist in the conversion of
non-teaching community facilities (HMO’s, community hospitals,
neighborhood health centers) into teaching facilities, together with
incentive grants to university health and science schools to encour­
age them to sponsor such affiliated centers. These centers would be
located in selected rural and poverty areas which could tie into planning now underway within the Administration for a "National growth policy."

The proposal is similar to a recommendation in the recent medical education report of the Carnegie Commission. If we set as a first step 20 centers in fiscal year 1972, the cost would be $40 million.

(2) The second option for improving the geographic distribution of health resources relates to the section above on Health Maintenance Organization (HMO's). Specifically, HEW proposes that financial incentives be provided to encourage the development of HMO's in scarcity areas.

(d) Health Service Corps.—An issue related to the geographic distribution of health resources is the pending legislation for a National Health Service Corps, which would provide two-year Federal personnel on a voluntary basis to deliver health services in scarcity areas. The bill passed the Senate 66-0 and is likely to be enrolled this year.

Reasons for signing it are: (1) that it would help serve poverty and scarcity areas; and (2) that it would capitalize on the social motivation of many young health professionals.

Reasons against are: (1) that it puts the Federal Government in the business of providing care directly; (2) that it contains a draft exemption, contrary to our policy; and (3) that it looks to be a typical "Great Society" approach with high drama, low dollars, and little assurance that it will work.

5. Disease Prevention through Research and Education—Financed by an Increased Tobacco Tax

(a) The Federal Role.—Disease prevention through research and education is of high priority, both for itself and as a means of reducing the pressure of demand on health care resources and prices. These activities are not provided in sufficient amount in the private market and require collective action, thus a clearly appropriate area for governmental action (and because of economic "spill-overs" and economies of scale), particularly Federal Government action.

(b) Option.—Secretary Richardson has proposed an increase in the Federal excise tax on cigarettes sufficient to raise the retail price by 20% (the tax is now 8 cents per pack) to finance health research and education activities, such as:

—Cancer and other disease research;
—Expanded citizen education on health including the effects of smoking; and
—Aid for delivery system reforms and the training of medical manpower.

The Secretary's proposal states:

"Through a measured increase in the excise tax now imposed on cigarettes, we propose to promote the public health by encouraging a reduction in cigarettes consumption within the United States."
The reduction will be of a size that will neither (a) impose sudden, drastically adverse economic effects on farmers, factory workers, or the tobacco industry, or (b) encourage widespread public evasion."

Such a tax would yield $860 million and HEW estimates would produce 13.5 billion hours of life gained per year.

If a decision is made to pursue this initiative seriously, it should be discussed with the Department of Agriculture. (HEW's proposal envisions that a portion of the added revenues would be used for training and relocation assistance to compensate for anticipated tobacco industry losses.)

Arguments in favor of the increased cigarette tax are:

(1) The proposal could save 13.5 billion hours of life per year, materially reduce the extent of disability from ailments associated with smoking, and effect reductions in the demand for health care services.

(2) The proposal appears to be the only one to reduce smoking for which there is both the statistical support of effectiveness and a reasonable possibility of congressional acceptance.

(3) There is some precedent for linking a preventive device with a revenue raising device, e.g., the Administration's proposed tax on polluters and leaded gas.

(4) It would generate revenues to cover many of the possible health initiatives in this paper. We would be setting an example of financing our proposals and could argue that any Congressman who wanted to outbid us would likewise have to show his source of revenue.

Arguments against the increased tax are:

(1) Excise taxes are regressive, bearing most heavily on the poor.

(2) The "elasticity" of cigarette demand may not operate effectively on persons whose income is such that the additional cost is of no consequence.

(3) Reduction of cigarette consumption will have an adverse effect on farm families, the cigarette industry workers, the cigarette companies, and two States.

(4) During the last decade, while Federal cigarette tax receipts have increased by less than 10 percent, State tax receipts have more than doubled. The smoking deterrence purposes of the proposal are, therefore, being accomplished by the States. Moreover, because of the economic effects of excise taxes, an increase in the Federal excise tax on cigarettes may impede future State increases, and thereby deprive States of needed revenues.

6. Oversight Body for Health Research

(a) The Problem.—The Federal Government currently spends $1.6 billion on research that is related to health and medical care. This ranges from fundamental studies in theoretical chemistry sponsored by the National Science Foundation to very practical experiments in applied health care supported by NIH. Yet this vast research enterprise has never had a
coherent policy or a body to guide it. Particularly in an era of tight budgets, it is important to ensure the optimal use of Federal funds in this field.

(b) The Federal Role.—The Federal Government provides 60% of all funds spent in the U.S. for health research. Health research funds are spent principally in medical schools, universities, and other non-profit institutions. There is a strong National interest in the annihilation of cancer, heart disease and other dread killers, as well as in combating tooth decay and the common cold. The support of biomedical research is an appropriate Federal function because the benefits accrue to all the people.

(c) The President could establish a broadly-based Health Research Policy Advisory Committee, consisting of outstanding researchers, scientists, and physicians in the Federal employ and from universities and the private sector, as well as economists and public administrators experienced with the relationship between program expenditures and results in the public sector.

The purpose of the Committee would be to advise the President, perhaps through the Director of OMB and the President’s Science Advisor, and the agency heads most directly concerned (HEW, NSF, OEO, DOD) on the direction of Federal policy in health research and on the optimal use of available funds. The Committee could at the same time serve as a “board of overseers” for the key health research agencies—NIH, NIMH, NSF, and VA.

The biggest drawback to this proposal is that the Committee could become an “advocacy group” pleading for more money, or be so abstractly scientific as not to be helpful to policy makers.

However, assuming that these tendencies can be curbed, this proposal has the advantages of: (1) being a bold step to give direction to powerful Federal agencies now conducting biomedical research; (2) having a low (or no) budget impact; and (3) giving the Administration an opportunity to highlight health research innovations in fields such as cancer, heart, and others.

7. Family Health Insurance

(a) The Federal Role.—Consistent with FAP and the Administration’s “income strategy”, the President on June 10, 1970 proposed to the Congress a Family Health Insurance Program (FHIP).

The President said legislation would be submitted at the beginning of the next Congress:

“to establish a Family Health Insurance Program for all poor families with children. This insurance would provide a comprehensive package of health services, including both hospital and outpatient care.”

(b) Relationship between FHIP and Health Services.—A critical point about this Presidential initiative is that it must be linked with (and preceded by) efforts, such as those in sections (1) through (6) above to increase the supply of factors needed to provide health care (doctors, physicians’ aides, health service institutions).

If FHIP goes into effect by fiscal year 1973, or fiscal year 1974, the acid test of health policy in 1971 is:
Can we increase the supply of health care services in the short-run so that this time a new financing system will not just be dissipated in higher prices?

(c) Elements of FHIP Plan Design.—In designing a health financing scheme such as FHIP, there are six key variables. They are:

1. **Cut-off level**: Up to what income level are families to be subsidized, e.g., $5,000, $8,000?

2. **Scope**: What kind of services will be included, e.g., hospital only, physician services, dental care, eyeglasses?

3. **Duration**: What limits, if any, will be placed on the services paid for, e.g., 14 days of hospital treatment, 12 outpatient visits, no limits?

4. **Premium**: What regular contribution, if any, does the family covered make in advance to the scheme?

5. **Deductibles**: At what stage does the family become entitled to benefits, e.g., after paying $100 out-of-pocket, after a family member is in the hospital one day?

6. **Co-insurance**: Once benefits begin, what part of the bill, if any, does the family pay, e.g., none, 20%, 30%?

At any given level of total Government expenditure, if any of these variables is moved in the direction of expanding benefits, another must be moved to contract them. If more families are to be subsidized, then some families must get less subsidy. If more benefits are to be included, then some durational limit must be put on them, or the deductible increased, or the family’s share of the payment (co-insurance) increased, or the premium increased.

(d) The Cost of FHIP.—When FHIP was announced, it was understood that it would absorb the cost of Medicaid in the year of its initiation.

At the November 10 meeting of the Domestic Council, Secretary Richardson made a proposal for FHIP which would include families up to $8000 income (part of the blue collar group), adding $3.0 billion to the Federal cost of Medicaid. (Present cost about $2.0 billion.) His proposal has been used as a basis for analysis in the sections which follow.

The Health Policy Review Group has established a FHIP cost-estimating Task Force under the direction of the CEA which will be available to analyze whatever alternative plan and cost combinations are felt to warrant further study.

(e) Three Options.—Below are three plans which demonstrate the range that can be obtained by possible combinations of the variables as listed in section (c) above. For purposes of illustration, each plan provides the same package of medical services (with an average value of $800 per family). Families with incomes under $3000 pay nothing at all, with the Federal subsidy decreasing gradually as income increases above $3000 in order to maintain the incentive to work. The gross Federal cost of each of the three programs is the same, $5 billion per annum ($3 billion more than Medicaid).

The major difference among the three plans is the extent to which a family pays for medical care through a fixed premium and the extent to
which a family spends money when it actually receives medical care.

The choice among the three plans depends in large part on how much the role of FHlP is to encourage low-income families to seek medical care and how much it is to protect families from the financial burden of large medical bills.

**Option I—High Premium/No Price for Medical Care**

Under this option, families would pay premiums on a sliding scale basis, paying more as income rises. They are then eligible to receive the specified set of medical services at no additional cost. By eliminating any charge for actually receiving medical care, this option puts primary emphasis on encouraging families to seek medical attention early in illness. Because its key characteristic is eliminating any charge for early medical care, less expensive programs using this approach must reduce coverage of the last dollars spent for medical care, leaving families exposed to catastrophic health expenses.

One disadvantage of this approach is that the high premium charged families in the upper income ranges may discourage them from joining the program.

**Option II—No Premium/Higher Price for Care**

Under this option, families would pay no premium or a very low premium, but instead pay a percent of their medical bills. There are two terms important to this plan which require definitions at this point in the discussion:

- the **deductible**, which is the portion of initial medical care charges which the family itself **fully** pays.
- the **co-insurance**, which is the proportion of a family's medical care bills which it pays above the amount of the deductible.

Under this second option, there is no premium, but there are these two types of charges which families above $3,000 must pay; thus, in effect, introducing a "price" for medical care, which many experts believe is necessary to prevent overutilization of services.

According to the schedule of deductibles and co-insurance in the table on page 140, the co-insurance rate is higher for higher income families. Above the co-insurance range shown in the table, expenditures are reimbursed fully by the Government, thus taking care of catastrophic health expenses.

**Discussion of Options I and II**

Because under Option II families with income over $3,000 pay a price for medical care at time they receive it, they will tend to use less care than under Option I, where families obtain free care once they have paid the premium. As already noted, this is considered to be an advantage of Option II by those who fear that families will over-utilize medical care if it is free. It is considered to be a disadvantage by those who feel that lower and middle income families will not seek adequate preventive care if they must pay anything for it.

Our illustrative examples used in this report blur these basic differences in approach, since the package of medical services is the same in
What the family would pay

<table>
<thead>
<tr>
<th>Family income</th>
<th>Premium</th>
<th>Deductible</th>
<th>Coinsurance rate</th>
<th>On charges between</th>
<th>Value of insurance protection</th>
<th>Federal subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0-3,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$800</td>
<td>$800</td>
</tr>
<tr>
<td>4,000</td>
<td>$200</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>800</td>
<td>600</td>
</tr>
<tr>
<td>6,000</td>
<td>500</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>800</td>
<td>300</td>
</tr>
<tr>
<td>8,000</td>
<td>800</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>800</td>
<td>0</td>
</tr>
</tbody>
</table>

Option II

<table>
<thead>
<tr>
<th>$0-3,000</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>800</th>
<th>800</th>
</tr>
</thead>
<tbody>
<tr>
<td>4,000</td>
<td>0</td>
<td>$150</td>
<td>25%</td>
<td>$150-700</td>
<td>600</td>
<td>600</td>
</tr>
<tr>
<td>6,000</td>
<td>0</td>
<td>475</td>
<td>45%</td>
<td>475-1475</td>
<td>300</td>
<td>300</td>
</tr>
<tr>
<td>8,000</td>
<td>200</td>
<td>700</td>
<td>60%</td>
<td>700-2000</td>
<td>200</td>
<td>0</td>
</tr>
</tbody>
</table>

Option III

<table>
<thead>
<tr>
<th>$0-3,000</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>800</th>
<th>800</th>
</tr>
</thead>
<tbody>
<tr>
<td>4,000</td>
<td>$150</td>
<td>$50</td>
<td>20%</td>
<td>$50-150</td>
<td>750</td>
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<tr>
<td>6,000</td>
<td>325</td>
<td>150</td>
<td>25%</td>
<td>150-450</td>
<td>625</td>
<td>300</td>
</tr>
<tr>
<td>8,000</td>
<td>500</td>
<td>250</td>
<td>30%</td>
<td>250-950</td>
<td>500</td>
<td>0</td>
</tr>
</tbody>
</table>

all plans. A more extreme example of Option I is a plan which limits hospital insurance coverage to say 14 days. A more extreme form of Option II is a plan with a high deductible, for example, a plan that only covers hospitalization in excess of 14 days.

Option III—Medium Premium/Medium Price

This approach is one of the many possible compromises between Options I and II. As shown in the table above, families would pay a premium which is lower than under Option I, and a higher percent of their medical bills, although a lower percent than under Option II. This plan, therefore, encourages families to use less medical care than does Option I, but more than Option II.

A variation which could be used in any plan is to define a deductible in terms of services rather than dollars. This enables the plan to discourage the use of some kinds of services without discouraging the use of others. A deductible of one hospital day rather than $75, for example, will discourage hospitalization but not routine physical examinations.

The Blue Collar Worker and FHIP.—The three options discussed here were developed with the objective of providing some help to blue collar workers. This is an important consideration which should be focused upon in the discussion of these three options and possible variants.

Part IV: Next Steps

Secretary Richardson in his memo to the President November 10 proposed a “sequence of events” on health in 1971 which would include:

(1) a section in the State-of-the-Union Message;
(2) a Presidential television address on health;
(3) a simultaneous detailed report on the Administration’s health strategy ("Brandeis Brief");
(4) a Presidential message transmitting new legislation to the Congress; and
(5) a series of White House meetings in the spring and summer with health leaders.

If we are to make this kind of major effort, a number of steps are suggested which flow from this report.

As a first step, a decision should be made about the general approach for FHIP. Specifications and legislation should be drafted accordingly.

Second, contingency plans should be developed for combining FHIP with a re-introduced, and possibly revised, Family Assistance Program (FAP) in the 92nd Congress. This bill could include other revisions of the Administration’s “income strategy” approach to social policy besides FHIP.

Third, other possible Presidential health initiatives, along the lines contained in this report, could be developed and prepared for discussion by HEW, VA, OEO, DOD, and others. This report, prepared over a short period of time, could not fully cover all available decision options in health.

Fourth, if Presidential decision-items included in this report are determined to be desirable initiatives, work should be started to spell out legislative and administrative specifications.

Fifth, work should also be undertaken to develop in a full and detailed form an analysis of the Administration’s achievements to date in health to be included in messages and reports next year. A similar effort should be undertaken as regards programs which we decide to reduce significantly or terminate, making the point that we have the will and clarity of purpose necessary to decide priorities and terminate programs that are not sufficiently important to be continued as part of the Administration’s 1971 health strategy.

Members of the Health Policy Working Group

Dr. Edward J. Burger, Jr.
Office of Science and Technology

Mr. Lewis H. Butler
Department of Health, Education, and Welfare

Mr. Chester E. Finn, Jr.
White House

Dr. Irene Lurie
Council of Economic Advisers

Mr. Donald H. Murdoch
Office of Economic Opportunity

Mr. Robert E. Patricelli
Department of Health, Education, and Welfare

Dr. Benjamin B. Wells
Veterans Administration

Mr. John F. Evans
White House

Dr. Jesse L. Steinfeld
Department of Health, Education, and Welfare

Mr. Paul H. O’Neill
Office of Management and Budget

Dr. Richard P. Nathan, Chairman
Office of Management and Budget